Alabama's Application Certification Statement - Section 1115(a) Extension 2021

This document, together with the supporting documentation outlined below, constitutes Alabama's application to the Centers for Medicare & Medicaid Services (CMS) to extend the 1115 Family Planning Waiver Demonstration for a period of five (5) years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

___X___ Section 1115(a) extension with program changes

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period November 27, 2017 through September 30, 2022 (i.e., Demonstration Years 18, 19, 20, 21 and 22).

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Section A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

- **Section B:** A narrative of the changes being requested along with the objective of the change and desired outcomes.

- **Section C:** A list and programmatic description of the waiver and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

- **Section D:** 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 and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

- **Section E:** Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.

- **Section F:** An evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

- **Section G:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115(a) Extension Application Attestation
2. **Attachment A** Covered Services
3. **Attachment B** Covered Nicotine Products
4. **Attachment C** AL FP Extension STCs
5. **Attachment D** AL FP Extension Expenditure Authority
6. **Attachment E** EQRO Report
7. **Attachment F** Annual Plan First Evaluation Report Demonstration Year 20
8. **Attachment G** Tribal Government Notice
9. **Attachment H** Six (6) Month Post Award Public Forum Questions and Answers
10. **Attachment I** Annual Public Forum Presentation
11. **Attachment J** Full Public Notice

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: [redacted] **Date:** 12-2-2021

[Governor]

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

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Signature:_____ **Date:**_____
[Governor]

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Section A: Historical Narrative

A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

The current Plan First 1115 Demonstration Waiver was approved for five (5) years, effective December 27, 2017 through September 30, 2022.

Historical Narrative of the Demonstration Project

Historical Narrative Summary

The Alabama Medicaid Agency (Medicaid) Plan First demonstration was initially approved on July 1, 2000, and implemented October 1, 2000. The demonstration has been consistently extended since that date. At its inception, the Alabama Plan First Program was implemented to provide family planning services to women whose Medicaid eligibility for pregnancy had ended and for those women who would not otherwise qualify for Medicaid unless pregnant, with an income at or below 141 percent of the Federal Poverty Level (FPL).

With the December 2014 extension of the demonstration, the State was approved to provide two new services: 1) removal of migrated or embedded intrauterine devices in an office setting or outpatient surgical facility, and 2) coverage of vasectomies for males 21 years of age or older with income at or below 141 percent of the FPL.

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

On June 15, 2017, Medicaid submitted a request to extend the demonstration for a five-year period with no program changes. CMS is approving this extension request through September 30, 2022, as agreed upon with the State, to realign Plan First's annual demonstration cycles back to the original date of implementation. The Special Terms and Conditions (STCs), accompanying the CMS approval letter, permit section 1115 demonstration authority for the Plan First demonstration through September 30, 2022. The program's overall goal is to reduce unintended pregnancies.

Inception

The Plan First Program was predicated on the recognized need for continued family planning services once Medicaid eligibility for pregnancy ended and for those women who would not

otherwise qualify for Medicaid unless pregnant. Women were able to obtain family planning services during their pregnancy related eligibility period, but often lost benefits when postpartum eligibility ended. The Plan First Program afforded the state the ability to extend Medicaid eligibility after the birth of the baby and provided an avenue for extending eligibility to women who may not otherwise qualify for Medicaid.

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. Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services. There are to be no co-payments on prescription drugs/supplies that are designated as family planning.

When the program began, approximately 60,000 women were automatically enrolled. Enrollment increased steadily for the first five years of the program to over 100,000 women, after which there was a decline. The requirement to re-enroll annually, which was implemented in the beginning of the second demonstration period, caused enrollment initially to decline, as did the requirement for citizenship and identification in 2006. The Alabama Medicaid Agency (AMA) implemented a Social Security Administration data match, effective January 2010, to verify citizenship. This has helped streamline the enrollment process. In February 2013, AMA implemented automated Express-Lane Eligibility (ELE) renewals for Plan First women as well as children. This expedited renewal process, completed by the system, requires no participation from the case worker or recipient, enhancing the enrollment process.

Enrollment Process

AMA uses the Federal hub services (IRS, SSA, Equifax), SSN, citizenship and alienage, Department of Homeland Security (DHS) as well as other sources (SVES, SDX, PARIS, SNAP, TANF, EDB, vital statistics, etc.) to verify income and other points of eligibility as listed in the Alabama verification plan.

AMA 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, AMA 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/Children's Health Insurance Program (CHIP) MAGI (Modified Adjusted Gross Income) 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 will be

transferred to Federally-facilitated Marketplace (FFM) for Advance Payments of the Premium Tax Credit (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 based on attestation and account will be 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 based on attestation. 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 documentation, the individual will be determined ineligible for Medicaid/CHIP, and account will be transferred to FFM for APTC eligibility.

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.

Population Groups Impacted by the Demonstration

Services under this Demonstration are designed to improve the well-being of children and families in Alabama by extending Medicaid eligibility for family planning services to eligible women between the ages of 19-55 whose income is at or below 141% of the Federal Poverty Level (FPL). A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

Eligible individuals are also men ages 21 or older who meet the eligibility criteria described below. Men can receive vasectomies/vasectomy related services only under this Demonstration. Below describes the population groups impacted by the Demonstration.

Group 1. 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, 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 recertification of their children. Eligibility is re-determined every 12 months.

Group 3**.** Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application.

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. AMA 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.

For Groups 1-3: Women can check on their initial application whether they want to renew their eligibility automatically up to 5 years using income data from tax returns.

Group 4. Males, ages 21 and older, wishing to have a vasectomy 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.

Services and Supplies Provided

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

a) FDA-approved methods of contraception, and vasectomy services for men;

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

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

d) Contraceptive management, patient education, and counseling, including care coordination services that provide enhanced education on appropriate use of the chosen family planning method and further assurance of correct and continued usage to address impediments to successful family planning. These care coordination services will be provided to female enrollees identified by providers as "high risk" or "at risk" for an unintended pregnancy and male enrollees seeking vasectomy services. Care coordination services include:
    i. Assistance with arranging a family planning visit;
    ii. Locating appropriate Medicaid doctor to perform sterilization procedures;
    iii. Assistance with referrals, making appointments, and follow-up to ensure appointments are kept, including subsequent family planning visits;
    iv. Provision of answers to general questions about family planning;
    v. Family planning education utilizing the standardized educational model (PT+3) for providing information in a manner that meets the recipients' level of understanding; and,
    vi. Counseling regarding problems with the selected family planning method.

Eligible men qualify for doctor/clinic visits related to vasectomy services only as a waiver service. The Plan First Program does not cover any other medical services, and individuals who have been previously sterilized are not eligible to participate in this program. Reference Attachment A: Covered Services for a listing of covered services for the Plan First Program.

Individuals eligible under this demonstration are also eligible to receive smoking cessation services and products as authorized in Alabama's approved Medicaid State Plan and provided by the Alabama Department of Public Health, through partnership with the Alabama Medicaid Agency. Recipients may also receive smoking cessation services through the Alabama Tobacco Quitline. The Quitline offers online and telephone counseling services at QuitNowAlabama.com for any Alabamian who is ready to quit tobacco use. Those who begin counseling can receive, if medically eligible, a free, eight-week supply of the nicotine patch to assist in their attempt to quit. The Quitline is not a waiver service. Reference Attachment B: Covered Nicotine Products for a listing of covered smoking cessation (nicotine) products.

Cost-sharing

Recipients are exempt from co-payment requirements for family planning services. There are no co-payments on prescription drugs or supplies that are designated as family planning.

Recent Program Changes

Care Coordination Transition

Family Planning Care Coordination was transitioned from the Alabama Department of Public Health (ADPH) to seven Alabama Coordinated Health Networks (ACHNs) organizations in October 2019. ACHNs receive monthly assignment file reports of all Plan

First/Family Planning eligible individuals (EIs). Care Coordinators utilize these reports to attempt outreach to EIs and to offer Family Planning Care Coordination services.

Although the care coordination was transitioned to the ACHNs, currently all counties within the State continue to have public provider options for Plan First services.

PHE Impact

As a result of the Center for Medicaid and Medicare Services (CMS) adjusting some policies for Medicaid due to the COVID-19 Public Health Emergency (PHE) beginning in March 2020, many services, particularly case management and care coordination services, were provided telephonically rather than face to face In accordance with the policy adjustments, AMA allowed a shift to telephonic service delivery instead of the required face-to-face visit(s) for both care coordination services and contraceptive visits. AMA will continue to allow the telephonic service delivery option for some of these services after the expiration of the PHE.

Additionally, enrollees who would typically enter Plan First from maternity care coverage under SOBRA, retained their SOBRA coverage during the PHE.

Dual Enrollment

Medicaid began allowing dual enrollment for care coordination services. However, family planning services can only be provided to maternity EIs during the month of delivery and after to facilitate early engagement with the family planning service options. Dual enrollment allows family planning care coordination to begin at the hospital after the birth which helps in the continuity of care as well as positively impacts enrollment.

Evaluation Design Changes

In March 2021, CMS approved Evaluation Design changes to better reflect the data now being captured for services provided by the ACHNs. This resulted in a partial DY 20 Annual Monitoring Report being submitted to CMS in June 2021.

Approved Demonstration Objectives and Evaluation (Findings)

AMA identified six objectives, goals and corresponding hypotheses for Demonstration Years 18, 19, 20, 21 and 22. The objectives, goals and findings (how these goals were met /not met) are outlined below.

Objective 1. Increase the enrollment of women eligible for Plan First and reduce race/ethnicity and geographic disparities in enrollment.

Goal: The program goal is to enroll 80% of eligible women under age 40 into Plan First.

Hypotheses: We anticipate that the composition of the enrolled population will be demographically similar to the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not

expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we anticipate lower enrollment rates among older women compared to younger women.

Findings: During this demonstration period, most of the women who enrolled in Plan First the previous year, renewed their enrollment the following year. However, Alabama Medicaid has not reached its program goal to enroll 80% of eligible women under age 40 into Plan First.

A factor to consider that may have impacted this is that family planning care coordination services transitioned to the ACHNs on October 1, 2019. The ACHNs are not as established in care coordination service provision as the previous provider. Prior to this transition, these services were provided by the Alabama Department of Public Health (ADPH). The table below provides the evaluation summary for the previous demonstration years. However, with this transition, the ACHNs have developed region specific care coordination communications, (e.g., brochures, one-page informationals) that have placed throughout the community and, in many instances, been in physician's offices. This information has also been made available in electronic formats to increase accessibility to the information.

The table below lists this goal's findings summary for each completed year included in the current demonstration period as stated in each of the Plan First Program's Annual Monitoring Reports.

Table 1.1. Annual Monitoring Reports Summary Findings Related to Enrollment Increase of Women Eligible for Plan First and Race/Ethnicity and Geographic Disparities Reduction in Enrollment

Demonstration Year (DY)	**Evaluation Summary** Source: Plan First Program Annual Monitoring Reports
DY18	Among the population of potentially eligible women in Alabama, Plan First enrollment falls short of the enrollment goal. Enrollment is lower than the statewide average for women ages 45 and older, women who are not Black or identify as more than one race, and women living in the Northern public health district. However, nearly two-thirds of women who enrolled in Plan First in DY17, renewed their enrollment the following year.
DY19	Among the population of potentially eligible women in Alabama, Plan First enrollment falls short of the enrollment goal. The goal for enrollment is that 80% of potentially eligible women enroll. We estimate that about 30% of eligible women did so. About 60% of women who enrolled in Plan First in DY18, renewed their enrollment the following year, and this is lower than the

	re-enrollment rate in the previous year. New enrollments in Plan First were also lower than in previous years.
DY20	Enrollment in Plan First remains significantly below the goal of 80% of eligible women. Enrollment declined 12.5% between DY 19 and DY 20. This was primarily due to a 53% decline in new enrollees. Many new enrollees in Plan First are flips from other Medicaid eligibility categories, particularly SOBRA coverage during pregnancy. Changes in enrollment and disenrollment policies in place in 2020 in response to the PHE Maintenance of Effort requirements are likely explanations for much of this change in enrollment.

Objective 2. Maintain a high level of awareness of the Plan First Program.

Goal: The program goal is that 90% of surveyed enrollees will have heard of Plan First and 85% will be aware that they are enrolled in the program.

Hypotheses: Since Plan First is a well-established program, we expect that the majority of women enrolled will have heard of it and will be aware that they are enrolled.

Findings: As of DY19, AMA has met its goal of 85% of the Plan First Program enrollees surveyed were aware that they were enrolled. (The survey data DY20 is not available.)

The table below lists this goal's findings summary for each year included in the current demonstration period as stated in each of the Plan First Program's Annual Monitoring Reports.

Table 2.1. Annual Evaluation Summary Findings of Number of Plan First Enrollees with Program Awareness

Demonstration Year (DY)	**Evaluation Summary** Source: Plan First Program Annual Monitoring Reports
DY18	Overall awareness of Plan First remains quite high (>90%) among enrollees. However, just over 20% of enrollees are not aware of their enrollment status, including the 9% who report they have never heard of Plan First, and another 13% who have heard of the program but did not know they were enrolled. Some of these are women who are concerned about the safety and effectiveness of contraception and thus may not have an incentive to learn about Plan First. However, others are women who do use contraception, and have concerns about affordability and access to services, which reflect the fact that they are not aware of their enrollment status.
DY19	807 current Plan First enrollees were surveyed in the Fall of 2019 and the Winter of 2020. All respondents to the survey were aware of Plan First. The percentage of those who are aware of Plan First and know that they are enrolled in program meets the 85% target, although 12% of respondents were not aware that they were enrolled.
DY20	Survey data to assess this program goal is not yet available.

The table below is a summary of care coordination activities provided by ADPH for Demonstration Years 17-19.

Table 2.2. Summary of Care Coordination Activities Provided by ADPH for DYs 17-19

Plan First									
Care Coordination Activities Provided Summary									
Provider: Alabama Department of Public Health (ADPH)									
Time Period: DY2017-2019									
	Care Coordination Activity Completed								
DY	Recruitment	Unduplicated Patients	Face to Face	Phone	Documentation	Total Assessments	Low-Risk Assessments	High-Risk Assessments	Cases Closed
2017	10,483	53,323	9,253	7,195	124,276	23,750	8,306	15,444	8,797
2018	4,014	47,543	7,618	16,477	98,580	20,389	6,738	13,651	7,938
2019	0	41,866	6,965	13,269	88,573	17,656	6,415	11,241	12,834
Totals	**14,497**	**142,732**	**23,836**	**36,941**	**311,429**	**61,795**	**21,459**	**40,336**	**29,569**

The table below is a summary of care coordination activities provided by ACHNs for DY 20 and DY 21 (3rd quarter data).

Table 2.3. Summary of Care Coordination Activities Provided by ACHNs for DYs 20-21 (Q3)

Plan First									
Care Coordination Activities Provided Summary									
Provider: Alabama Coordinated Health Networks (ACHNs)									
Time Period: DY2020-DY2021 Q3									
	Care Coordination Activity Completed								
DY	Screened (Not Enrolled)	Unduplicated Patients	Face to Face	Telephonic	Total Encounters	Low-Risk Assessments	High-Risk Assessments	Total Assessments	Cases Closed
2020	1,664	1,874	1,973	672	2,645	1,306	1,339	2,645	3,041
2021	3,426	4,688	5,157	1,487	6,644	2,965	3,679	6,644	7,243
Totals	**5,090**	**6,562**	**7,130**	**2,159**	**9,289**	**4,271**	**5,018**	**9,289**	**10,284**

Objective 3. Increase Family Planning Service use among Plan First enrollees. Increase the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and in subsequent years.

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

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

Findings: AMA has not met the goal of 70% of Plan First enrollees using family planning services in the first year of enrollment and 60% using services in the subsequent years.

The table below lists the annual evaluation summary for each year within this demonstration period.

Table 3.1. Annual Evaluation Summary Related To Use of Family Planning Services Used By Enrollees in the Initial Enrollment Year and Subsequent Years

Demonstration Year (DY)	**Evaluation Summary** Source: Plan First Program Annual Monitoring Reports
DY18	Approximately 25% of women enrolled in Plan First had a claim for services, which is similar to the percentage using services in prior years of the program. Nearly two-thirds (64.8%) of women who were enrolled in Plan First and used clinical services in DY18 had a claim for a moderately or highly effective contraceptive method.
DY19	Overall, 35,180 enrollees in Plan First, or 34% of those enrolled, had a claim for services. This is similar to the percentage using services in prior years of the program. Overall, 21,466 Plan First enrollees had a claim for any moderately or highly effective contraceptive method in DY19. This was about 20% of the 103,281 DY19 Plan First enrollees, and 58% of the 35,180 Plan First users of any clinical services.
DY20	Claims data showing DY 20 use of care coordination services is not yet available.

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

Goal: The program goal is to have 85% of smokers receiving these services. Smoking cessation related coverage has been available in Plan First since 2012.

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

Findings: As of DY19, at least 85% of smokers were asked about smoking at family planning visit and 70% plans to quit smoking in the next year. The survey data related to the content of smoking cessation discussions at family planning visits is not yet available for DY 20. However, the table below shows the cumulative data available.

Table 4.1. Smoking Among Plan First Participants and Content of Smoking Cessation Discussions at Family Planning Visits (Cumulative)

Survey Questions	**DY17*** N (%)	**DY18** N (%)	**DY19** N (%)	**DY20** N (%)
	baseline			
Reported Smoking	534 (26.0)	190 (24.2)	179 (22.8)	Not available
Asked about smoking at FP visit	488 (91.4)	174 (91.6)	160 (89.4)	Not available
Advised to quit by FP provider	402 (82.4)	133 (76.4)	124 (69.3)	Not available
Received NRT	233 (47.7)	--	--	Not available
Referred to Quit Line	265 (54.3)	88 (50.6)	76 (42.4)	Not available
Received either NRT or Quit Line referral	316 (64.7)	--	--	Not available
Paid out of pocket for NRT products	57 (11.7)	25 (14.4)	22 (12.2)	Not available
Provider recommended NRT^	--	76 (43.7)	87 (48.6)	Not available
Discussed how to quit with FP provider^	--	--	88 (49.2)	Not available
Plans to quit smoking in the next year^	--	139 (72.8)	127 (70.9)	Not available

-- Not asked in Enrollee Survey
* Results for DY17 represent the average of those reported in DY15 and DY16, as a separate survey was not conducted for this reporting year.
^Among women who reported smoking

However, the provisional table below, Table 4.2 assumes that the same proportion of individuals used services in DY 20 as in DY 19 (34%), and the same portion of these service users are smokers as found in DY 19 (22.8%). Based on these provisional assumptions, only half a percent of clinical service users had a claim filed for a Nicotine Replacement Therapy (NRT) product.

Table 4.2. Smoking cessation based on claims

	DY17 (Baseline)		DY 18		DY 19		DY 20	
	N	%	N	%	N	%		
Plan First service users	52,359		39,196	--	35,180	--	31,267*	--
Estimated number of smokers (based on survey data)	13,613		9,485	24.2	8,021	22.8	7,129	22.8*
Service users with claims for covered NRT products (% of estimated number of smokers)	167		102	1.1%	63	0.8%	38	0.5%

Objective 5. Maintain low birth rates among Plan First users.

Goal: Maintain birth rates among Plan First participants that are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

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

Findings: Birth rates remain much lower with the Plan First program than estimated to be, based on pre-program birth rates. Birth rates were lower for clinical service users than for enrollees who did not use services. The tables below shows the related historical data.

Table 5.1. Averted Births Data

Demonstration Year (DY)	Plan First Enrollees	Estimated Births At Pre-Waiver Fertility Levels	Actual Births	Births Averted with Waiver
DY 14	148,060	30,071	10,720	19,351
DY 15	128,473	25,271	8,055	17,216
DY 16	131,302	23,949	7,966	15,983

DY 17	119,432	21,128	5,542	15,586
DY 18	116,671	18,692	4,161	14,531
DY 19	103,281	16,484	5,257	11,227

Note: DY 20 information is not available yet because births are counted through 9 months after the end of the year.

Table 5.2. Estimated and actual birth rates to women enrolled in Plan First (claims data)

Demonstration Year (DY)	**Estimated birth rate if fertility rates continued at pre-waiver levels***	**Actual birth rates <u>all enrollees</u> – pregnancies starting during DY**	**Actual birth rates <u>service users</u> – pregnancies starting during DY**	**Actual birth rates <u>non-service users</u> – pregnancies starting during DY**
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9
DY15	196.7	62.7	61.0	63.9
DY16	182.4	60.9	63.1	59.0
DY17	176.9	46.4	34.5	53.6
DY18	160.2	42.4	40.8	43.1
DY19	159.6	51.0	49.0	52.1

*Adjusted for age and race

Objective 6. Increase male enrollment and vasectomy service use. Increase enrollment of men eligible for Plan First and the portion of the male enrollees undergoing vasectomy services. Activities to achieve this objective includes assisting with the application process for Plan First through AMA, identifying Medicaid approved vasectomy providers, facilitating the initial appointment process, and providing appointment reminders.

Goal: The goal is that the number of men enrolled in Plan First for vasectomies and vasectomy related covered services will increase by 10% annually; 85% of male Plan First enrollees will receive care coordination services; and 75% of male enrollees will undergo the procedure within the enrollment year. This goal will be evaluated based on the number of male enrollees, claims for care coordination and sterilizations performed statewide.

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

Findings: During DY20, that male enrollment in Plan First increased almost 10% between Demonstration Year 19 and Demonstration Year 20, in line with program goals. Enrollment of males has increased each year since DY15, the inception of male enrollment for family planning services through Plan First. Although the State has not met its 'undergo the procedure' goal, it and care coordination services continue to be benefits offered to enrollees.

Table 6.1. Percentage of men enrolled who obtained care coordination and vasectomy through Plan First (claims and enrollment data)

Demonstration Year (DY)	Activity	Enrolled N (%)	Obtained Vasectomy N (%)
DY15	Enrollment	n/a	0 (0)
DY16	Enrollment	823	14 (1.7)
DY17	Enrollment	1241	29 (2.3)
DY18	Enrollment	1159	34 (2.9)
	Care Coordination Received	21 (1.8)	21 (100)
	Did Not Receive Care Coordination	1138 (98.2)	13 (1.1)
DY19	Enrollment	1500	14 (0.9)
	Care Coordination Received	21 (1.4)	5 (23.8)

	Did Not Receive Care Coordination	1479 (98.6)	9 (0.6)
DY20*	Enrollment	1647	
	Care Coordination Received	14	
	Did Not Receive Care Coordination	1633	

n/a – information on gender was not included in the enrollment files
*-claims data not available to calculate actual vasectomy rates

Future Objectives and Goals of the Program

The State will continue to strive to improve its performance of the current goals. The evaluation objectives and goals for Demonstration Year 23 - Demonstration Year 27 are:

Objective 1. **Increase the portion of women eligible for Plan First who enroll and reduce race/ethnicity and geographic disparities in enrollment.**

Goal: The program goal is to enroll 80% of eligible women under age 40 into Plan First.

Objective 2. Maintain a high level of awareness of the Plan First Program. Maintain a high level of awareness of the Plan First program among enrollees.

Goal: The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be aware that they are enrolled in the program.

Objective 3. Increase Family Planning Service use among Plan First enrollees. Increase the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and in subsequent years.

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

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

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

Objective 5. Maintain low birth rates among Plan First users.

Goal: Maintain birth rates among Plan First participants, which are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

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

Goal: The program goal is that male enrollment in Plan First will increase by 10% annually; 85% of male Plan First enrollees will receive care coordination services; and 75% of male enrollees will undergo vasectomy within the enrollment year.

Section B: Narrative Changes

A narrative of the changes being requested along with the objective of the change and desired outcomes.

The Alabama Medicaid Agency will continue the Plan First Waiver in the same manner with the following anticipated change effective with the waiver renewal:

- Add, as a family planning service, the removal of migrated or embedded contraceptive methods, such as implantable contraceptives, in an office setting or outpatient surgical facility.

Currently, in accordance with this Waiver, AMA reimburses providers for family planning services only when rendered to enrolled family planning recipients. This includes the insertion and removal of implantable contraceptives. However, in instances where the implantable contraceptive has migrated or has become embedded, AMA does not reimburse because it is not a service included in the family planning program.

Although the removal is not covered and as required by AMA, the family planning provider refers the recipient to a specialist to determine the best approach for removal. The removal, in these instances, is not covered as a family planning service and because the recipient is a family only enrollee, therefore no additional medical coverage is provided by Alabama Medicaid. The cost of this service is shifted to the recipient because it is not a service covered for family planning only enrollees. This could become a deterrent for acceptance of contraception provided to family planning enrollees.

A prior authorization process could be established to ensure medical necessity when rendered in the office setting. The reimbursement for those provided in an outpatient setting would be essentially cost neutral due to the AMA's current hospital reimbursement model.

AMA is requesting that removal of migrated or embedded implantable contraceptives be covered as a family planning service and therefore, would provide reimbursement to providers in these instances.

Section C: Description of Waiver and Expenditure Authorities

A list and programmatic description of the waiver and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

Waiver Description

A list and programmatic description of the waiver is as follows:

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

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

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

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

4. Contraceptive management, patient education, and counseling, including care coordination services that provide enhanced education on appropriate use of the chosen family planning method and further assurance of correct and continued usage to address impediments to successful family planning. These care coordination services will be provided to female enrollees identified by providers as "high risk" or "at risk" for an unintended pregnancy and male enrollees seeking vasectomy services. Care coordination services include:
    a. Assistance with arranging a family planning visit;
    b. Locating appropriate Medicaid doctor to perform sterilization procedures;
    c. Assistance with referrals, making appointments, and follow-up to ensure appointments are kept, including subsequent family planning visits;
    d. Provision of answers to general questions about family planning;
    e. Family planning education utilizing the standardized educational model (PT+3) for providing information in a manner that meets the recipients' level of understanding; and,

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

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

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

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

Special Terms and Conditions (STCs)

Reference Attachment C: AL FP Extension STCs to view the Special Terms and Conditions (STCs) for applicable to the current waiver period of November 27, 2017 through September 30, 2022 (i.e., Demonstration Years 18, 19, 20, 21 and 22).

Expenditure Authority

Reference Attachment D: Expenditure Authority for the applicable expenditure authorities for the current waiver period of November 27, 2017 through September 30, 2022 (i.e., Demonstration Years 18, 19, 20, 21 and 22).

Also, listed below are the expenditure authorities for the current waiver period of November 27, 2017 through September 30, 2022 (i.e., Demonstration Years 18, 19, 20, 21 and 22):

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Alabama for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as

expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

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

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

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

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

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

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

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

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

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services and tobacco cessation services. Alabama Plan First CMS Approved November 27, 2017; Effective through September 30, 2022 Page 2 of 2

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

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

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

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

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

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

Section D: Summaries of State Quality Assurance Monitoring

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 and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

AMA has a consistent and coordinated framework for authority and oversight to deliver timely, appropriate quality family planning services to Medicaid recipients. The services under this Demonstration Waiver are administered by various providers; however, AMA maintains authority over monitoring and oversight of the Plan First Program.

The Demonstration Waiver has the following major goals for quality assurance and monitoring:

- To assure accessibility of family planning services to eligible recipients
- To assure that recipient assessments include the assessment and care plan appropriate for the risk level
- To assure that the family planning encounters provided through enrolled providers follows the guidelines in the Alabama Medicaid Provider Manual as well as Appendix C: Family Planning of the Provider Manual and the approved Waiver Demonstration.
- To ensure that an effective complaint and grievance system is in place for both providers and recipients
- To ensure quality and utilization management
- To ensure satisfaction of family planning services

State Quality Assurance Monitoring

Alabama Medicaid has several entities involved in its quality assurance monitoring strategy. Listed below are the descriptions of quality activities performed by the University of Alabama at Birmingham (UAB), Alabama Department of Public Health (ADPH), the Alabama Coordinated Health Networks (ACHNs) and the Alabama Medicaid Agency (AMA).

University of Alabama at Birmingham (UAB)

The Demonstration Waiver has provisions for UAB to assist in providing outcome and summary reports to support effectiveness of the Program. This will enable comparisons between different sectors of populations and historical data.

UAB conducts ongoing internal evaluations for this Demonstration Waiver. The primary contact person is Dr. Martha Wingate, Health Care Organization & Policy, University of Alabama at Birmingham. Her responsibility is to evaluate the program. UAB has designed data collection tools that collect, compile and analyze data, providing feedback annually to AMA and the Department of Public Health 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.

Alabama Department of Public Health (ADPH)

As before mentioned, ADPH provided family planning care coordination services to AMA's Plan First enrollees until September 30, 2019. A component of their monitoring process related to this care coordination was to conduct audits.

ADPH's monitoring process is as follows: Public Health Area supervisors audit Plan First care coordination patient records quarterly utilizing a standardized audit tool. These audits are submitted to the Public Health Central Office and are available for review by Medicaid. All care coordination patient records are documented electronically, and the Central Office conducts an annual desk review of the patient records for each Care Coordinator, submitting a written report to supervisors. Six weeks after Care Coordinators complete certification training, the Central Office training staff reviews their documentation and submits a 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.

The table below summarizes the number or audits completed for each Demonstration Year included in this Demonstration's period.

Table D.1. Family Planning Care Coordination Audits Summary (ADPH)

Plan First Family Planning Care Coordination Audits Summary ADPH			
Demonstration Year (DY)	**DY17**	**DY18**	**DY19**
Audits Completed	3,143	3,113	2,855
Compliance Rate	99%	95.25%	99%

Alabama Coordinated Health Networks (ACHN)

Alabama Medicaid implemented the Alabama Coordinated Health Networks (ACHNs) on October 1, 2019. This program was designed to create a single care coordination delivery system that effectively links patients, providers and community resources. This program consolidates the pre-existing case management programs of Maternity Care, Health Homes, and portions of Family Planning into seven Primary Care Coordination Management Entities (PCCM-E) that provide seamless, care coordination that focuses on quality and improved health outcomes of Alabama Medicaid's recipients. However, delivery of medical services is not component of this program.

For more information regarding the ACHNs, visit the Agency's website at: https://medicaid.alabama.gov/content/5.0_Managed_Care/default.aspx

Completion of compliance audits related to service delivery is a requirement for the ACHNs. The table below is a summary of family planning care coordination audits completed by the ACHNs for DY20 and DY21 (Q3).

Table D.2. Family Planning Care Coordination Audits Summary (ACHNs)

Plan First **Family Planning Care Coordination Audits Summary** **ACHNs**			
Demonstration Year (DY	**DY20**	**DY21 (Q3)**	**DY22**
Audits Completed	279	830	N/A
Compliance Rate	89%	89%	N/A

Alabama Medicaid Agency (AMA)
Clinical record desk reviews of services provided by the ACHNs, to monitor compliance with program guidelines, have been completed by the Agency's (AMA) Managed Care Operations (MCO) Audit Unit. The ACHN program was implemented on October 1, 2019. These audits monitor the compliance of the paid case management activities of the ACHNs. The recipient populations included were: general, family planning, and maternity. There is also a monitoring medical component of the audit.

The table below summarizes the family planning care coordination related deficiencies identified in the reviews conducted since the initial case management activities review of the ACHNs.

Table D.3. MCO Audit Unit Family Planning Related Deficiencies Identified and Audit Compliance Rate

Deficiencies Identified	**Occurrences Per Audit Period**			
	Jan-20	**Jun-20**	**Jul-20**	**Feb-21**
No Consent to Receive Services	**5**	**2**	**5**	**7**
PT+3 Teaching Method not Utilized for Family Planning Counseling	**10**	**3**	**1**	**0**
Care Plan Not Completed at Initial Encounter	**1**	**0**	**0**	**1**
No Care Plan	**1**	**0**	**0**	**1**

Psychosocial Assessment Identified Needs Not Addressed In the Care Plan	**4**	**3**	**2**	**0**
No Psychosocial Assessment	**0**	**0**	**0**	**2**
No Documentation in HIMS for Paid Date of Service (Risk Screening, Psychosocial Assessment & Care Plan)	**0**	**0**	**0**	**1**
Total Deficiencies Identified	**21**	**8**	**8**	**12**
Compliance Rate	**58%**	**77%**	**86%**	**91%**

Prior to the audit conducted in February 2021, education was provided to the ACHNs related to the deficiencies identified. Beginning with the February 2021 audit, development and implementation of corrective action plans (CAPs) to address the deficiencies were requested by AMA and in some instances, recoupment of reimbursement paid for case management activities were recommended. AMA will continue to work to maintain a quality program and educate providers regarding the requirements of the Plan First Program.

Complaints and Grievances

AMA has the primary responsibility of monitoring overall program performance, complaints and grievances. No complaints or grievances were received from recipients during this Waiver Demonstration period.

External Evaluations

As mentioned previously, AMA implemented ACHNs, it's version of a managed care program. An external review to assess quality is a required component of the program. Reference Attachment E: EQRO Report for the external reviews' summary.

Section E: Historical and Projected Expenditures

Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.

Historical and Projected Expenditures for the Requested Period of the Extension and Prior Demonstration Years

It is anticipated that enrollment in the Plan First Program will fluctuate for a variety of reasons. For instance, 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. In addition, once a recipient receives sterilization, he/she is no longer eligible to receive family planning services under this Demonstration Waiver.

The following tables illustrate the State's enrollment and expenditure projections by total member months and historical expenditures.

Table E.1. Projected Expenditures for the Requested Extension Demonstration Period (DY23-27)

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS								
			DEMONSTRATION YEARS (DY)					TOTAL WW
ELIGIBILITY GROUP	DY 22	DEMO TREND RATE	DY 23	DY 24	DY 25	DY 26	DY 27	
Family Planning								
Pop Type:	**Hypothetical**							
Eligible Member Months		0.0%	853,953	853,953	853,953	853,953	853,953	4,269,765
PMPM Cost		0.0%	$ 26.76	$ 26.76	$ 26.76	$ 26.76	$ 26.76	$ 26.76
Total Expenditure			$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 114,258,911
Tobacco Cessation								
Pop Type:	**Hypothetical**							
Eligible Member Months			853,953	853,953	853,953	853,953	853,953	
PMPM Cost			$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 0.50	
Total Expenditure			$ 426,977	$ 426,977	$ 426,977	$ 426,977	$ 426,977	$ 2,134,883

Table E.2. Historical Expenditures for the Current Demonstration Period- Demonstration Years (DY17-22)

		2017	2018	2019	2020	2021
Family Planning	Total Exp	$ 27,327,762	$ 23,475,183	$ 22,851,782	$ 22,222,762	$ 22,851,782
	PMPM	$ 26.01	$ 26.76	$ 26.76	$ 26.76	$ 26.76
	Mem-Mon	1,050,567	877,249	853,953	830,447	853,953
Tobacco Cessation	Total Exp		$ 261.00	$ 127.50	$ 123.00	$ 127.50
	PMPM		$ 0.50	$ 0.50	$ 0.50	$ 0.50
	Mem-Mon		522	255	246	255
Total		**$ 27,327,762**	**$ 23,475,444**	**$ 22,851,910**	**$ 22,222,885**	**$ 22,851,910**

ANNUAL CHANGE

		2017	2018	2019	2020	2021
Family Planning	Total Exp		-14%	-3%	-3%	3%
	PMPM		3%	0%	0%	0%
	Mem-Mon		-16%	-3%	-3%	3%
Tobacco Cessation	Total Exp			-51%	-4%	4%
	PMPM			0%	0%	0%
	Mem-Mon			-51%	-4%	4%

Note: For 2017, Family Planning and Tobacco Cessation were combined when calculating total expenditures and member months

Table E.3. Historical Expenditures for the Demonstration Period-Demonstration Years (DY) 12-16

Medicaid Pop 1	2012	2013	2014	2015	2016	5-YEARS
TOTAL EXPENDITURES	$38,653,857	$40,474,930	$ 36,304,281	$33,658,061	$29,404,472	$ 178,495,601
ELIGIBLE MEMBER MONTHS	1,137,183	1,238,964	1,318,825	1,220,933	1,098,710	
PMPM COST	$ 33.99	$ 32.67	$ 27.53	$ 27.57	$ 26.76	
SMOKING CESSATION EXPENDITURES	N/A	$ 42,517	$ 31,338	$ 17,779	$ 23,261	
ELIGIBLE MEMBER MONTHS	N/A	1,238,964	1,318,825	1,220,933	1,098,710	
SMOKING CESSATION PMPM COST	N/A	$ 0.03	$ 0.02	$ 0.01	$ 0.02	
TREND RATES						**5-YEAR**
		ANNUAL CHANGE				**AVERAGE**
TOTAL EXPENDITURE		4.71%	-10.30%	-7.29%	-12.64%	-6.61%
ELIGIBLE MEMBER MONTHS		8.95%	6.45%	-7.42%	-10.01%	-0.86%
PMPM COST		-3.89%	-15.74%	0.14%	-2.92%	-5.80%
						4-YEAR
		ANNUAL CHANGE SMOKING CESSATION				**AVERAGE**
TOTAL EXPENDITURE		N/A	-26.29%	-43.27%	30.84%	-18.20%
ELIGIBLE MEMBER MONTHS		N/A	6.45%	-7.42%	-10.01%	-3.90%
TREND RATES		N/A	-30.76%	-38.72%	45.39%	-11.37%

Financial Analysis of Changes to the Demonstration Requested by the State

AMA does not anticipate any financial changes during the requested extended demonstration period and maintains that the program will remain budget neutral.

Section F: Evaluation and Projected Expenditures

An evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

Reference Attachment F: Annual Monitoring Report for DY20. This report includes evaluation activities and findings for DY20.

The plans for evaluation activities during the extension period will continue as already approved by CMS.

Section G: Public Notice

Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

Public Notices

In accordance with all applicable regulations, the Alabama Medicaid Agency (the Agency), has complied with the full, abbreviated public and tribal notice requirements related to this demonstration's extension application.

Full Public Notice

This extension application's full public notice is available on the Agency's website at https://medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning/4.2.4.2_FP_1115_Waiver.aspx

Additionally, Reference Attachment J to view the full public notice.

Abbreviated Public Notice

This extension application's abbreviated public notices are available on the Agency's website at:

https://medicaid.alabama.gov/documents/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning/4.2.4.2_FP_1115_Waiver/4.2.4.2_Abbreviated_Public_Notice_7-28-21.pdf (July 28, 2021)

Tribal Notice

Reference Attachment G: Tribal Government Notice to view the notification sent to the tribal/Indian health providers and urban Indian organizations for consultation and seeking advice related to this extension application.

Post Award Public Forums

The Agency has complied with the monitoring and compliance requirements as they relate to the post award public forums. The chart below lists the public forums held by the Agency during the current demonstration period:

Demonstration Year (DY)	Forum Date	Forum Time	Forum Location	Public Notice Date
6 Month Post Award	May 1, 2018	10:00am	Alabama Medicaid Agency Montgomery, AL	March 28, 2018
DY18	May 1, 2018	10:00am	Alabama Medicaid Agency Montgomery, AL	March 28, 2018

DY19	May 1, 2019	10:00am	Alabama Medicaid Agency Montgomery, AL	March 20, 2019
DY20	May 1, 2020	1:00pm	Virtual	March 9, 2020
DY21	May 11, 2021	1:00pm	Virtual	April 5, 2021
	Link: Online:	Notification: https://medicaid.alabama.gov/news_detail.aspx?ID=15422 Meeting: https://algov.webex.com/algov/j.php?MTID=m0098afa9234426b3355363ce56da30b2 Meeting number (access code): 133 647 9901 Meeting password: Medicaid1		
	Dial-in Information:	Dial: 1-415-655-0001 Access Code: 133 647 9901 Attendee ID number: enter #		
Application Extension DY21-1	**August 18, 2021**	**11:00am**	**Virtual**	**July 31, 2021**
	Link: Online:	Notification: 4.2.4_Upcoming_Webinar_Family_Planning_8-21.pdf (alabama.gov) Meeting: https://algov.webex.com/algov/j.php?MTID=m8fd75929259ce912a61111e04c02e108 Meeting number (access code): 1776 20 8380 Meeting password: Medicaid1		
	Dial-in Information	Dial: 1-415-655-0001 (US Toll) Access Code: 1776 20 8380 Attendee number: enter #		
Application Extension DY21-2	**August 25, 2021**	**10:00am**	**Virtual**	**July 31, 2021**
	Link: Online:	Notification: 4.2.4_Upcoming_Webinar_Family_Planning_8-21.pdf (alabama.gov) Meeting: https://algov.webex.com/algov/j.php?MTID=meaf9a82d9e8a40f78724b55958903d55 Meeting number (access code): 1777 83 5482 Meeting password: Medicaid1		
	Dial-in Information:	Dial: 1-415-655-0001 (US Toll) Access Code: 1777 83 5482 Attendee number: enter #		
Application Extension DY21-3	**October 5, 2021**	**12:00- 1:00pm**	**Virtual**	**September 30, 2021**

	Online:	https://algov.webex.com/algov/j.php?MTID=m3574da5a54a1a26b18a3c7a e91e30c4e Meeting number (access code): 1776 35 4888 Meeting password: Medicaid1		
	Dial-in Information:	Dial: 1-415-655-0001 (US Toll) Access Code: 1776 35 4888 Attendee number: enter #		
Application Extension DY21-4	**October 7, 2021**	**4:00-5:00pm**	**Virtual**	**September 30, 2021**
	Online:	https://algov.webex.com/algov/j.php?MTID=me8f59784b1e03abd0334b4a 79e1113ae Meeting number (access code): 1778 05 0502 Meeting password: Medicaid1		
	Dial-in Information:	Dial: 1-415-655-0001 (US Toll) Access Code: 1778 05 0502 Attendee number: enter #		

Six-Month Post Award Public Forum

Reference Attachment H: Six-Month Post Award Public Forum's Questions and Answers to view the questions and corresponding responses related to the Six-Month Post Award Public Forum presentation conducted by the Agency on May 1, 2018.

Annual Public Forum

An annual public forum was held on May 11, 2021. The Agency published the date, time and location of the forum in a prominent location on its website, at least 30 days prior to the date of the planned public forum. The public notice announcement was posted on Medicaid's website on April 5, 2021. This notice can be viewed by accessing the following link: https://medicaid.alabama.gov/news_detail.aspx?ID=15422

There were 11 attendees and no questions or comments were submitted.

Reference Attachment I: Annual Public Forum Presentation to view the annual public forum's presentation. There were no comments received in reference to this forum.

Attachment A
Covered Services List for Plan First Recipients

Code	Procedure Description
99402	STD/HIV Post-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. (Must use diagnosis code Z309 for ICD-10)
99401	STD/HIV Risk Screening and HIV Pre-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. (Must use diagnosis code Z309 for ICD-10)
88305	Level IV Surgical Pathology, gross and microscopic examination
88304	Level III Surgical Pathology, gross and microscopic examination
88302	Surgical pathology, gross and microscopic examination
88300	Level I Surgical Pathology, gross examination only
89300	Semen analysis; presence and/or motility of sperm
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision.
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision.
88167	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88165	Cytopathology, slides, cervical or vaginal
88164	Cytopathology, slides, cervical or vaginal
88162	Cytopathology, any other source
88161	Cytopathology, any other source
88160	Cytopathology, smears, any other source
88155	Cytopathology, slides, cervical or vaginal
88154	Cytopathology, slides, computer assisted
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154, 88164-88167)
88152	Cytopathology, slides, cervical or vaginal
88150	Cytopathology, manual screening under physician supervision
88148	Cytopathology, screening by automated system with manual rescreening
88147	Cytopathology smears, screening by automated system under physician supervision
88143	Cytopathology, manual screening & rescreening under physician supervision
88142	Cytopathology, cervical or vaginal, automated thin layer preparation
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)
88108	Cytopathology, concentration technique, smears and interpretation
87850	Neisseria gonorrhea
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism. (Not billable by ADPH effective June 30, 2015.)
87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique
87661	Trichomonas vaginalis, amplified probe technique
87660	Trichomonas vaginalis, direct probe technique
87625	Human Papillomavirus (HPV), types 16 & 18 only
87624	Human Papillomavirus (HPV), high-risk types
87623	Human Papillomavirus (HPV), low-risk types
87592	Neisseria gonorrhea, quantification
87591	Neisseria gonorrhea, amplified probe technique. (Not billable by ADPH effective June 30, 2015.)
87590	Neisseria gonorrhea, direct probe technique
87539	HIV-2, quantification
87538	HIV-2, amplified probe technique
87537	HIV-2, direct probe technique
87536	HIV-1, quantification

Attachment A
Covered Services List for Plan First Recipients

Code	Procedure Description
87535	HIV-1, amplified probe technique
87534	HIV-1, direct probe technique
87533	Herpes virus-6, quantification
87532	Herpes virus-6, amplified probe technique
87531	Herpes virus-6, direct probe technique
87530	Herpes simplex virus, quantification
87529	Herpes simplex virus, amplified probe technique
87528	Herpes simplex virus, direct probe technique
87512	Gardnerella vaginalis, quantification
87511	Gardnerella vaginalis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique. (Not billable by ADPH effective June 30, 2015.)
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.
87482	Candida species, quantification
87481	Candida species, amplified probe technique
87480	Candida species, direct probe technique
87389	Infectious Agent Antigen
87220	Tissue examination for fungi
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain for bacteria, fungi, or cell types
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
87177	Smear, primary source, with interpretation, wet and dry mount for ova and parasites, concentration and identification
87164	Dark field examination, any source; includes specimen collection
87110	Culture, chlamydia
87081	Culture, bacterial, screening only, for single organisms
86780	Antibody; Treponema Pallidum
86703	HIV – 1&2
86702	Antibody HIV-2
86701	HIV – 1
86695	Herpes simples, type 1
86694	Herpes simplex, non-specific type test
86689	HTLV or HIV antibody
86593	Syphilis
86592	Syphilis
85032	Manual cell count (erythrocyte, leukocyte or platelet) each
85027	Blood count; RBC only
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85018	Blood count; hemoglobin
85014	Blood count; other than spun hematocrit
85013	Blood count; spun microhematocrit
85009	Blood count; differential WBC count, buffy coat
85008	Blood count; manual blood smear examination without differential parameters
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
84703	HCG qualitative
84702	HCG quantitative

Attachment A
Covered Services List for Plan First Recipients

Code	Procedure Description
81025	Urine pregnancy test
81020	Urinalysis; two or three glass test
81015	Urinalysis microscopic only
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81003	Urinalysis; automated without microscopy
81002	Urinalysis; non-automated without microscopy
81001	Urinalysis; automated with microscopy
81000	Urinalysis by dip stick or tablet reagent
76881	Contraceptive surveillance, unspecified of a missing Nexplanon
76830	Transvaginal Ultrasound Non-OB
76857	Ultrasound, Pelvic (Nonobstetric), real time with image documentation; limited or follow-up (EG, for follicles) **(This procedure is to be used for locating missing IUDs Only)**
74740	Hysterosalpingography, radiological supervision and interpretation
73060	X-ray of Humerus-Purpose Location of Nexplanon Capsules
58671	Tubal ligation by laparoscopic surgery
58670	Tubal ligation by laparoscopic surgery
58615	Tubal ligation by suprapubic approach
58611	Tubal ligation done in conjunction with a c-section (*Not applicable for Plan first)*
58605	Tubal ligation by abdominal approach (postpartum) (*Not applicable for Plan first)*
58600	Tubal ligation by abdominal incision
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (by Prior Approval only; **See note box below)
58562	Hysteroscopy, surgical; with removal of impacted foreign body
A4264	Intratubal occlusion device (by Prior Approval only; **See note box below)
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58301	IUD removal
58300	IUD insertion
57800-FP	Dilation of cervical canal, instrumental (separate procedure)
57410-FP	Pelvic examination under anesthesia (other than local)
57170	Diaphragm – fitting with instructions **only.** Does not include the device.
55250	Vasectomy –unilateral or bilateral, including postoperative semen examination(s)
11980	Subcutaneous hormone pellet implantation(implantation of estradiol and/or testosterone beneath the skin)
11976	Removal, implantable contraceptive capsule
11981-FP	Insertion, non-biodegradable drug delivery implant
11982-FP	Removal, non-biodegradable drug delivery implant
00921	Anesthesia for vasectomy, unilateral or bilateral
00952-FP	Anesthesia for hysteroscopy and/or hysterosalpingography procedures
00940-FP	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
00851	Anesthesia Intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection.
J1050-FP	Depo-Provera-no less than 104 mg and no more than 150 mg per injection once every 70 days
J7296	Kyleena IUD (Levonorgestrel-releasing intrauterine contraceptive system, 19.5mg limited to one every 5 years). Exceptions are in NOTE box below.

Attachment A
Covered Services List for Plan First Recipients

Code	Procedure Description
	Effective January 1, 2018, providers should bill J7296 on the claim form for reimbursement.
J7297	Liletta IUD (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg) limited to one every 5 calendar years. Exceptions are in the NOTE box below
J7298	Mirena IUD (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg) limited to one every 5 calendar years. Exceptions are in the NOTE box below
J7301	Skyla IUD (limited to one every 3 years). Exceptions are in NOTE box below.
J7304-FP	Contraceptive Patch (For Health Department Billing Only) TPL exempt
J7304-SE	Contraceptive Patch (For FQHCs, PRHCs, IRHCs Billing only)
J7303-FP	Vaginal Ring (For Health Department billing only and is covered for Plan First)
*J3490	Kyleena IUD (limited to one every 5 years). Exceptions are in NOTE box below. * For dates of service April 01, 2017 through June 30, 2017 bill J3490. See Q9984 for dates of service July 01, 2017 through December 31, 2017.
99205-FP	Initial visit
99214-FP	Annual visit
99213-FP	Periodic visit
99347-FP	Home visit – Limited to one per 60 day post-partum period as a family planning covered service. (Not applicable for Plan First eligible recipients)
S4993-FP	Birth control pills (For Health Department billing only)
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
99212-FP	Extended contraceptive counseling visit (May be billed in conjunction with the postpartum visit – Limited to one service during the 60 day postpartum period as a family planning covered service. (Not applicable for Plan First eligible recipients.)
S4993-SE	Birth Control Pills (For FQHCs, PRHCs, IRHCs Billing only)
J7307	Etonogestrel (contraceptive) implant system, including implants and supplies also known as Nexplanon Effective 1/1/2008, J7307 replaces S0180
J7300	Mechanical (Paragard) IUD
Q0091	Collection of Pap smear specimen
Q0111	Wet mounts
Q9984	Kyleena IUD (limited to one every 5 years). Exceptions are in NOTE box below. Bill Q9984 for dates of service July 01, 2017 through December 31, 2017. See J7296 for dates of service January 1, 2018 and thereafter.
36415-90	Routine venipuncture for collection
36416-90	Collection of capillary blood specimen (eg, finger, heel, ear stick)

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

Effective **January 1, 2014**, Alabama Medicaid began covering smoking cessation products for all recipients. These products continue to be covered for Plan First recipients without prior authorization. Prior authorization is required for all other recipients. The list below contains nicotine products which are currently covered by the Alabama Medicaid Agency. **The list is subject to change.** For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

NDC Code	Label Name Description	Generic Drug Description
00009540001	NICOTROL CARTRIDGE INHALER	NICOTINE INHALATION 10 MG CARTRIDGE
00009540101	NICOTROL NS 10 MG/ML SPRAY	NICOTINE NASAL 10 MG/ML SPRAY
00113002960	GS NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00113002971	GS NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00113020625	GS NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00113045660	GS NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00363036506	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536136206	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536136223	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536136234	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536302906	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536302923	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536302934	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536311201	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536311237	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536338601	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536340401	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
11917015386	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
24385059471	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800002925	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800020625	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800035278	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800045678	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205020323	NICOTINE 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205020367	NICOTINE 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
45802020625	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
46122017125	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
46122017320	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
46122017360	GNP NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
46122028460	GNP NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
46122044858	GNP NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
46122066478	GNP NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348057308	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348057336	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348069109	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348069136	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348078710	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348078759	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
62011004702	HM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
62011042501	HM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
63739037010	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
63739037163	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
70000034501	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC Code	Label Name Description	Generic Drug Description
70000034601	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
70000034701	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
70000034801	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
70000034802	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
70677008501	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
87701041281	GNP NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00113034405	GS NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
36800034403	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
36800034405	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
43598048610	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
43598048624	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
43598048627	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
43598048672	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
43598048681	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
45802008901	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
45802008902	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
45802034403	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
45802034405	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
46122017608	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
49035020110	EQ NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
49348085216	SM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
62011004801	HM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
62011004803	HM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
62011042701	HM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
70000034901	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
70000056201	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
70677008701	SM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
70677008901	SM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00113073402	GS NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
00536123927	NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
00536123981	NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
46122025415	NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
46122025460	NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
46122066315	GNP NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
62011019901	HM NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
62011042901	HM NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
70000056001	NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZNG MINI
00113017060	GS NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00113017071	GS NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00113042225	GS NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00113053260	GS NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00113053278	GS NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536137206	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536137223	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536137234	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536303006	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536303023	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536311301	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536311337	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC Code	Label Name Description	Generic Drug Description
00536338701	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536340501	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
24385059871	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800017025	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800017071	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800042271	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800053260	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800053278	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800085478	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
45802000125	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
46122017225	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
46122017420	GNP NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
46122017460	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
46122028660	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
46122044958	GNP NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
46122066678	GNP NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348057208	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348057236	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348069209	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348069236	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348078810	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348078859	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
62011017001	HM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
62011042601	HM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
63739036810	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
63739036910	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
70000034101	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
70000034201	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
70000034301	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
70000034401	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
70000034402	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
70677008601	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00113087303	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00113087305	GS NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00113087306	GS NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
36800053905	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
36800087305	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
43598048710	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
43598048724	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
43598048727	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
43598048772	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
43598048781	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
45802087303	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
45802087305	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
45802095701	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
45802095702	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
46122017708	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
49348085316	SM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
62011017101	HM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC Code	Label Name Description	Generic Drug Description
62011042801	HM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
70000035001	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
70677008801	SM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
70677009001	SM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00113095702	GS NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
00113095760	GS NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
00536124127	NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
00536124181	NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
46122025515	NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
46122025560	NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
46122066515	GNP NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
62011020001	HM NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
62011043001	HM NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
70000012100	NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZNG MINI
00363089588	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00536110788	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00536589553	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00536589571	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00536589588	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
11917015691	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
36800003414	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
43598044770	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
43598044771	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
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46122035274	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
60505706200	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
60505708900	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
62011035001	HM NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
63868073414	QC NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
68001043388	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
68001043390	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
70000051101	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
70000051102	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
70677003101	SM NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00363089653	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00363089688	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00536589653	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00536589671	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00536589688	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
11917015690	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
11917015693	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
36800003814	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
43598044828	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
43598044870	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
43598044874	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
46122035374	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
46122056803	GNP NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
46122056807	GNP NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
60505706300	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC Code	Label Name Description	Generic Drug Description
60505709000	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
62011035101	HM NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
63868073514	QC NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
68001043488	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
68001043490	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
68001043491	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
70000051201	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
70000051202	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
70677003201	SM NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
43598044556	NICOTINE TRANSDERMAL SYSTEM	NICOTINE TRANSDERM 21-14-7MG PATCH DYSQ
00363089488	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00536110688	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00536589453	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00536589488	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
11917015692	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
36800003214	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
43598044670	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
43598044671	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
43598044674	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
46122035474	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
60505706100	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
60505708800	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
62011034901	HM NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
68001043288	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
68001043290	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
70000051001	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
70000051002	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
70677003001	SM NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24

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State of Alabama
Alabama Medicaid Agency

Annual External Quality Review Technical Report
Aggregate Report

Measurement Years 2019–2020
April 2021

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Executive Summary

Purpose of Report

The Balanced Budget Act of 1997 established that state agencies contracting with the following managed care entities (MCEs), provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCE: Medicaid managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), prepaid inpatient health plans (PIHPs), and primary care case management (PCCM) entities (PCCM-Es). Quality, as it pertains to an external quality review (EQR), is defined in 42 CFR 438.320 as "[t]he degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement." Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual EQR of contracted MCEs. CFR 438.350 requires states to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCE. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS).

These same federal regulations require that the annual EQR be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality, timeliness, and access to health care services that MCEs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCEs regarding health care quality, timeliness, and access, as well as make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MCEs.

To meet these federal requirements, the Alabama Medicaid Agency (AMA) has contracted with Island Peer Review Organization (IPRO), an EQRO, to conduct the annual EQR of the Alabama Coordinated Health Network (ACHN) entities.

Scope of EQR Activities Conducted

This EQR technical report focuses on the two EQR activities that were conducted. As set forth in 42 CFR 438.358, these activities were:

Systems Performance Review (SPR) – This review determines ACHN entity compliance with its contract and with state and federal regulations in accordance with the requirements of 42 CFR 438 Subpart E.

Validation of Quality Improvement Projects (QIPs) – While regulations do not require ACHN entities to conduct QIPs, states may require them to do so. It is recommended that if states do require their ACHN entities to carry out QIPs, then they should consider validating those projects. AMA requires their ACHN entities to carry out QIPs, and IPRO has been tasked with the validation of those QIPs. QIPs were reviewed to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

CMS defines *validation* in the Final Rule in 42 CFR 438.320 as "[t]he review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

The results of the EQR activities performed by IPRO are detailed in the **Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access** section of this report.

Overall Conclusions and Recommendations

The following is a high-level summary of the conclusions drawn from the findings of the EQR activities regarding Alabama Medicaid ACHN's strengths and IPRO's recommendations with respect to quality, timeliness, and access. Specific findings, strengths, and recommendations are described in detail in the **Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access** section of this report.

Alabama Care Network Mid-State

Quality

The Quality domain encompasses QIP activities and findings from five of the eight SPR domains: EI Materials, EI Rights, Grievances, Health Information Management Systems (HIMS), and Quality Management.

Quality Improvement Projects

In 2019, Alabama Care Network (ACN) Mid-State submitted proposals for three QIP topics: Adverse Birth Outcomes, Childhood Obesity, and Substance Use Disorder. ACN Mid-State is targeting eligible individuals (EIs) at high risk for adverse maternal outcomes, by focusing on chronic conditions such as hypertension and diabetes in pregnant women and EIs of childbearing age (defined by the entity as those 18–44 years of age). The entity has focused their efforts on implementing the use of in-house hypertension/diabetes monitoring, providing blood pressure monitors to hypertensive EIs, performing a screening for social determinants of health for EIs that have delivered a low birth-weight baby and then connecting to community resources, and engaging postpartum EIs in family planning. For childhood obesity, the ACHN is focusing on EIs 3 - 11 years of age with a BMI > 85th percentile, with the goal of reducing the percentage of children with an overweight or obese diagnosis. ACN Mid-State has targeted EIs with a mailing campaign, wherein letters are sent and a follow-up phone call is made to educate parents on the importance of the well child visit, and to help with scheduling a visit with the child's provider. Additionally, the ACHN has implemented their Healthy Eating Active Living (HEAL) program and has been providing MyPlate materials to EIs for nutrition education, as well as jump ropes and Frisbees to promote physical activity. Lastly, for their substance use disorder project, ACN Mid-State is targeting EIs who were newly prescribed Medication Assisted Therapy (MAT) within the last 6 months, as well as pregnant EIs who were identified with a history of substance use disorder (SUD), or with active SUD. ACN Mid-State is utilizing AMA data to identify and outreach EIs with SUD for care coordination (to assist with primary/mental health care as well as connection to community resources), referral to Peer Support Specialist, and appointment coordination for those with a new MAT prescription. Further, the ACHN is referring pregnant EIs (i.e., those identified at assessment by maternity care coordinator with history/active SUD) to peer support, or the Children's Policy Council a plan of safe care. Intervention tracking measures have not been reported by ACN Mid-State to date; however they will be provided going forward, and reviewed to assess intervention progress and provide additional insight into potential gaps in care.

Systems Performance Review

ACN Mid-State received a designation of full compliance for EI Rights and Quality Management. The ACHN received a designation of partial compliance for EI Materials, HIMS, and Grievances:

- Of the 45 standards reviewed for EI Materials, 37 standards were fully compliant, 5 were partially compliant, 2 were non-compliant, and 1 was not applicable. The following details findings from the review of the partially compliant and non-compliant standards:
  - While ACN Mid-State has a written description of all planned health education activities, they do not indicate if the targeted implementation dates are at a frequency and in a format determined by the Agency.
  - The requirement that states that "Materials identified or developed for use shall be reviewed and approved by the Agency, including, but not limited to, letters, educational Materials, programs, promotional, on-line content, and forms" is not addressed in ACN Mid-State's policies.
  - ACN Mid-State EI Materials policies do not indicate that updates from the Agency be addressed.
  - The requirement that states "Website content must be approved in advance by the Agency. Website content is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information" is not addressed in ACN Mid-State's policies.
  - The following requirement is not addressed within ACN Mid-State's policies: The PCCM-E may only use electronic methods of communication with an EI if an EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication; the EI has requested or approved

electronic transmittal; and all Health Insurance Portability and Accountability Act (HIPAA) requirements are satisfied with respect to PHI.
    - The policy that governs the community resource guide does not indicate that it must be updated at least annually and made available to the PCCM-E's care coordination staff who have contact with EIs.
    - The following requirement is not addressed on the ACN Mid-State website: "If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation."
- Of the 11 standards reviewed for HIMS, 9 standards were fully compliant, and 2 were partially compliant. The following details findings from the review of the partially compliant standards:
    - Language that indicates that failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions is not found within the ACHN's policies.
    - Language that indicates that the entity's HIMS system must provide the Agency a monthly extract of data in the format prescribed by the Agency is not found within ACN Mid-State's policies.
- Of the six standards reviewed for Grievances, five standards were fully compliant, and one was partially compliant. The following details findings from the review of the partially compliant standard:
    - The following requirement was not found within the Grievances policies/procedures: "A summary and, if necessary, a request for a corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP."

In the domain of Quality, IPRO recommends that ACN Mid-State:

- Capture intervention tracking measures for each intervention across the three QIP topic areas.
- Update their policies to include verbiage related to their health education activities and targeted implementation dates at a frequency and format determined by the Agency.
- Update their policies to include verbiage related to the review and approval by the Agency of EI materials.
- Update their policies to include verbiage related to addressing updates from the Agency.
- Revise Policy ACHN 015 to include language that addresses incorporating their website to the Agency or State website.
- Revise their EI Materials policy to include language that addresses the use of electronic methods of communication.
- Revise Policy ACHN 015 to include website language. ACN Mid-State should also review the formalized process to ensure regular updates.
- Revise Policy ACHN 015 to include language that addresses incorporating their website to the Agency or State website.
- Add language indicating that "failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions" to their HIMS policy.
- Add language to HIMS policy indicating that the HIMS system must provide the Agency a monthly extract of data in the format prescribed by the Agency.
- Revise its complaints and grievances policy and procedure to reflect the activities outlined in the requirement pertaining to corrective action plans.

Timeliness

The Timeliness domain includes findings from the SPR Grievance domain.

Systems Performance Review

Of the six standards reviewed for Grievances, five standards were fully compliant, and one was partially compliant. This partially compliant standard was not related to timeliness, but rather quality, and is reflected above.

There are currently no recommendations in the domain of Timeliness.

Access

The Access domain includes findings from three of the eight SPR domains; Care Coordination, Enrollment/Disenrollment and Provider Participation.

Systems Performance Review

ACN Mid-State received a designation of full compliance for Enrollment/Disenrollment and Provider Participation. The ACHN received a designation of partial compliance for Care Coordination:

- Of the 134 standards reviewed for Care Coordination, 125 were fully compliant, and 9 were partially compliant. The following details findings from the review of the partially compliant standards:
  - There is no documentation indicating that a certified letter informing EIs of care coordination service will be sent to members (as opposed to letters sent via standard mail). This will not be a requirement going forward and thus there is no corresponding recommendation.
  - File review results indicated that three files were applicable for a high-risk face-to-face postpartum visit; however, these files did not include documentation of this visit. Furthermore, eight files were eligible for a follow-up visit in the second/third trimester; however, five of these files did not have evidence of this follow-up visit.
  - Two files did not include a maternal health risk identification strategy.
  - Four files did not include a maternal health risk and psychosocial assessment for all EIs at the first face-to-face initial assessment.
  - Seven files did not meet the requirement that the maternal health care plan must be patient-/caregiver-centered with a team approach.
  - Two files did not meet the requirement that the maternal health care plan must include the primary care providers (PCPs) and/or community agencies as appropriate.
  - One file did not meet the requirement that the PCCM-E must provide Care Coordination for newborns delivered with no prenatal care, who will receive a face-to-face inpatient delivery encounter by a Care Coordinator.
  - Two files did not demonstrate counseling on contraception and family planning services.
  - One file did not demonstrate counseling on appropriate postpartum care.

In the domain of Access, IPRO recommends that ACN Mid-State:

- Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.
- Conduct testing to ensure that the new calculation for psychosocial assessment score and risk stratification will fulfill the requirement related to maternal health risk identification strategy.
- Ensure that internal training provided to ACN Mid-State's encompasses identification of maternal health risks as well as how to address these risks.
- Ensure that EI-specific risks are addressed in care plans.
- Bolster care coordination by including other providers and external agencies whenever warranted, to meet the requirement that the maternal health care plan must include the PCPs/community agencies as appropriate.
- Ensure that EIs eligible for a delivery encounter receive a delivery visit or missed delivery visit within 20 calendar days.
- Ensure that counseling is conducted appropriately for contraception and family planning services, and postpartum care.

Alabama Care Network Southeast

Quality

The quality domain encompasses QIP activities and findings from five of the eight SPR domains: EI Materials, EI Rights, Grievances, HIMS, and Quality Management.

Quality Improvement Projects

In 2019, ACN Southeast submitted proposals for three QIP topics: Adverse Birth Outcomes, Childhood Obesity, and Substance Use Disorder. To address adverse birth outcomes, ACN Southeast is targeting all pregnant EIs, as well as delivering health care providers (DHCPs) and primary care providers (PCPs) in order to encourage visit compliance. ACN

Southeast has initiated outreach to DHCP offices and EIs to schedule an initial visit within the first trimester; issued an incentive delivery package at delivery for EIs who attend at least 80% of prenatal visits, postpartum visit, and all care coordination visits; referred pregnant EIs with hypertension or diabetes to their internal bio-monitoring program; distributed safe sleep information to caregivers of EIs 0–6 months of age; and provided targeted case management to EIs 0–15 months of age. Intervention tracking measures have been recorded for several interventions, and demonstrate both a consistent increase in the percentage of initial visits scheduled with DHCP offices and improvement in the percentage of EIs who qualify for the incentive package. Intervention tracking measures also demonstrated a steady decline in the percentage of EIs with hypertension or diabetes that deliver after 37 weeks, as well as an increase in the percentage of live births weighing less than 2500 grams born to EIs with hypertension or diabetes. For childhood obesity, the ACHN is targeting EIs 3–6 years of age, in order to promote well-child visits and improve outcomes among those with a body mass index (BMI) > 85th percentile. ACN Southeast has distributed MyPlate educational materials, provided gardening materials and seeds to children in pre-K, kindergarten, and first grade, and provided education and support to encourage breastfeeding in infants 0–6 months of age. The first two interventions launched (the MyPlate and gardening initiatives) began in November 2020, and tracking measures demonstrate that there remains much opportunity to continue the distribution of MyPlate educational materials (evidenced by only 2.1% of EIs with BMI >85th percentile ages 3–6 who received education in Q4) and an opportunity to expand the percentage of schools that received gardening materials (14.5% in Q4). Lastly, for their substance use disorder project, ACN Southeast is targeting EIs 18 years of age and older with a diagnosis of alcohol or other drug (AOD) abuse or dependence. ACN Southeast has proposed funding non-billing treatment facilities, arranging transportation when non-emergency transport is unavailable, and partnering with SpectraCare to add peer support specialists in their region. Intervention tracking measures have not been reported by the entity to date, given the changes that were made to the scope of this project and to the interventions; however, they will be provided going forward, and reviewed to assess intervention progress and provide additional insight into potential gaps in care.

Systems Performance Review

ACN Southeast received a designation of full compliance for EI Rights and Quality Management. The ACHN received a designation of partial compliance for EI Materials, HIMS, and Grievances:

- Of the 45 standards reviewed for EI Materials, 41 were fully compliant, 2 were partially compliant, and 2 were non-compliant. The following details findings from the review of the partially compliant and non-compliant standards:
  - ACN Southeast's EI policies do not address the requirement that states that the PCCM-E may only use electronic methods of communication with an EI, if the EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication.
  - The requirement that states that "The PCCM-E must provide the Agency with a written description of all planned health education activities and targeted implementation dates at a frequency and in a format determined by the Agency" is not fully addressed within ACN Southeast's documentation.
  - The requirement that states "If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation" is not evidenced within ACN Southeast's website or within policies/procedures.
  - ACN Southeast's policies do not include verbiage related to the website content being approved in advance by the Agency, and that the content be accurate, current, and designed so that EIs and providers can easily locate relevant information.
- Of the 11 standards were reviewed for HIMS, 9 were fully compliant, and 2 were partially compliant. The following details findings from the review of the partially compliant standards:
  - Language regarding sanctions if 95% accuracy rate of maternity data and care coordination documentation into the Health Information System/Database is not demonstrated is not reflected in HIMS policies.
  - The requirement that the HIMS must provide the Agency with a monthly extract of data in the format prescribed by the Agency is not evident within ACN Southeast's policies.
- Of the six standards were reviewed for Grievances, five were fully compliant, and one was partially compliant. The following details findings from the review of the partially compliant standard:
  - The following requirement was not found within the Grievances policies/procedures: "A summary and, if necessary, a request for a corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP."

In the domain of Quality, IPRO recommends that ACN Southeast:

- Increase the distribution of MyPlate educational materials and expand the percentage of schools that received gardening materials.
- Update EI Materials policies to include missing language related to using electronic methods of communication with an EI if the EI has provided an email address to the PCCM-E and has not requested to not receive electronic methods of communication.
- Ensure that all planned health education activities, along with implementation dates, are provided to the Agency and that their policies indicate they are at a frequency and format determined by the Agency.
- Ensure that language related to the Agency or State standards for website structure, coding, and presentation is incorporated into their policies and procedures.
- Ensure that language related to approval of website content, and that this content is accurate, current, and designed in a way that EIs and providers can easily locate information, is incorporated into their policies and procedures.
- Incorporate language into HIMS policies that reflects the requirement that failure to input maternity data and/or care coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions.
- Ensure the reporting extract requirement is added to their HIMS policy.
- Revise its complaints and grievances policy and procedure to reflect the activities outlined in the requirement pertaining to corrective action plans.

Timeliness

The Timeliness domain includes findings from the SPR Grievance domain.

Systems Performance Review

Of the six standards reviewed for Grievances, five standards were fully compliant, and one was partially compliant. This partially compliant standard was not related to timeliness, but rather quality, and is reflected above.

There are currently no recommendations in the domain of Timeliness.

Access

The Access domain includes findings from three of the eight SPR domains; Care Coordination, Enrollment/Disenrollment and Provider Participation.

Systems Performance Review

ACN Southeast received a designation of full compliance for Enrollment/Disenrollment and Provider Participation. The ACHN received a designation of partial compliance for Care Coordination:

- Of the 134 care coordination standards that were reviewed, 124 were fully compliant and 10 were partially compliant. The following details findings from the review of the partially compliant standards:
  - There is no documentation that conveys that a certified letter informing EIs of care coordination service will be sent to members. This will not be a requirement going forward; thus, there is no corresponding recommendation.
  - Two files demonstrated that the EI's risk level was not assessed within the contractually mandated timeframe.
  - Two files did not demonstrate medication reconciliation, while one file was also missing a PHQ and substance abuse screen.
  - Two files did not demonstrate high-risk face-to-face postpartum visit. Furthermore, four files did not demonstrate follow-up visits in the second/third trimester.
  - One file did not contain evidence that a maternal health screening was conducted within five business days of contact with EI.
  - Six files did not meet the requirement that the care plan be patient-/caregiver-centered with a team approach.
  - One file did not contain evidence that the EI had a delivery visit.
  - One file did not demonstrate counseling on contraception and family planning services, and two files did not demonstrate counseling on appropriate postpartum care.

- Two files did not contain evidence of a complete medication list used during the EI interview of the Health Risk and Psychosocial Assessment.

In the domain of Access, IPRO recommends that ACN Southeast:

- Ensure that risk assessments are conducted within the contractually mandated timeframes.
- Ensure that additional assessments (related to PHQ, substance abuse screening, etc.) are conducted appropriately for each EI according to contract requirements.
- Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.
- Ensure that maternal health screenings are conducted in a timely manner.
- Ensure that all aspects of an EI's medical history are addressed to inform a thorough, patient-/caregiver-centered care plan.
- Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.
- Ensure that counseling on contraception and family planning services, and appropriate postpartum care, is conducted appropriately for maternal health care coordination.
- Ensure that a complete medication list is included in each EI's record.

Gulf Coast Total Care

Quality

The Quality domain encompasses QIP activities and findings from five of the eight SPR domains: EI Materials, EI Rights, Grievances, HIMS, and Quality Management.

Quality Improvement Projects

In 2019, Gulf Coast Total Care (GCTC) submitted proposals for three QIP topics: Adverse Birth Outcomes, Childhood Obesity, and Substance Use Disorder. To address adverse birth outcomes, GCTC is targeting EIs with a critical risk, which they defined as an individual with a previous pre-term birth and/or a diagnosis of hypertension or diabetes. The ACHN is utilizing the assessment carried out by the maternity care coordinator. The care coordinator then confirms EI self-reporting with DHCP records and Alabama Medicaid claims data. Once EIs are identified, GCTC focuses their efforts around bio-monitoring and enrollment of EIs into the Today's Mom program. Intervention tracking measures demonstrate an opportunity to improve EI compliance with bio-monitoring (all EIs that were identified as critical risk agreed to bio-monitoring; however, only 19% on average were compliant at least 50% of the time). For childhood obesity, the ACHN is targeting EIs 7–11 years of age diagnosed as overweight or obese. The ACHN has evaluated the percentage of children in the southwest region with their BMI assessed who also had an overweight/obese diagnosis to determine the extent of the public health issue. Of those identified, GCTC has proposed to work with PCPs to refer these EIs to care coordination, and then track the percentage that enrolled in care coordination and became involved in the 14,000 Step Challenge (including a pedometer and tracking chart provided by GCTC) or Teen Cuisine program (a cooking and nutrition education curriculum available through the Alabama Cooperative Extension System). Furthermore, the ACHN seeks to support and assist PCPs in contacting and scheduling appointments for EIs 7–11 years of age that are due or past due for an annual PCP visit. Intervention tracking measures for this project have not been reported by the entity to date, given the changes that were made to the scope of this project and to the interventions; however, it is expected that they will, going forward. Lastly, for their substance use disorder project, GCTC is focusing its efforts on EIs with a new episode of alcohol or other drug use (AOD), specifically opioid related, and EIs with their first Medication Assisted Treatment (MAT) prescription fill. The ACHN has developed a procedure where a certified recovery support specialist (CRSS) will perform outreach within 24 hours of receipt of referral to EIs that have a new episode of AOD or have received their first MAT prescription. The CRSS will assist EIs in enrolling in care coordination and completing a placement assessment. Further, the CRSS will assist EIs with accessing outpatient treatment through barrier assessment and support. GCTC is also conducting educational outreach to PCPs to improve their comfort level in managing EIs with AOD. Intervention tracking measures have not been reported by the entity to date; however, it is expected that they will, going forward.

Systems Performance Review

GCTC received a designation of full compliance for EI Rights. The ACHN received a designation of partial compliance for EI Materials, Grievances, HIMS, and Quality Management:

- Of the 45 EI Materials standards that were reviewed, 41 were fully compliant, 2 were partially compliant, and 2 were non-compliant. The following details findings from the review of the partially and non-compliant standards:
  - GCTC documentation does not address the requirement of implementing education activities at a frequency and in a format determined by the Agency.
  - Some requirements regarding situations when the PCCM-E may use electronic communication are not found within GCTC's EI Materials policies.
  - The requirement that states "If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation" is not addressed on the GCTC website or within their policies/procedures.
  - The requirement regarding accurate/current website content, and for it to be approved in advance by the Agency, was not found within GCTC policies.
- Of the six Grievance standards that were reviewed, five were fully compliant and one was partially compliant. The following details findings from the review of the partially compliant standard:
  - Language related to the following requirement was not found within GCTC's grievances policies: "A summary and, if necessary, a request for a corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP."
- Of the 11 HIMS standards that were reviewed, 9 were fully compliant and 2 were partially compliant. The following details findings from the review of the partially compliant standards:
  - Language regarding sanctions if 95% accuracy rate of maternity data and care coordination documentation into the Health Information System/Database is not demonstrated is not reflected in GCTC's HIMS policies.
  - The requirement that the HIMS must provide the Agency with a monthly extract of data in the format prescribed by the Agency is not evident within GCTC's policies.
- Of the 42 Quality Management standards that were reviewed, 41 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standard:
  - Documentation related to provider participation in the Medical Management meetings does not convey if all providers in GCTC's network have met the participation requirement.

In the domain of quality, IPRO recommends that Gulf Coast Total Care:

- Conduct root-cause analysis to identify barriers to EI compliance with bio-monitoring.
- Capture intervention tracking measures for each intervention across the Childhood Obesity and Substance Use Disorder QIPs.
- Ensure that all planned health education activities, along with implementation dates, are provided to the Agency and that their policies indicate they are at a frequency and format determined by the Agency.
- Update EI Materials policy to include language related to the requirement about the use of electronic methods of communication (specifically, only if EI has provided an email address and has not requested to no longer receive electronic communication, if the EI has requested or approved electronic transmittal, or if all HIPAA requirements are satisfied with respect to PHI).
- Ensure their policy is updated to reflect language that "If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation."
- Update policies to ensure language related to website content is included (specifically, how content must be approved in advance by the Agency, and is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information. If directed by the Agency, the PCCM-E must establish appropriate links on the PCCM-E's website that direct users back to the Agency's website).
- Revise its complaints and grievances policy and procedure to reflect the activities outlined in the requirement pertaining to corrective action plans.
- Incorporate language into HIMS policies reflecting the requirement that failure to input maternity data and/or care coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions.

- Add the reporting extract requirement to their HIMS policy.
- Develop a roster for provider participation in the Medical Management meetings, to ensure active participation requirements are being met.

Timeliness

The Timeliness domain includes findings from the SPR Grievance domain.

Systems Performance Review

Of the six standards reviewed for Grievances, five standards were fully compliant, and one was partially compliant. This partially compliant standard was not related to Timeliness, but rather Quality, and is reflected above.

There are no current recommendations in the domain Timeliness.

Access

The access domain includes findings from three of the eight SPR domains; Care Coordination, Enrollment/Disenrollment and Provider Participation.

Systems Performance Review

GCTC received a designation of full compliance for Enrollment/Disenrollment and Provider Participation. The ACHN received a designation of partial compliance for Care Coordination:

- Of the 134 care coordination standards that were reviewed, 125 were fully compliant, and 9 were partially compliant. The following details findings from the review of the partially compliant standards:
  - There is no documentation indicating that a certified letter informing EIs of care coordination service will be sent to members. This will not be a requirement going forward; thus, there is no corresponding recommendation.
  - Four requirements related to the multidisciplinary care team (MCT) were not evidenced within several (three) files that were reviewed as part of SPR.
  - One file did not contain evidence that consultation with the MCT occurred for an EI with a behavioral health issue.
  - One file did not include a maternal Health Risk and Psychosocial Assessment for the EI at the first face-to-face initial assessment.
  - Three files did not contain evidence that the care plan was patient-/caregiver-centered with a team approach.
  - Two files did not contain evidence of a delivery encounter.

In the domain of access, IPRO recommends that Gulf Coast Total Care:

- Ensure that the MCT meets regularly as the EI's risk stratification designates, is comprised of professionals from a variety of disciplines, has discussions focused on the EI's recovery and wellbeing, and documents meetings in detail.
- Ensure that the MCT continue to discuss and consult with applicable parties, and monitor behavioral health issues.
- Take into account all of the EI's risk factors and past health risks when conducting the initial assessment as they need to be included in the care plan.
- Review the EI's medical history and include documentation of this history in the care plan.
- Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.

My Care Central

Quality

The Quality domain encompasses QIP activities and findings from five of the eight SPR domains: EI Materials, EI Rights, Grievances, HIMS, and Quality Management.

Quality Improvement Projects

In 2019, My Care Central submitted proposals for three QIP topics: Adverse Birth Outcomes, Childhood Obesity, and Substance Use Disorder. To address adverse birth outcomes, My Care Central has implemented an evidence-based sexual/reproductive health curriculum in a regional high school and has partnered with Baptist Health Family Medicine to ensure women's access to screening and other preventive health measures. For childhood obesity, the ACHN is taking

a preventive approach, targeting pregnant women and EIs 0–15 months of age. My Care Central has employed nurses to provide in-home breastfeeding education and support, improve early prenatal access to WIC, and provide education on the importance of the well-child visit in the first 15 months of life. Lastly, for their substance use disorder project, My Care Central is targeting all EIs with a substance use disorder diagnosis to connect them with peer support specialists and improve their access to treatment. The ACHN is working to increase the ability of a mental health professional to initiate treatment by providing Adult Placement Assessments (APAs) in the targeted region, and connecting EIs with transportation and other services offered by peer support specialists. Intervention tracking measures show that a very low percentage of EIs with a substance use disorder diagnosis initiate treatment.

Systems Performance Review

My Care Central received a designation of full compliance for EI Materials, EI Rights, and Grievances. The ACHN received a designation of partial compliance for HIMS and Quality Management:

- Of the 11 HIMS standards that were reviewed, 10 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standards:
  - My Care Central policies do not indicate that the EI has the right to use any hospital or other setting for emergency care.
- Of the 42 Quality Management standards that were reviewed, 41 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standard:
  - While a monthly/quarterly provider participation report template was submitted as evidence of participation in the Medical Management meetings, it was not populated; thus, it is not possible to tell whether all providers had adequate representation at these meetings.

In the domain of Quality, IPRO recommends that My Care Central:

- Conduct root-cause analysis to uncover why so few EIs with a diagnosis of substance use disorder are initiating treatment.
- Add the EI right to use any hospital or other setting for emergency care to their policies, and ensure it is expressed to EIs through written materials.
- Ensure that provider participation is logged throughout the year so that participation in at least two quarterly meetings and one exercise with the Network Medical Director is evidenced.

Timeliness

The Timeliness domain includes findings from the SPR Grievance domain.

Systems Performance Review

Of the six standards reviewed for Grievances, all six were fully compliant.
There are no current recommendations in the domain of timeliness.

Access

The Access domain includes findings from three of the eight SPR domains; Care Coordination, Enrollment/Disenrollment and Provider Participation.

Systems Performance Review

My Care Central received a designation of full compliance for Enrollment/Disenrollment and Provider Participation. The ACHN received a designation of partial compliance for Care Coordination:

- Of the 134 care coordination standards that were reviewed, 122 were fully compliant, and 12 were partially compliant. The following details findings from the review of the partially compliant standards:
  - The Care Plan Policy outlines how to develop and implement a care plan with specific EI-centered goals; however, the Care Plan Policy does not specifically address catastrophic or severe illness.
  - The following requirement was not comprehensively addressed within My Care Central's policies: "The PCCM-E will implement a program approved by the Agency to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care."
  - The following requirement was not comprehensively addressed within My Care Central's policies: "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for

Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."
  - The following requirement is not reflected in materials provided to EIs: "EIs must be allowed to change a DHCP once without cause within the first ninety (90) Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E."
  - The following requirement is not reflected in materials provided to EIs: "The PCCM-E must inform the EI of the EI's rights to change DHCPs, with and without cause at the initial contact and at least once per year."
  - Materials communicating EI rights and responsibilities and appropriate telephone numbers were provided only verbally to EIs upon initial contact.
  - Four files did not demonstrate that risk assessments took place during the required timeframe.
  - One file did not contain evidence that the MCT met quarterly as required due to the risk level of the EI.
  - Four files did not contain evidence of a face-to-face postpartum visit, and two files did not contain evidence of a follow-up visit in the second/third trimester.
  - Two files demonstrated that EI-specific risks were not contained within the care plan.
  - Five files did not contain evidence of a delivery visit or missed delivery visit within the required 20 calendar days.
  - One file did not contain a medication list.

In the domain of access, IPRO recommends that My Care Central:

- Add language to their Care Plan Policy that incorporates processes to support Care Coordination for EIs, specifically with regard to reducing the potential for risks of catastrophic or severe illness.
- Incorporate language within their policies related to maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care.
- Incorporate language within their policies related to the requirement that states "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."
- Add the following language to EI-facing materials: "EIs must be allowed to change a DHCP once without cause within the first ninety (90) Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E."
- Ensure that evidence is provided of communicating (verbally and with written materials) to EIs that it is their right to change DHCPs, with and without cause at the initial contact and at least once per year.
- Ensure that materials communicating EI rights and responsibilities and appropriate telephone numbers are provided to EIs upon initial contact.
- Ensure that all risk assessments are conducted within the contractually-required timeframe.
- Ensure that the MCT is meeting within the required timeframes.
- Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.
- Ensure care plans are addressing EI-specific risks in the care plan, and are patient/caregiver centered with a team approach.
- Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.
- Ensure that all necessary documentation (the medication list in particular) is included in an EI's record to ensure proper care coordination.

My Care East

Quality

The Quality domain encompasses QIP activities and findings from five of the eight SPR domains: EI Materials, EI Rights, Grievances, HIMS, and Quality Management.

Quality Improvement Projects

In 2019, My Care East submitted proposals for three QIP topics: Adverse Birth Outcomes, Childhood Obesity, and Substance Use Disorder. My Care East is focusing on smoking cessation and EI compliance with prenatal and postpartum

visits in order to mitigate adverse birth outcomes. The ACHN is increasing support, resources and education through incentivizing EIs to complete a smoking cessation program through the mobile app Quit Genius. In order to bolster prenatal and postpartum care, My Care East initiated an incentive program, which rewards EIs with gift cards if they attend a prenatal care appointment in the first trimester, and/or a postpartum care appointment 21–56 days following delivery. While 100% of DHCPs were educated about My Care East's incentive program, less than 20% of EIs collected their gift card for a prenatal visit in the first trimester or a postpartum visit in the 21–56 days following delivery; however, there has been quarter-to-quarter improvement in this effort. For childhood obesity, the ACHN is targeting three high-risk engaged pediatric practices, as well as two Title I schools, in order to mitigate childhood obesity. My Care East is providing incentives for EIs that attend well-child visits and participate in nutrition and physical activity counseling, implementing the Healthy Eating and Acting Living (HEAL) Program in physical education classes for the two selected Title I schools in My Care East's region, and partnering with the University of Alabama (UAB) to provide registered dieticians to offer telehealth counseling sessions to children 6–12 years of age with a BMI > 85th percentile. Intervention tracking measures indicate 100% of targeted pediatric providers received education about the well-child visit incentives for EIs. The percentage of EIs that attended their well-child visit over the first year of the project remained relatively constant; however, the percentage of EIs that collected their incentive gift card steadily increased. Lastly, for their substance use disorder project, My Care East is targeting all EIs with a substance use disorder diagnosis to connect them with peer support specialists and improve their access to treatment. The ACHN has implemented the use of peer support specialists in partnership with Recovery Outreach and Support Services (ROSS), implemented the use of My Care East master's-level social workers (MSWs) to conduct timely APAs to improve entry into substance treatment facilities after detox, and plans to establish a substance use disorder task force to improve community capacity to identify and connect recipients to substance use resources. Intervention tracking measures indicate that an increasing percentage of EIs with an active SUD diagnosis have been connected with peer support, and have been connected to the ROSS helpline. Furthermore, tracking measures demonstrate that 100% of MSWs have been trained to conduct the APAs and all EIs with MSW-completed APA have entered into an SUD treatment center.

Systems Performance Review

My Care East received a designation of full compliance for EI Materials, EI Rights, and Grievances. The ACHN received a designation of partial compliance for HIMS and Quality Management:

- Of the 11 HIMS standards that were reviewed, 10 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standards:
  - My Care East policies do not indicate that the EI has the right to use any hospital or other setting for emergency care.
- Of the 42 Quality Management standards that were reviewed, 41 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standard:
  - It is unclear from the Medical Management meeting minutes and monthly/quarterly provider participation reports whether all My Care East providers had adequate representation at the Medical Management meetings.

In the domain of quality, IPRO recommends that My Care East:

- Add the EI right to use any hospital or other setting for emergency care to their policies and ensure it is expressed to EIs through written materials.
- Continue to work with providers to educate them on the requirements related to active participation, as well as how attendance in the Medical Management meetings affects the quality bonus or provider participation rates, in order to ensure active participation status is met for all providers.

Timeliness

The Timeliness domain includes findings from the SPR Grievance domain.

Systems Performance Review

Of the 6 standards reviewed for Grievances, all 6 standards were fully compliant.
There are no current recommendations in the domain of timeliness.

Access

The Access domain includes findings from three of the eight SPR domains; Care Coordination, Enrollment/Disenrollment and Provider Participation.

Systems Performance Review

My Care East received a designation of full compliance for Enrollment/Disenrollment and Provider Participation. The ACHN received a designation of partial compliance for Care Coordination:

- Of the 134 care coordination standards that were reviewed, 109 were fully compliant and 25 were partially compliant. The following details findings from the review of the partially compliant standards:
  - The Care Plan Policy outlines how to develop and implement a care plan with specific EI-centered goals; however, this policy does not specifically address catastrophic or severe illness.
  - My Care East's policies do not fully express the requirement related to the implementation of a program to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care.
  - The following requirement is not referenced in its entirety within My Care East's documentation: "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."
  - My Care East provides verbal notification of the EI's right to change a DHCP once without case in the first 90 days of selection and at any time for just cause (defined as a valid complaint submitted orally or in writing to the PCCM-E); however, materials communicating this right are not provided to the EI. Furthermore, the related requirement that the PCCM-E must inform the EI of this right at initial contact and at least once per year should also be evidenced within My Care East documentation.
  - Materials communicating EI rights and responsibilities and appropriate telephone numbers were provided to EIs only verbally upon initial contact.
  - One file demonstrated that the risk assessment was not performed within the required 90 day time period.
  - One file did not contain evidence of the MCT meeting. This resulted in a review determination of "Partial" for four separate standards that were evaluated as part of SPR.
  - One file had a risk assessment that did not take place within the required 10 calendar days of discharge.
  - One file demonstrated that medication reconciliation took place after the required 10 calendar days from discharge, and another did not contain evidence of medication reconciliation at all.
  - One file demonstrated that medical management education was not provided to the EI within the required 10 calendar-days from discharge.
  - Two files were applicable for a high-risk face-to-face postpartum visit, but only one of the two files had documentation of this visit. Nine files were eligible for a follow-up visit in the second/third trimester; however, four of these files did not have evidence of this follow-up visit.
  - One file demonstrated that there was a delivery visit with no risk assessment or care plan, with sparse documentation.
  - With regard to the maternal health screening within 5 business days of contact with the EI, two files did not meet the required timeframe and one file did not contain evidence of this screening.
  - One file did not contain evidence of a Maternal Health Risk and Psychosocial Assessment at the first face-to-face initial assessment.
  - One file did not contain evidence of a maternal health care plan.
  - Two files did not include EI-specific risks in care planning, and one file did not have a care plan at all.
  - One file demonstrated a delivery visit with no coordination with the EI's PCP.
  - Fourteen files were applicable for a delivery encounter; however, only thirteen of these files had a delivery visit or missed delivery visit within 20 calendar days.
  - One file did not contain evidence of Counseling on contraception and family planning services, and counseling on appropriate postpartum care.
  - One file had an incomplete medication list, as it was missing the discharge instruction, prescription fill history, and the PCP chart.

In the domain of Access, IPRO recommends that My Care East:

- Add language to their Care Plan Policy that incorporates processes to support Care Coordination for EIs, specifically with regard to reducing the potential for risks of catastrophic or severe illness.

- Develop language within policies to comprehensively address the requirement related to the implementation of a program to integrate and manage all maternal health Care Coordination, including family planning, interconception care, prenatal care, and postnatal care.
- Add language to policies that fully captures the following requirement: "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."
- Ensure that an EI's right to change a DHCP once without cause in the first 90 days of selection and at any time for just cause (defined as a valid complaint submitted orally or in writing to the PCCM-E) is conveyed in written format to EI (within EI materials and/or on My Care East website). Furthermore, the related requirement that the PCCM-E must inform the EI of this right at initial contact and at least once per year should also be evidenced within My Care East documentation.
- Ensure that materials communicating EI rights and responsibilities and appropriate telephone numbers are provided to EIs upon initial contact.
- Ensure that all risk assessments are conducted within the designated 90-day time period.
- Ensure that an MCT is established for every EI in active care in order to ensure successful care coordination.
- Ensure that all post-hospitalization risk assessments are conducted within the required timeframe of 10 calendar days, to ensure appropriate home-based support and services are available.
- Ensure that medication reconciliation is conducted at discharge to facilitate proper transitional care, and that designated timeframes are observed.
- Ensure that required timeframes for providing EIs with medical management education post-discharge are observed in order to ensure successful transitional care.
- Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.
- Ensure that there is a system in place to identify EIs with missing assessments and care plans, as these are critical for successful care. Additionally, documentation should be included in every EI's file to justify risk ratings.
- Ensure that there is a system in place to identify EIs missing maternal health screenings in order to conduct them as expediently as possible. Required timeframes also need to be observed for the execution of the screening.
- Implement a system to identify EIs with missing maternal health risk assessments and missing maternal health care plans.
- Ensure that there is a system in place to identify EIs with missing care plans, and ensure that the care plans address all EI needs and EI-specific risks.
- Include the PCP in the creation of EI care plans.
- Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.
- Ensure that counseling (on contraception and family planning services and appropriate postpartum care) is provided to EIs, and if there are communication issues, these need to be documented within the record.
- Attempt to obtain full documentation related to the medication list; however, if issues arise ensure, they are documented in the EI's record.

My Care Northwest

Quality

The Quality domain encompasses QIP activities and findings from five of the eight SPR domains: EI Materials, EI Rights, Grievances, HIMS, and Quality Management.

Quality Improvement Projects

In 2019, My Care Northwest submitted proposals for three QIP topics: Adverse Birth Outcomes, Childhood Obesity, and Substance Use Disorder. To address adverse birth outcomes, My Care Northwest is targeting pregnant EIs as well as women of childbearing age to improve receipt of prenatal/postpartum care and contraception use, respectively. The ACHN has collaborated with Nurse Family Partnership to provide education to EIs regarding the importance of prenatal and postpartum visits. Given that face-to-face discussion has not always been possible due to the restrictions posed by COVID-19, the ACHN has pivoted towards providing handouts to members to educate them on prenatal/postpartum

visits as well as the various types of contraceptive methods. Intervention tracking measures indicate that the majority of pregnant EIs have received education regarding prenatal care visits, and all have been educated about postpartum visits and contraception use. Tracking measures also demonstrate that the usage of long acting reversible contraception (LARC) has increased for adult EIs between October and November of 2020; however, usage has declined for teenagers.

For childhood obesity, the ACHN is targeting children, community agencies, and providers to provide EIs with education regarding changing their diets to incorporate healthy food selections and being more active. The ACHN has partnered with the Auburn Extension Office to provide nutritional classes via Zoom, and has made it part of their procedure to identify EIs with a past-due well-child visit and assist with scheduling an appointment with their PCP. Further, My Care Northwest will have their registered dietician work with community agencies to improve knowledge of available community resources, develop a "cheat sheet" for providers to assist them with coding BMI correctly, and partner with Alabama Cooperative Extension Office to provide education to improve healthy eating habits and encourage middle school children to become more active. Intervention tracking measures demonstrate the need for increased participation into the nutritional classes, as well as well-child visits. Intervention tracking measures have not been collected for the interventions that started later in the project year, but it is expected that the ACHN will provide them going forward. Lastly, for their substance use disorder project, My Care Northwest has sought to increase the number of peer support specialists (PSSs) through a partnership with Recovery Organization of Support Specialists (ROSS), and has provided training to their masters-level social workers (MSWs) on how to complete the Adult Placement Assessments (APAs). Further, the ACHN has begun addressing the transportation barrier by having PSSs provide this service to EIs. The only tracking measure that has been evaluated to date is the percentage of EIs who were connected with PSS to assist with treatment. It is expected that My Care Northwest will provide tracking measures for each intervention going forward.

Systems Performance Review

My Care Northwest received a designation of full compliance for EI Materials, EI Rights, and Grievances. The ACHN received a designation of partial compliance for HIMS and Quality Management:

- Of the 11 HIMS standards that were reviewed, 10 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standards:
  - My Care Northwest policies do not indicate that the EI has the right to use any hospital or other setting for emergency care.
- Of the 42 Quality Management standards that were reviewed, 41 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standard:
  - While a monthly/quarterly provider participation report template was submitted for the Medical Management meetings, it was not populated; thus, it is not possible to tell whether all providers had adequate representation at these meetings.

In the domain of Quality, IPRO recommends that My Care Northwest:

- Evaluate the key drivers of contraceptive use among teenagers to bolster the percentage of those that utilize contraception.
- Ensure intervention tracking measures are recorded for each intervention across quality improvement projects.
- Add the EI right to use any hospital or other setting for emergency care to their policies and ensure it is expressed to EIs through written materials.
- Ensure that provider participation is logged throughout the year so that participation in at least two quarterly meetings and one exercise with the Network Medical Director is evidenced.

Timeliness

The Timeliness domain includes findings from the SPR Grievance domain.

Systems Performance Review

Of the six standards reviewed for Grievances, all six standards were fully compliant. There are no current recommendations in the domain of Timeliness.

Access

The Access domain includes findings from three of the eight SPR domains; Care Coordination, Enrollment/Disenrollment and Provider Participation.

Systems Performance Review

My Care Northwest received a designation of full compliance for Enrollment/Disenrollment and Provider Participation. The ACHN received a designation of partial compliance for Care Coordination:

- Of the 134 care coordination standards that were reviewed, 118 were fully compliant, and 16 were partially compliant. The following details findings from the review of the partially compliant standards:
  - The Care Plan Policy outlines how to develop and implement a care plan with specific EI-centered goals; however, this policy does not specifically address catastrophic or severe illness.
  - Two files (family planning cases) did not contain evidence of a health risk screening.
  - Two files did not demonstrate that the risk assessment was completed every 90 days, as required by the Agency's contract with ACHNs.
  - Three files did not demonstrate that MCT meetings were conducted according to the schedule stipulated in the contract.
  - My Care Northwest's policies do not fully express the requirement related to the implementation of a program to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care.
  - The following requirement is not fully expressed in My Care Northwest's policies: "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."
  - Four files did not have evidence of a high risk postpartum encounter, and two files did not contain evidence of a follow-up visit in the second/third trimester.
  - One file did not contain evidence that the maternal care plan was initiated and completed within the required timeframe of 7 days of the initial encounter.
  - Five files did not contain evidence that the care plan was patient-/caregiver-centered with a team approach.
  - One file did not include PCPs/community agencies as appropriate in the care plan.
  - One file did not have notation of whether the EI received prenatal care, and so it could not be determined if newborn care coordination was required. One file did not have a delivery visit or missed delivery encounter within 20 calendar days.
  - Two files did not contain evidence of postpartum care counseling.
  - Two files did not contain evidence of a medication list.
  - My Care Northwest provides verbal notification of the EI's right to change a DHCP once without case in the first 90 days of selection and at any time for just cause (defined as a valid complaint submitted orally or in writing to the PCCM-E); however, materials communicating this right are not provided to the EI. Furthermore, the related requirement that the PCCM-E must inform the EI of this right at initial contact and at least once per year should also be evidenced within My Care Northwest documentation.
  - Materials communicating EI rights and responsibilities and appropriate telephone numbers were provided only verbally to EIs upon initial contact.

In the domain of Access, IPRO recommends that My Care Northwest:

- Conduct root cause analysis to understand the decline in use of contraception among teenagers.
- Add language to their Care Plan Policy that incorporates processes to support Care Coordination for EIs, specifically with regard to reducing the potential for risks of catastrophic or severe illness
- Ensure that all required health risk screenings and assessments are conducted for each EI, and they take place during the required time period. Any difficulties contacting the EI should be documented in the record.
- Ensure that the MCT meets within the required timeframes as outlined in the contract.
- Ensure that all EI needs are addressed to inform a thorough care plan that is patient/caregiver centered with a team approach.

- Develop language within policies to comprehensively address the requirement related to the implementation of a program to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care.
- Develop language within policies to comprehensively address the following requirement: "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."
- Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.
- Ensure that maternal care plans are executed in the required timeframe as outlined in the contract.
- Include PCP and community agencies in care plan creation and implementation process.
- Ensure that newborn care coordination is conducted for all EIs with a newborn delivery who did not receive prenatal care. EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.
- Ensure that postpartum care counseling is conducted appropriately for maternal care coordination.
- Ensure that the Medication List is included within the EI's record to enhance drug use information gathering.
- Ensure that an EI's right to change a DHCP once without case in the first 90 days of selection and at any time for just cause (defined as a valid complaint submitted orally or in writing to the PCCM-E) is conveyed in written format to EI (within EI materials and/or on My Care Northwest website). Further, the related requirement that the PCCM-E must inform the EI of this right at initial contact and at least once per year should also be evidenced within My Care Northwest documentation.
- Ensure that materials communicating EI rights and responsibilities and appropriate telephone numbers are provided to EIs upon initial contact.

North Alabama Community Care

Quality

The Quality domain encompasses QIP activities and findings from five of the eight SPR domains: EI Materials, EI Rights, Grievances, HIMS, and Quality Management.

Quality Improvement Projects

In 2019, North Alabama Community Care (NACC) submitted proposals for three QIP topics: Adverse Birth Outcomes, Childhood Obesity, and Substance Use Disorder. NACC is focusing their efforts on EIs with a BMI greater than or equal to 30.0 in order to mitigate poor birth outcomes. The ACHN has developed interventions that target the identification of EIs who fail their glucose tolerance test (GTT) or who have a BMI greater than or equal to 30.0 at their initial prenatal visit. The ACHN then provides education about physical activity, smoking cessation and breastfeeding, and enrollment into Plan First Services. Intervention tracking measures demonstrate that NACC has been successful in nutrition counseling, as well as mitigating excessive weight gain during pregnancy in those with a high BMI. The ACHN was also effective in helping to facilitate smoking cessation in the two pregnant EIs that were identified. For childhood obesity, the ACHN is targeting EIs 3–6 years of age, as well as pregnant EIs. NACC has begun educating PCPs and pediatricians on the correct collection and reporting of BMI, and requesting from these providers referrals to NACC counseling for EIs 3–6 years of age with a BMI between 85% and 94%. Case Management assesses these EIs for readiness for change, and group sessions that focus on child nutrition, increasing physical activity, and reducing screen time are made available. Furthermore, the ACHN has begun to distribute food boxes to EIs. NACC's intervention targeting pregnant women focuses on Maternity Care Coordinators providing education about the benefits of breastfeeding with first time pregnant EIs, and then these EIs are offered coordination with local lactation support services. Intervention tracking measures demonstrate that the percentage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) claims for EIs ages 3–6 with BMI classification diagnosis codes has steadily increased since the inception of the project. Data that have been reported are limited for the tracking measures that assess the other interventions; however, it is expected that NACC will provide these going forward. Lastly, for their substance use disorder project, NACC is targeting EIs 13 years of age and older with a diagnosis of substance use disorder, as well as providers, to improve access to treatment and recovery services. The ACHN has initiated provider group training sessions via GoTo Meeting (to educate on the referral process to identify EIs in need of brief intervention for SUD). The brief intervention is completed by NACC staff

to educate on the consequences of substance use and encourage healthy lifestyle choices. Further targeting providers, the ACHN has implemented an incentive program to promote MAT certification. Lastly, NACC has coordinated with ROSS to address the support needs of EIs with SUD and complete referrals to residential facilities for treatment. Intervention tracking measures are not available to date, due to the changes in the project due to COVID-19 restrictions. It is expected that NACC will provide these measures going forward, and they will be reviewed to assess intervention progress and provide additional insight into potential gaps in care.

Systems Performance Review

NACC received a designation of full compliance for EI Rights and Grievances. The ACHN received a designation of partial compliance for EI Materials, HIMS, and Quality Management:

- Of the 45 EI Materials standards that were reviewed, 43 were fully compliant and 2 were partially compliant. The following details findings from the review of the partially compliant standards:
  - The ACHN's Proposed Health Education Activities Tool does not include verbiage related to "targeted implementation dates at a frequency and in a format determined by the Agency."
  - The following is not expressed in NACC's policies related to when electronic methods of communication with an EI can be used: The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication; and language and alternative format accommodations are available.
- Of the 11 HIMS standards that were reviewed, 10 were fully compliant and 1 was partially compliant. The following details findings from the review of the partially compliant standards:
  - The requirement related to the accuracy rate at which maternity data and/or care coordination documentation are entered into the HIMS/database, and how falling short of this rate could result in sanctions, is not found within NACC policies.
- Of the 42 Quality Management standards that were reviewed, 40 were fully compliant and 2 were partially compliant. The following details findings from the review of the partially compliant standard:
  - Within the Quality Improvement Plan Evaluation, there is an opportunity to evaluate aspects of quality outside of the quality measures (e.g., chart audits, QIPs, data collection/HIMS, grievances, etc.).
  - Twenty-three unique practices out of 149 participating providers were not in compliance with the active participation requirements associated with attending the Medical Management meetings.

In the domain of Quality, IPRO recommends that North Alabama Community Care:

- Continue tracking their efforts around breastfeeding to see if the intervention is effective.
- Ensure intervention tracking measures are being captured and reported throughout the project period.
- Update documentation to include verbiage related to "targeted implementation dates (for planned health activities) at a frequency and in a format determined by the Agency."
- Update policies related to when electronic methods of communication with an EI can be used by including the following from contract requirements: The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication, and language and alternative format accommodations are available.
- Update University of Alabama's RMEDE documents with the accuracy rate requirement, or add it to an internal NACC policy. NACC could also consider capturing their data validation process in a policy and procedure as another best practice.
- Evaluate aspects of quality outside of the quality measures within the Quality Improvement Plan Evaluation (e.g., chart audits, QIPs, data collection/HIMS, grievances, etc.).
- Continue their outreach efforts to providers to ensure they meet the minimum attendance requirements to achieve active participation status in Medical Management meetings.

Timeliness

The Timeliness domain includes findings from the SPR Grievance domain.

Systems Performance Review

Of the six standards reviewed for Grievances, all six standards were fully compliant.
There are no current recommendations in the domain of Timeliness.

Access

The Access domain includes findings from three of the eight SPR domains; Care Coordination, Enrollment/Disenrollment and Provider Participation.

Systems Performance Review

NACC received a designation of full compliance for Enrollment/Disenrollment and Provider Participation. The ACHN received a designation of partial compliance for Care Coordination:

- Of the 134 care coordination standards that were reviewed, 116 were fully compliant, and 18 were partially compliant. The following details findings from the review of the partially compliant standards:
  - The Transitional Care Program Description includes reference to a review of hospital census reports once per week at a minimum, as opposed the daily review required by the contract.
  - One file did not demonstrate that the risk assessment was completed within the required timeframe.
  - Two files did not contain evidence of an MCT meeting (impacting four standards); NACC indicated this was due to the case being closed before the MCT could meet. These cases appeared to be prematurely closed.
  - One file did not contain evidence that the MCT was consulted regarding the EI's behavioral health issue.
  - One file did not contain a face-to-face Health Risk and Psychosocial Assessment within the required 10 calendar days of discharge.
  - One file did not contain evidence that medication reconciliation occurred within 10 calendar days of discharge.
  - One file did not contain evidence of education regarding medical management within 10 calendar days of discharge.
  - Four files did not contain evidence of a high-risk face-to-face postpartum visit, and two files did not have evidence of a follow-up visit in the second/third trimester.
  - One file did not contain evidence that a maternal health screening took place within the required 5 business days of contact with the EI.
  - Three files did not contain maternal health care plans.
  - Five files did not demonstrate that risks were fully addressed within the care plan.
  - One file indicated involvement from the Alabama Department of Human Resources; however, there was no coordination with this organization that was noted.
  - Five files did not contain evidence of a delivery visit or missing delivery visit within 20 calendar days.
  - One file did not contain evidence that counseling on contraception/family planning services and appropriate postpartum care took place (impacting two standards).

In the domain of Access, IPRO recommends that North Alabama Community Care:

- Update the Transitional Care Program Description to reflect the review of hospital census reports daily (as opposed to "once per week at a minimum").
- Ensure that risk assessments are conducted within the required timeframe, which could determine if goals have been met and if the case can be closed. Further, when an EI is unable to be reached, the entity should document all contact attempts to ensure due diligence is met.
- Ensure that closing of cases are warranted and fully reviewed before action, and that all outreach attempts are documented if communication with the EI is proving difficult. There is an opportunity to analyze how care plan goals are created, which would impact MCT involvement.
- Ensure that the MCT is consulted for all aspects of the EI's needs, including behavioral health, in order to fully integrate and coordinate care.
- Ensure that all face-to-face Health Risk and Psychosocial Assessments are conducted within 10 calendar days of discharge.
- Ensure that medication reconciliation occurs within 10 calendar days of discharge.
- Ensure that education regarding medical management is conducted within 10 calendar days of discharge.
- Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.
- Ensure that maternal health screenings take place within the required 5 business days of contact with the EI.
- Train Care Coordinators to ensure execution of the creation of the care plan within the required timeframe.

- Follow-up with Care Coordinators that were retrained on how to appropriately document and address EI risks and review EI records to determine if the training was successful, and that records contain evidence that risks are being addressed in the care plan.
- Train staff to better detect when additional support from providers or outside agencies should be included in care planning.
- Ensure that EIs eligible for a delivery encounter receive a delivery visit or missed delivery visit within 20 calendar days.
- Ensure that counseling for contraception/family planning and postpartum care is conducted appropriately for maternal health care coordination.

Alabama Medicaid Program: Alabama Coordinated Health Network

The State of Alabama's Medicaid program is administered through the Alabama Medicaid Agency (AMA). The Medicaid program provides healthcare coverage for approximately 957,000 individuals, with 757,000 of those individuals enrolled in the ACHN.

AMA was established in 1970. From 2013 to 2017, Alabama Medicaid transitioned to a full-risk managed care program through an 1115 waiver to implement regional care organizations (RCOs). This demonstration ended in 2017, and in 2019 the state went live with their 1915(b) waiver, which consolidated their previous programs (Patient 1st, Health Home, Maternity Care, and Plan First) into a single, region-specific program referred to as the ACHN.

The Patient 1st Program (launched in 2004) followed a traditional PCCM, wherein AMA contracted directly with physicians who had agreed to serve as primary medical providers, providing medical services directly or through a referral process. The Health Home Program (established regionally in 2012 and expanded statewide in 2015) relied on primary medical providers contracted with health homes to provide PCCM services to health home enrollees. The Maternity Care Program (established in 1988) was developed to address infant mortality and the lack of DHCPs. Plan First (implemented in 2002) was established to address the need for continued family planning services to individuals who would have otherwise lost eligibility, with services designed to reduce unintended pregnancies and improve the well-being of children and families. Women 19–55 years of age and men 21 years of age and older whose income was at or below 141% of the Federal Poverty Level (FPL) were eligible. It is anticipated that combining these programs (Patient 1st, Health Home, Maternity Care, and Plan First) will help improve care coordination efforts and health outcomes among Alabama's Medicaid population.

Table 1 displays the seven ACHN entities and the counties within their regions.

Table 1: Alabama ACHN Entities and Counties

ACHN Entities	Counties
ACN Southeast	Chambers, Lee, Macon, Russell, Bullock, Barbour, Pike, Henry, Dale, Coffee, Covington, Geneva, Houston
ACN Mid-State	Jefferson, Shelby
Gulf Coast Total Care	Choctaw, Clarke, Monroe, Washington, Conecuh, Escambia, Baldwin, Mobile
My Care Central	Chilton, Perry, Autauga, Elmore, Dallas, Lowndes, Montgomery, Crenshaw, Butler, Wilcox, Marengo
My Care East	DeKalb, Cherokee, Etowah, Blount, Calhoun, Cleburne, St. Clair, Talladega, Clay, Randolph, Coosa, Tallapoosa
My Care Northwest	Lauderdale, Colbert, Lawrence, Franklin, Winston, Marion, Lamar, Fayette, Walker, Tuscaloosa, Pickens, Bibb, Hale, Greene, Sumter
North Alabama Community Care	Limestone, Madison, Jackson, Morgan, Marshall, Cullman

ACHN: Alabama Coordinated Health Network; ACH: Alabama Care Network.

ACHN participants include:

- General population: previous enrollees of Patient 1st (which included children not in foster care, parents or other caretakers, refugees, infants of SSI mothers, and aged/blind/disabled not on Medicare), and children in foster care.
- Maternity population: pregnant women.
- Plan First population: women 19–55 years of age and men 21 years of age and older, whose income is at or below 141% of the FPL.

Table 2 displays Medicaid enrollment across the seven regions as of December 2020.

Table 2: Medicaid Enrollment by ACHN Entity as of December 2020

ACHN Entity	Enrollment
ACN Mid-State	138,786
ACN Southeast	123,492
Gulf Coast Total Care	151,161
My Care Central	119,943
My Care East	122,717
My Care Northwest	116,588
North Alabama Community Care	125,340

ACHN: Alabama Coordinated Health Network; ACN: Alabama Care Network.

Alabama Quality Goals and Objectives

AMA developed the ACHN to better monitor, serve, and treat actively enrolled Medicaid participants, ultimately improving their quality of care. AMA has proposed to use the ACHN entities to foster and encourage innovation, improvement, and clinical transformation at the care delivery level. AMA believes that incentivizing change at the delivery system level will create the impetus for sustainable health reform and clinical transformation that will ultimately benefit all patients in the state.

AMA seeks to achieve the following goals under the ACHN program:

- Improve care coordination and reduce fragmentation in the state's delivery system;
- Create aligned incentives to improve beneficiary clinical outcomes;
- Improve access to health care providers; and
- Reduce the rate of growth of Medicaid expenditures.

AMA anticipates that the ACHN program, and the care coordination activities that encompass it, will drive quality improvements and decrease the rate of expenditure growth for Medicaid in the long term. AMA expects these efforts to reduce costs related to preventable admissions, readmissions and emergency department (ED) utilization, and rationalize care delivery to the most efficient and appropriate care setting. In addition, AMA's expectation is that ACHN entities will work to align all members with a PCP and will administer care coordination services for their members to ensure all EIs have a medical home while monitoring these EIs to improve health outcomes.

External Quality Review Activities

Over the course of 2020, IPRO conducted a systems performance review and a validation of QIPs. Each activity was conducted in accordance with CMS protocols. Details of how these activities were conducted are described in **Appendices A** and **B** and address:

- objectives for conducting the activity,
- technical methods of data collection,
- descriptions of data obtained, and
- data aggregation and analysis.

Conclusions drawn from the data and recommendations related to access, timeliness and quality are presented in the **Executive Summary** section of this report.

Findings, Strengths and Recommendations with Conclusions Related to Health Care Quality, Timeliness and Access

Introduction

This section of the report addresses the findings from the assessment of the ACHN entities' strengths and areas for improvement related to quality, timeliness and access. The findings are detailed in each subpart of this section (i.e., Systems Performance Review and Validation of Quality Improvement Projects).

Systems Performance Review

This section of the report presents the results of the review by IPRO of the ACHN entities' compliance with regulatory standards and contract requirements for October 1, 2019–September 30, 2020. The review is based on information derived from IPRO's conduct of the annual SPR, which took place in December 2020. IPRO's assessment methodology is consistent with the protocols established by CMS and is described in detail in **Appendix A**.

A description of the content evaluated under each SPR domain follows:

- Care Coordination – The evaluation of care coordination includes, but is not limited to, a review of: policies and procedures for the entity's care coordination program (including general and maternity care); health-risk assessment development and data collection; and file review of care coordination records.
- EI Rights – The evaluation of EI rights includes, but is not limited to, a review of: policies and procedures for EI rights; selecting a PCP, DHCP, care coordinator, and community health care worker; and medical record requests and amendments.
- EI Materials – The evaluation of EI materials includes, but is not limited to, a review of: policies and procedures for EI materials; a review of the ACHN entity's website, sample EI communications and the accessibility to material in other languages; documentation of advance medical directives; and community resource guides distributed to EIs.
- Enrollment/Disenrollment – The evaluation of enrollment/disenrollment includes, but is not limited to, a review of: policies and procedures for enrollment, disenrollment, anti-discrimination; and review of the ACHN entity's website.
- Grievances – The evaluation of grievances includes, but is not limited to, a review of: policies and procedures for grievances; review of member grievances; ACHN entity program reports on grievances (such as the quarterly grievance log); and Quality Assurance Committee meeting minutes.
- HIMS – The evaluation of HIMS includes, but is not limited to, a review of: policies and procedures for HIMS; monitoring for accuracy; system demonstration; and EI services telephone line demonstration.
- Provider Participation – The evaluation of provider participation includes, but is not limited to, a review of: policies and procedures for participation agreements; and the requirements associated with active participation.
- Quality Management – The evaluation of quality management includes, but is not limited to, a review of: the Quality Improvement (QI) Program Description; Annual QI Evaluation; QI Work Plan; Quality Assurance Committee and Medical Management Committee structure and function, including meeting minutes; QIPs; and documentation related to performance measure results and follow-up.

Table 3 displays the 2020 SPR designations for each ACHN entity.

Table 3: Summary of 2020 SPR Findings

SPR Domain[1]	ACN Mid-State	ACN Southeast	GCTC	My Care Central	My Care East	My Care NW	NACC	Performance Domain(s)
Care Coordination 42 CFR 438.208 42 CFR 438.236	Partial	Partial	Partial	Partial	Partial	Partial	Partial	Access
Provider Participation 42 CFR 438.214 42 CFR 438.206	Full	Full	Full	Full	Full	Full	Full	Access
Enrollment/ Disenrollment 42 CFR 438.210 42 CFR 438.207	Full	Full	Full	Full	Full	Full	Full	Access
EI Materials 42 CFR 438.224	Partial	Partial	Partial	Full	Full	Full	Partial	Quality
EI Rights 42 CFR 438.224 42 CFR 438.206	Full	Full	Full[2]	Full	Full	Full	Full	Quality
HIMS 42 CFR 438.242	Partial	Partial	Partial	Partial	Partial	Partial	Partial	Quality
Quality Management 42 CFR 438.330	Full	Full	Partial	Partial	Partial	Partial	Partial	Quality
Grievances 42 CFR 438.228	Partial	Partial	Partial	Full[2]	Full	Full[2]	Full[2]	Quality and Timeliness

[1] Measurement period: 10/1/19–9/30/20.
[2] SPR designation full with a recommendation.
SPR: systems performance review; ACN: Alabama Care Network; GCTC: Gulf Coast Total Care; NW: Northwest; NACC: North Alabama Community Care; EI: eligible individual; HIMS: health information management system.

For each ACHN entity, a description is provided below, including: content reviewed, current year findings and recommendations, and ACHN entity response and action plan. IPRO will assess the effectiveness of the ACHN entity actions during the next annual SPR.

ACN Mid-State

Care Coordination
A total of 134 standards were reviewed; 125 were fully compliant, and 9 were partially compliant. These partially compliant care coordination standards are presented in **Table 4**.

Table 4: ACN Mid-State Care Coordination Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
Once an EI who may need Care Coordination services is identified, contact must be attempted within five (5) Business Days of screening. At least three (3) attempts must be made within thirty (30) Calendar Days,	This requirement is partially addressed in the General Care Coordination Policy on page 2 and the Care Coordination Process on page 1; there is no documentation that the letter to be sent will be certified.	N/A – No recommendation noted due to change in contract requirement.

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
including a certified letter to explain and offer Care Coordination services.	Additionally, during the interview portion of the review, ACN Mid-State confirmed that this letter was sent via standard mail and not certified. Regarding implementation, the samples provided of the chart audit tool and the attempted outreach screenshots met the requirement. **Recommendation** The entity was only partially compliant in addressing this requirement for the review period (October 1, 2019 – September 30, 2020); however, moving forward, the contract requirement does not mandate letters to be certified. Therefore, at this time, there is no recommendation.	
Track EIs throughout pregnancy and postpartum periods.	This requirement is addressed in the Provision for Maternity Care Coordination Policy on page 3. File Review Results Three files were applicable for a high-risk face-to-face postpartum visit, yet all three had no documentation of this visit. Eight of the files were eligible for a follow-up visit in the second/third trimester; however, five of these files did not have evidence of this follow-up visit. **Recommendation** The entity should ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for eligible EIs.	Additional staff training with Care Coordinators has taken place, addressing timely referrals for those EIs appropriate for high-risk face-to-face postpartum visits. Also, a monthly report has been created and is being distributed to Care Coordinators, to assist them by alerting them to EIs where a high-risk face-to-face postpartum visit is indicated. Additional staff training with Care Coordinators has also taken place to address the importance of follow-up visits in the second/third trimester for those EIs who have been deemed high risk.
Include a maternal health risk identification strategy.	This requirement is addressed in the Maternity Risk Stratification and Assessment Policy on pages 2 to 3. File Review Results Of the 20 files reviewed, 18 met the requirement and two did not meet the requirement. **Recommendation** There was continued discussion	As noted in the Reviewer Comments, logic has been built into the ACHN application to calculate psychosocial assessment score and risk stratification. Additional testing has been performed to assure that the logic is calculating correctly. Additional staff training was also conducted to review the risk stratification scoring methodology used to assess the risk status of each

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
	between the entity and IPRO post-interview to discuss the files that were not fully compliant with the requirement. In ACN Mid-State's response, the entity reported that logic had been built into the ACHN application to calculate psychosocial assessment score and risk stratification. The entity is not required to implement electronic calculation: additional testing should be implemented to ensure that the new calculation will fulfill this requirement, and if necessary, a backup manual process should be established in order to safeguard full compliance.	EI.
Include a maternal Health Risk and Psychosocial Assessment for all EIs at the first face-to-face initial assessment.	File Review Results Of the 20 files reviewed, 15 met the requirement, one was not applicable, and four did not meet the requirement. **Recommendation** There was continued discussion between the entity and IPRO post-interview to discuss the files that were not fully compliant with the requirement. The four files that did not meet compliance were all timely; however, the assessments did not take into account apparent health risks. In ACN Mid-State's response, the entity reported that additional training was being developed to address these findings. The entity should ensure that the training encompasses identification of health risks as well as how to address them.	Additional staff training was conducted to address the importance of a comprehensive Psychosocial Assessment and Risk Stratification to identify all health risks and how they will be addressed, as evidenced by a patient-centered care plan being present.
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must be patient/caregiver centered with a team approach.	This requirement is addressed in the Maternity Risk Stratification and Assessment Policy on page 4. File Review Results Of the 20 files reviewed, 13 met the requirement and seven did not meet the requirement. **Recommendation** Of the seven files that were non-compliant, there were a variety of	Additional staff training was conducted to address the importance of a comprehensive Psychosocial Assessment and Risk Stratification to identify all health risks and how they will be addressed, as evidenced by a patient-centered care plan being present.

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
	issues that were omitted from care plans that had been identified elsewhere in the records for these EIs, mostly social issues, behavioral health issues, or simply not including everything from the EI's history. The entity should ensure that EI-specific risks are addressed in care plans.	
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must include the PCPs/community agencies as appropriate.	This requirement is addressed in the Maternity Risk Stratification and Assessment Policy on page 4. File Review Results Of the 20 files reviewed, 17 met the requirement, two did not meet the requirement, and one was not applicable. **Recommendation** Of the two files that did not demonstrate full compliance, one file had a social issue that should have included community agency collaboration, while the other file included a chronic diagnosis that merited coordination with a specialist. The entity should bolster care coordination by including other providers and external agencies whenever warranted.	The Community Resource Guide and the Community Resource Guide Process have been updated to include annual review of available resources and procedure for adding additional resources. This has been made available to all Care Coordination staff, along with guidance on how it is to be used.
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator.	This requirement is addressed in the Newborns No Prenatal Care Coordination Policy on page 2. File Review Results Of the 20 files reviewed, eleven of the files were applicable for a delivery encounter; however, only 10 of these files had a delivery visit. **Recommendation** The entity should ensure that EIs eligible for a delivery encounter receive a delivery visit or missed delivery visit within 20 calendar days.	Additional training has been conducted with the care coordination staff to include delivery notification process at each delivering hospital. Outreach was done where there was indication that timely notification was not occurring.
Counseling on contraception and family planning services.	This requirement is addressed in the Newborns No Prenatal Care Coordination Policy on page 2. File Review Results Of the 20 files reviewed, 11 met the	Additional staff training was conducted to address the importance of counseling on contraception and family planning services. Where possible, Care Coordinators are now initiating the

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
	requirement, two did not meet the requirement, and seven were not applicable. **Recommendation** There was continued discussion between the entity and IPRO post-interview to discuss the identified files that did not demonstrate compliance. The entity acknowledged that this information was also not documented elsewhere in their records. The entity should ensure that counseling is conducted appropriately for maternal health care coordination.	Family Planning Screening at the Hospital Delivery Visit or Missed Visit, as well as the Hospital Delivery Visit with No Prenatal Care.
Counseling on appropriate postpartum care.	This requirement is addressed in the Newborns No Prenatal Care Coordination Policy on page 2. File Review Results Of the 20 files reviewed, 14 met the requirement, one did not meet the requirement, and five were not applicable. **Recommendation** There was continued discussion between the entity and IPRO post-interview to discuss the identified files that did not demonstrate compliance. The entity acknowledged that this information was also not documented elsewhere in their records. The entity should ensure that counseling is conducted appropriately for maternal health care coordination.	Additional staff training was conducted to address the importance of the EI attending the postpartum visit following delivery.

EI Materials

A total of 45 standards were reviewed; 37 were fully compliant, 5 were partially compliant, 2 were non-compliant and 1 was not applicable. These partially compliant and non-compliant EI Materials standards are presented in **Table 5.**

Table 5: ACN Mid-State EI Materials Partially Compliant and Non-Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
The PCCM-E must provide the Agency with a written description of all planned health education activities and targeted implementation dates at a frequency and in a format determined by the Agency.	This requirement is addressed in the Alabama Care Network Mid-State EI Outreach document and DHCP Semi-Annual Outreach and Education Report Template however, does not address if the targeted	Revision to Policy 015 has been drafted and includes verbiage related to health education activities and targeted implementation dates at a frequency and format determined by the Agency. Policy has been

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
	implementation dates are at a frequency and format determined by the Agency. **Recommendation** ACN Mid-State should update their policies to include verbiage related to their health education activities and targeted implementation dates at a frequency and format determined by the Agency.	submitted to the agency for approval.
The PCCM-E must make PCPs, EIs, and the community aware of the purpose and the services offered by the PCCM-E. Materials identified or developed for use shall be reviewed and approved by the Agency, including, but not limited to, letters, educational Materials, programs, promotional, on-line content, and forms.	This requirement is addressed on the ACN Mid-State website in the "Coordination Services We Offer" section however the requirement of "Materials being identified or developed for use shall be reviewed and approved by the Agency…" is not addressed in the Eligible Individual Materials including Interpretation Services Policy No. 015 Policy. **Recommendation** ACN Mid-State should update their policies to include verbiage related to the review and approval by the Agency of these materials.	Revision to Policy 015 has been drafted and includes verbiage related to the review and approval by the Agency of these materials. Policy has been submitted to the agency for approval.
The PCCM-E must provide semi-annual outreach and education to DHCPs. At a minimum program guidelines, updates from the Agency and referral processes must be addressed.	This requirement is addressed in the DHCP Semi-Annual Outreach and Education Report Template however the requirement of addressing "updates from the Agency" is not addressed. **Recommendation** ACN Mid-State should update their policies to include verbiage related to addressing updates from the Agency.	Revision to Policy 015 has been drafted and includes language addressing DCHP outreach requirements. Policy has been submitted to the agency for approval.
Website content must be approved in advance by the Agency. Website content is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information. If directed by the Agency, the PCCM-E must establish appropriate links on the PCCM-E's website that direct users back to the Agency's website.	This requirement is partially addressed on the ACN Mid-State website as there is a link, Alabama Medicaid Recipient Site, however, the requirement of "Website content must be approved in advance by the Agency. Website content is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information." is not addressed. **Recommendation**	Revision to Policy 015 has been drafted and includes language to address incorporating their website to the Agency or State website. Policy has been submitted to the agency for approval.

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
	ACN Mid-State should revise Policy ACHN 015 to include language to address incorporating their website to the Agency or State website.	
In addition to the requirements of Section II.W Information Requirements of this RFP, the PCCM-E may only use electronic methods of communication with an EI if: a. The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication; b. The EI has requested or approved electronic transmittal; c. The identical information is available in written format upon request; d. Language and alternative format accommodations are available; and e. All Health Insurance Portability and Accountability Act (HIPAA) requirements are satisfied with respect to PHI.	The requirements of: identical information is available in written format upon request (c) and addressing language and alternative format accommodations (d) are in the ACN Mid-State 2019 Eligible Individual Materials Including Interpretation Services Policy No. 015 however, does not address the requirements a, b, and e. **Recommendation** ACN Mid-State should revise their policy to include language to address the requirements of this section.	Revision to Policy 015 has been drafted and includes language to address electronic communication requirements. Policy has been submitted to the Agency for approval.

Non-Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
The community resource guide must be updated at least annually and made available to the PCCM-E's Care Coordination staff who have contact with EIs.	This requirement is not addressed in the ACN Mid-State Resource Guide or on the ACN Mid-State website. **Recommendation** ACN Mid-State should revise Policy ACHN 015 to include website language. ACN Mid-State should also review the formalized process to ensure regular updates.	Revision to Policy 015 has been drafted & includes language addressing annual updates to community resource guide and its being made available to CC staff. Policy has been submitted to the agency for approval.
If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation.	This requirement is not addressed on the ACN Mid-State website. **Recommendation** ACN Mid-State should revise Policy ACHN 015 to include language to address incorporating their website to the Agency or State website.	Revision to Policy 015 has been drafted and includes language to address incorporating their website to the Agency or State website. Policy has been submitted to the agency for approval.

EI Rights
A total of 10 standards were reviewed; all were fully compliant.

Enrollment/Disenrollment
A total of 11 standards were reviewed; all were fully compliant.

Grievances
A total of six standards were reviewed; five were fully compliant, and one was partially compliant. This partially compliant grievance standard is presented in **Table 6**.

Table 6: ACN Mid-State Grievances Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
A summary and, if necessary, a request for a corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP. The PCCM-E must forward their CAP to the Agency. The Agency will evaluate the CAP within seven (7) Calendar Days of receipt. If the CAP is not responsive to the complaint, it will be returned to the PCCM-E within two (2) Business Days. The revised CAP will be resubmitted to the Agency within two (2) Business Days. If the summary or CAP carried out is found not to be responsive, the PCCM-E will have up to forty-five (45) Calendar Days to revise the plan and carry out the appropriate action.	This requirement is not addressed in any policy submitted by the entity. After the interview, the entity provided their Grievances and Dispute Resolution Process, which contains the language for this requirement, however; this document has not been approved by the Agency and is not an official policy. **Recommendation** It is recommended that the entity revise its complaints and grievances policy and procedure to reflect the activities outlined in this requirement.	Grievance Policy revised to address this requirement & policy submitted to Agency for approval.

HIMS
A total of 11 standards were reviewed; 9 were fully compliant, and 2 were partially compliant. These partially compliant HIMS standards are presented in **Table 7**.

Table 7: ACN Mid-State HIMS Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
The Agency is requiring a case management system that includes Care Coordination documentation, maternity data and the ability to accept Admission/Discharge/Transfer (ADT) feeds. Failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in Sanctions (see Section II.M.2.i.).	This requirement is partially addressed in the ACHN Application process provided by ACN Mid-State. **Recommendation** ACN Mid-State should add the accuracy rate requirement to their policy.	HIMS policy drafted to address the requirement to have a case management system & policy submitted to Agency for approval.
g. The PCCM-E HIMS must comply with the following: i. The system must provide the Agency a monthly extract of data in the format prescribed by the Agency.	This requirement is partially addressed in the ACHN Application process provided by ACN Mid-State. The ACHN provided data files demonstrating that extracts are created.	HIMS policy drafted to address the requirement for Mid-State to provide a monthly data extract to the Agency & policy submitted to Agency for

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Mid-State Response and Action Plan
	Recommendation ACN Mid-State should add the reporting extract requirement to their policy.	approval.

Provider Participation
A total of 12 standards were reviewed; all were fully compliant.

Quality Management
A total of 42 standards were reviewed; all were fully compliant.

ACN Southeast

Care Coordination
A total of 134 standards were reviewed; 124 were fully compliant, and 10 were partially compliant. These partially compliant care coordination standards are presented in **Table 8**.

Table 8: ACN Southeast Care Coordination Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
Once an EI who may need Care Coordination services is identified, contact must be attempted within five (5) Business Days of screening. At least three (3) attempts must be made within thirty (30) Calendar Days, including a certified letter to explain and offer Care Coordination services.	This requirement is partially addressed in the General Care Coordination Policy on page 2 and the Care Coordination Process on page 1; however, there is no documentation that the letter to be sent will be certified. Regarding implementation, the samples provided of timely audit screening and attempted outreach address the requirement. **Recommendation** The entity was only partially compliant in addressing this requirement for the review period (October 1, 2019 - September 30, 2020); however, moving forward, the contract requirement does not mandate letters to be certified. Therefore, at this time, there is no recommendation.	N/A- no recommendation at this time.
As the EI's needs are identified or goals are met, the EI's risk level may change. The PCCM-E will complete a risk reassessment form to change the EI's risk level. At the minimum, a risk assessment must be completed every ninety (90) Calendar Days.	This requirement is addressed in the General Care Coordination Policy on page 3. File Review Results Of the 20 files reviewed, one met the requirement, two did not meet the requirement, and 17 were not applicable.	ACN Southeast completed additional training on 1/27/2021 with care coordinators to teach new RFP requirements that risk assessments are completed every six months. General Care Coordination Policy has

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
	Recommendation The entity should ensure that risk assessments are conducted within the contractually mandated timeframes.	been updated and submitted to the Agency for approval. Monthly audits will be completed for each care coordinator to ensure compliance.
Additional assessments required for each EI receiving general Care Coordination include: i. PHQ-A for EIs ages 12-17 ; ii. PHQ-2 for EIs age 18 and older; iii. PHQ-9 for EIs age 18 and older that score a four (4) or higher on the PHQ-2; iv. Substance abuse screening tool approved by the Agency; and v. Medication Reconciliation.	This requirement is addressed in the General Care Coordination Policy on page 3. File Review Results Of the 20 files reviewed, 18 met the requirement and two did not meet the requirement. **Recommendation** Of the two non-compliant files, both files did not include medication reconciliation; one file was also missing a PHQ and substance abuse screen. The entity should ensure that additional assessments are conducted appropriately for each EI.	ACN Southeast completed training on medication lists/reconciliation process on 1/20/2021 with all care coordinators. Monthly audits will be completed for each care coordinator to ensure compliance of medication lists, PHQ screenings and substance abuse screenings.
Track EIs throughout pregnancy and postpartum periods;	This requirement is addressed in the Provision for Maternity Care Coordination Policy on page 3. File Review Results Of the 20 files reviewed, two were applicable for a high-risk face-to-face postpartum visit, yet both had no documentation of this visit. Twelve of the files were eligible for a follow-up visit in the second/third trimester; however, four of these files did not have evidence of this follow-up visit. **Recommendation** The entity should ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for eligible EIs.	Staff training has been provided on 1/13/2021 to address timely visits of high-risk EIs who need a postpartum visit. We also trained on the importance of completing the follow-up visits in the second/third trimester. A monthly report has been created and is distributed to our care coordinators to identify the high-risk EIs who need a postpartum visit completed.
Include a maternal health screening within five (5) Business Days of contact with the EI;	This requirement is addressed in the Maternity Risk Stratification and Assessment Policy on page 2. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the	ACN Southeast provided additional training on 1/13/2021 to care coordinators regarding timely maternal health screenings.

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
	requirement. **Recommendation** The entity should ensure that maternal health screenings are conducted in a timely manner.	
Be patient/caregiver centered with a team approach;	This requirement is addressed in the Maternity Risk Stratification and Assessment Policy on page 4. File Review Results Of the 20 files reviewed, 14 met the requirement and six did not meet the requirement. **Recommendation** There was continued discussion between the entity and IPRO post-interview to discuss the identified problematic files. Although the entity did provide some clarity as to why certain files had missed opportunities to create a more patient-centered care plan for these EIs, these answers did not justify a change of determination for these files. For the two files where there was an unknown type of STD, the entity stated that both files had EIs with a "low" risk stratification, so no follow-up regarding medication was needed as the STD was already addressed. Even if the STD was addressed, it should still be included in the care plan as this is part of the medical history and relevant to the EI's condition, in the very least. For the two files where the EIs had severe preeclampsia/hypertension, the entity responded that care coordinators were not aware of these issues until after delivery. Additionally, multiple files identified EIs with obesity, yet the entity did not address this issue. The entity should ensure that all aspects of an EI's medical history are addressed to inform a thorough care plan.	Additional staff training was provided on 1/13/2021 regarding risk stratification of EIs and care plans to include all medical history. A report has been developed regarding EIs without a care plan and is distributed to care coordinators weekly. Monthly audits will be performed for each care coordinator to ensure compliance.
The PCCM-E must provide Care	This requirement is addressed in the	Additional staff training was

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator. The following services shall be provided to the newborn's mother:	Newborns No Prenatal Care Coordination Policy on page 2. File Review Results Of the 20 files reviewed, none of the files were applicable for newborn care coordination, as all files had evidence of prenatal care. Twelve of the files were applicable for a delivery encounter; however, only 11 of these files had a delivery visit. **Recommendation** The entity should ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	completed on 1/13/2021 regarding the importance of the delivery encounter and to remind care coordinators of the importance of completing these visits timely. A report has been developed and is distributed to care coordinators with a list of EIs who need delivery visits within 20 calendar days.
Counseling on contraception and family planning services; and	This requirement is addressed in the Newborns No Prenatal Care Coordination Policy on page 2. File Review Results Of the 20 files reviewed, 16 met the requirement, one did not meet the requirement, and three were not applicable. **Recommendation** The entity should ensure that counseling is conducted appropriately for maternal health care coordination.	Additional staff training was completed on 1/13/2021 regarding the importance of counseling on contraception and family planning services, and appropriate postpartum care. Additional staff training was completed on 1/13/2021 regarding the importance of counseling on contraception and family planning services, and appropriate postpartum care.
Counseling on appropriate postpartum care.	File Review Results Of the 20 files reviewed, 13 met the requirement, 2 did not meet the requirement, and 5 were not applicable. **Recommendation** There was continued discussion between the entity and IPRO post-interview to discuss the identified problematic files. Although the entity did provide some clarity as to why certain files had missed opportunities to provide counseling on postpartum care, these answers did not justify a change of determination for all of the identified files. For one file, the EI developed severe preeclampsia which was not addressed (in regards to this requirement, this could be in the form of a discussion regarding	Additional staff training was completed on 1/13/2021 regarding the importance of counseling on contraception and family planning services, and appropriate postpartum care.

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
	warning signs, early follow-up, finding out what discharge medication was needed, etc.); however, the entity stated that the care coordinator was unaware of this until the delivery visit. The entity should ensure that counseling is conducted appropriately for maternal health care coordination.	
The Medication List shall be used during the EI interview of the Health Risk and Psychosocial Assessment to enhance drug use information gathering. The caregiver or family may be present at the interview. Medication List should also include discharge instructions, PCP chart, prescription fill history, and patient report, as appropriate.	This requirement is addressed in the Medication List Policy on page 2. <u>File Review Results</u> Of the 20 general care coordination files reviewed, 18 met the requirement and two did not meet the requirement. Of the 20 maternity care files reviewed, 18 were not applicable and two met the requirement. **<u>Recommendation</u>** The entity should ensure that a complete medication list is included in each EI's record where appropriate.	Additional training was provided on 1/20/2021 to the care coordinators regarding the importance of completing a thorough medication list for each EI. Monthly audits will be performed for each care coordinator to ensure compliance.

EI Materials

A total of 45 standards were reviewed; 41 were fully compliant, 2 were partially compliant and 2 were non-compliant. These partially compliant and non-compliant EI materials standards are presented in **Table 9**.

Table 9: ACN Southeast EI Materials Partially Compliant and Non-Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
In addition to the requirements of Section II.W Information Requirements of this RFP, the PCCM-E may only use electronic methods of communication with an EI if: a. The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication; b. The EI has requested or approved electronic transmittal; c. The identical information is available in written format upon request; d. Language and alternative format accommodations are available; and e. All Health Insurance Portability	This requirement is addressed in the ACN Southeast Consent to Receive Text Messages, Authorization for Disclosure of Protected Health Information (PHI) and the Eligible Individual Materials including Interpretation Services Policy No. 015 on pages 2-3 however, does not address requirement (a.), "The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication." **<u>Recommendation</u>** ACN Southeast should update their policies to include this missing language.	ACN Southeast revised EI Materials Including Interpretation Services Policy No. 015 and submitted to the Agency for approval to include the verbiage to include the narrative, "The EI has provided an email address and has not requested to no longer receive electronic methods of communication."

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
and Accountability Act (HIPAA) requirements are satisfied with respect to PHI.		
The PCCM-E must provide the Agency with a written description of all planned health education activities and targeted implementation dates at a frequency and in a format determined by the Agency.	This requirement is partially addressed in the ACN Southeast 2019 Proposed Health Education Activities document. **Recommendation** ACN Southeast should ensure that all planned health education activities, along with implementation dates, are provided to the Agency and that their policies indicate they are at a frequency and format determined by the Agency.	ACN Southeast revised EI Materials Including Interpretation Services Policy No. 015 and submitted to the Agency for approval to include the verbiage "health education activities and targeted implementation dates are provided to the Agency and that these activities are at a frequency and format determined by the Agency."
Non-Compliant Standards	**Findings and Recommendations for Improvement**	**ACN Southeast Response and Action Plan**
If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation.	This requirement is not addressed on the ACN Southeast website or within the ACHN's policies and procedures. **Recommendation** ACN Southeast should ensure that language related to the Agency or State standards for website structure, coding, and presentation is incorporated into their policies and procedures.	ACN Southeast revised EI Materials Including Interpretation Services Policy No. 015 and submitted to the Agency for approval to include the verbiage to make sure language related to the Agency or State standards for website structure, coding and presentation.
Website content must be approved in advance by the Agency. Website content is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information. If directed by the Agency, the PCCM-E must establish appropriate links on the PCCM-E's website that direct users back to the Agency's website.	This requirement is not addressed on the ACN Southeast website or within the ACHN's policies and procedures. **Recommendation** ACN Southeast should ensure that language related to approval of website content, and that this content is accurate, current, and designed in a way that EIs and providers can easily locate information, is incorporated into their policies and procedures.	ACN Southeast revised EI Materials Including Interpretation Services Policy No. 015 and submitted to the Agency for approval to include the narrative that our website content is to be accurate, current and designed so that EIs and Providers may easily locate all relevant information and that ACHN SE will establish appropriate links on the website that directs users back to the Agency's website.

EI Rights
A total of 10 standards were reviewed; all were fully compliant.

Enrollment/Disenrollment
A total of 11 standards were reviewed; all were fully compliant.

Grievances
A total of six standards were reviewed; five were fully compliant, and one was partially compliant. This partially compliant grievance standard is presented in **Table 10**.

Table 10: ACN Southeast Grievances Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
A summary and, if necessary, a request for a corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP. The PCCM-E must forward their CAP to the Agency. The Agency will evaluate the CAP within seven (7) Calendar Days of receipt. If the CAP is not responsive to the complaint, it will be returned to the PCCM-E within two (2) Business Days. The revised CAP will be resubmitted to the Agency within two (2) Business Days. If the summary or CAP carried out is found not to be responsive, the PCCM-E will have up to forty-five (45) Calendar Days to revise the plan and carry out the appropriate action.	This requirement is not addressed in any policy submitted by the entity with the exception of the 45-day resolution timeframe requirement. At the interview, the entity confirmed it does not have a policy that includes the remaining language in this requirement, but it does have an internal process that was submitted for review. The grievances and dispute resolution process document that was submitted does contain the language from this requirement. However; this is not a formal policy approved by the Agency. **Recommendation** It is recommended that the entity revise the grievances and complaints policy and procedure to include language for this requirement.	ACN Southeast has updated Grievance Policy for Agency approval to include the verbiage below: A corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP. The PCCM-E must forward their CAP to the Agency. The Agency will evaluate the CAP within seven (7) Calendar Days of receipt. If the CAP is not responsive to the complaint, it will be returned to the PCCM-E within two (2) Business Days. The revised CAP will be resubmitted to the Agency within two (2) Business Days.

HIMS
A total of 11 standards were reviewed; 9 were fully compliant, and 2 were partially compliant. These partially compliant HIMS standards are presented in **Table 11**.

Table 11: ACN Southeast HIMS Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
The Agency is requiring a case management system that includes Care Coordination documentation, maternity data and the ability to accept Admission/Discharge/Transfer (ADT) feeds. Failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in Sanctions (see Section II.M.2.i.).	This requirement is partially addressed in the ACHN Application process provided by ACN Southeast. **Recommendation** ACN Southeast should add the accuracy rate requirement to their policy.	ACN Southeast has drafted a HIMS policy and has submitted to the Agency for approval to include the 95% accuracy rate requirement.
The PCCM-E HIMS must comply with the following: The system must provide the Agency a monthly extract of data in the format prescribed by the Agency.	This requirement is partially addressed in the ACHN Application process provided by ACN Southeast. The ACHN provided data files demonstrating that extracts are created.	ACN Southeast has drafted a HIMS policy and has submitted to the Agency for approval to include the narrative that states "the system must provide the

Partially Compliant Standards	Findings and Recommendations for Improvement	ACN Southeast Response and Action Plan
	Recommendation ACN Southeast should add the reporting extract requirement to their policy.	Agency a monthly extract of data in the format prescribed by the Agency."

Provider Participation
A total of 12 standards were reviewed; all were fully compliant.

Quality Management
A total of 42 standards were reviewed; all were fully compliant.

Gulf Coast Total Care

Care Coordination
A total of 134 standards were reviewed; 125 were fully compliant, and 9 were partially compliant. These partially compliant care coordination standards are presented in **Table 12**.

Table 12: GCTC Care Coordination Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
Once an EI who may need Care Coordination services is identified, contact must be attempted within five (5) Business Days of screening. At least three (3) attempts must be made within thirty (30) Calendar Days, including a certified letter to explain and offer Care Coordination services.	This requirement is partially addressed in the General Care Coordination Policy on page 2 and the Care Coordination Process on page 1; however, there is no documentation that the letter to be sent will be certified. Regarding implementation, the samples provided of the chart audit tool and the attempted outreach screenshots met the requirement. **Recommendation** The entity was only partially compliant in addressing this requirement for the review period (October 1, 2019 - September 30, 2020); however, moving forward, the contract requirement does not mandate letters to be certified. Therefore, at this time, there is no recommendation.	Moving forward, the Medicaid contract no longer requires the letter to be sent certified mail. The Care Coordinators will document that a letter has been and attach a copy of the letter in the HIMs for further verification.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Meet regularly as outlined in Exhibit G;	File Review Results Of the 20 files reviewed, 14 met the requirement, three did not meet the requirement, and three were not applicable. **Recommendations** The entity should ensure that the MCT meets regularly as the EI's risk	Care Coordination supervisors developed and presented an all staff training to ensure that Care Coordinators are following the updated MCT policy. The 3 hour training was held on 12.30.20. It was recorded and will be uploaded into the LMS system and required to attend

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
	stratification designates. Additionally, of the files that did not meet the requirement, it is noted that these EIs were newborns or toddlers, and that there was no MCT meeting documented on these files. An additional review might be warranted to determine if there is a gap in care for this population.	for staff that could not attend the live training.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Include multi-disciplines;	This requirement is addressed in the MCT GCTC Policy on page 2. File Review Results Of the 20 files reviewed, 14 met the requirement, three did not meet the requirement, and three were not applicable. **Recommendation** The entity should ensure that the MCT for each EI is comprised of professionals from a variety of disciplines. Additionally, of the files that did not meet the requirement, it is noted that these EIs were newborns or toddlers, and that there was no MCT meeting documented on these files. An additional review might be warranted to determine if there is a gap in care for this population.	Care Coordination supervisors developed and presented an all staff training to ensure that Care Coordinators are following the updated MCT policy. The 3 hour training was held on 12.30.20. It was recorded and will be uploaded into the LMS system and required to attend for staff that could not attend the live training.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Discuss EI's needs, solutions, and potential outcomes;	This requirement is addressed in the MCT GCTC Policy on page 2. File Review Results Of the 20 files reviewed, 14 met the requirement, three did not meet the requirement, and three were not applicable. **Recommendation** The entity should ensure that the MCT has discussions focused on the EI's recovery and wellbeing. Additionally, of the files that did not meet the requirement, it is noted that these EIs were newborns or toddlers, and that there was no MCT meeting documented on these files. An additional review might be warranted to determine if there is a gap in care for this population.	Care Coordination supervisors developed and presented an all staff training to ensure that Care Coordinators are following the updated MCT policy. The 3 hour training was held on 12.30.20. It was recorded and will be uploaded into the LMS system and required to attend for staff that could not attend the live training.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital,	This requirement is addressed in the MCT GCTC Policy on page 2.	Care Coordination supervisors developed and presented an all staff training to ensure that

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Document, in detail, issues as described above and participating staff.	File Review Results Of the 20 files reviewed, 14 met the requirement, three did not meet the requirement, and three were not applicable. **Recommendation** The entity should ensure that the MCT meetings are documented in detail. Additionally, of the files that did not meet the requirement, it is noted that these EIs were newborns or toddlers, and that there was no MCT meeting documented on these files. An additional review might be warranted to determine if there is a gap in care for this population.	Care Coordinators are following the updated MCT policy. The 3 hour training was held on 12.30.20. It was recorded and will be uploaded into the LMS system and required to attend for staff that could not attend the live training.
Consultation to the MCT regarding behavioral health issues or topics and resources in the area	This requirement is addressed in the Behavioral Health Program GCTC Policy on page 2. File Review Results Of the 20 files reviewed, four met the requirement, one did not meet the requirement, and 15 were not applicable. **Recommendation** Regarding the file that did not meet the requirement, the entity provided an explanation in the file review correspondence that the EI had denied substance abuse, and therefore it was not an active problem that needed to be addressed (this is in addition to the smoking cessation education and nicotine patches that the transitional care nurse was working to obtain for the EI). Despite the denial, there was a documented positive substance screen as well as multiple references to a history of polysubstance abuse in the file, which should warrant a closer examination of this EI's behavioral health issues. The entity should not dismiss an identified, documented behavioral health issue because an EI is no longer recognizing it as an active problem. At the very least, the entity should ensure that the MCT continue to discuss, consult with applicable parties, and monitor the issue, with careful note to document this in the EI's file.	Care Coordinator supervisors held an all staff training for Care Coordinators in order to further develop care planning skills and ensure that they meet Medicaid requirements. Monthly audits will be completed to determine if documentation requirements are being met. Moving forward, all behavioral health and substance abuse concerns, whether or not the EI denies an issue, will be addressed on the care plan and reviewed at each contact, where the Care Coordinators will utilize Motivational Interviewing to assist the EI to move to a higher level of change motivation.

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
Include a maternal Health Risk and Psychosocial Assessment for all EIs at the first face-to-face initial assessment.	This requirement is addressed in the Maternity Risk Stratification and Assessment Policy on pages 2 to 3. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the requirement. **Recommendation** The entity should take into account all of the EI's risk factors and past health risks when conducting the initial assessment as they need to be included in the care plan. It is noted that the entity has acknowledged this opportunity for improvement and received guidance and training from the Agency earlier this year to fully address this requirement.	Training was conducted on 12/30/2020 with all of care coordination staff regarding Medicaid's expectation of Care Plans for all identified health risks. We will continue to monitor adherence to this requirement during our routine monthly audits process.
Be patient/caregiver centered with a team approach;	This requirement is addressed in the Maternity Risk Stratification and Assessment Policy on page 4. File Review Results Of the 20 files reviewed, 17 met the requirement and three did not meet the requirement. **Recommendation** During the interview portion of the compliance review, in response to the non-compliant files, the entity stated that if the EI had past issues that weren't considered current, these past issues would not be addressed in the care plan. In order to fully address this requirement, the entity should review the EI's medical history and include documentation of this in the care plan.	Training was conducted on 12/30/2020 with all of care coordination staff regarding Medicaid's expectation of Care Plans for all identified health risks. We will continue to monitor adherence to this requirement during our routine monthly audits process.
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator.	This requirement is addressed in the Newborns No Prenatal Care Coordination Policy on page 2. File Review Results Of the 20 files reviewed, none of the files were applicable for newborn care coordination, as all files had evidence of prenatal care. Fourteen of the files were applicable for a delivery encounter; however, only 12 of these files had a delivery visit.	On 12/30/20, we discussed with the care coordinator's the importance of having a patient tracking system in place and kept current. Additionally, we now distribute to the care coordinators a monthly spreadsheet of EIs with upcoming/past EDCs to work in an effort to ensure all delivery encounters are completed within the required timeframe.

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
	Recommendation The entity should ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	We will continue to monitor progress through monthly routine audit process.

EI Materials

A total of 45 standards were reviewed; 41 were fully compliant, 2 were partially compliant and 2 were non-compliant. These partial and non-compliant EI materials standards are presented in **Table 13**.

Table 13: GCTC EI Materials Partially Compliant and Non-Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
The PCCM-E must provide the Agency with a written description of all planned health education activities and targeted implementation dates at a frequency and in a format determined by the Agency.	This requirement is addressed in the Gulf Coast Total Care 2019-2020 Section Y Outreach Education Program however, this document does not address the requirement of implementing education activities at a frequency and in a format determined by the Agency. **Recommendation** GCTC should ensure that all planned health education activities, along with implementation dates, are provided to the Agency and that their policies indicate they are at a frequency and format determined by the Agency.	The ACHN 015 EI Materials and Interpretation Services policy has been updated and submitted to Medicaid for approval.
In addition to the requirements of Section II.W Information Requirements of this RFP, the PCCM-E may only use electronic methods of communication with an EI if: a. The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication; b. The EI has requested or approved electronic transmittal; c. The identical information is available in written format upon request; d. Language and alternative format accommodations are available; and e. All Health Insurance Portability and Accountability Act (HIPAA) requirements are satisfied with respect to PHI.	Requirements “c” and “d” are addressed in the Eligible Individual Materials including Interpretation Services Policy No. 015, however requirements “a”, “b” and “e” are not addressed on the Gulf Coast Total Care website or in submitted documentation. **Recommendation** GCTC should ensure their policy is updated to reflect language within this requirement.	The ACHN 015 EI Materials and Interpretation Services policy has been updated and submitted to Medicaid for approval.

Non-Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation.	This requirement is not addressed on the Gulf Coast Total Care website or within their policies and procedures. **Recommendation** GCTC should ensure their policy is updated to reflect language within this requirement.	The ACHN 015 EI Materials and Interpretation Services policy has been updated and submitted to Medicaid for approval.
Website content must be approved in advance by the Agency. Website content is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information. If directed by the Agency, the PCCM-E must establish appropriate links on the PCCM-E's website that direct users back to the Agency's website.	This requirement is not addressed on the Gulf Coast Total Care website or within their policies and procedures. **Recommendation** GCTC should ensure their policy is updated to reflect language within this requirement.	The ACHN 015 EI Materials and Interpretation Services policy has been updated and submitted to Medicaid for approval.

EI Rights
A total of 10 standards were reviewed; all were fully compliant. There was one recommendation for GCTC to consider adding language to the Eligible Individual's Rights Policy No. 021 that states that the EI is allowed to request and receive a copy of their Medical Records and request that they be amended or corrected. The ACHN responded that they updated their Eligible Individual's Rights Policy No. 021 with the recommended language.

Enrollment/Disenrollment
A total of 11 standards were reviewed; all were fully compliant.

Grievances
A total of six standards were reviewed; five were fully compliant, and one was partially compliant. This partially compliant grievances standard is presented in **Table 14**.

Table 14: GCTC Grievances Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
A summary and, if necessary, a request for a corrective action plan (CAP) will be sent from the Agency for all complaints reported within thirty (30) Calendar Days of the request for the summary or CAP. The PCCM-E must forward their CAP to the Agency. The Agency will evaluate the CAP within seven (7) Calendar Days of receipt. If the CAP is not responsive to the complaint, it will be returned to the PCCM-E within two (2) Business Days. The revised CAP will be resubmitted to the Agency within two (2) Business Days. If the summary or CAP carried out is found not to be responsive, the PCCM-E will have up to	This requirement is not addressed in any policy submitted by the entity. After the virtual interview, the entity provided their Grievances and Dispute Resolution Process, which contains the language for this requirement, however; this document has not been approved by the Agency and is not an official policy document. **Recommendation** It is recommended that the entity revise its complaints and grievances policy and procedure to reflect the activities outlined in this requirement.	Grievance process has been updated and submitted to AMA for approval.

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
forty-five (45) Calendar Days to revise the plan and carry out the appropriate action.		

HIMS
A total of 11 standards were reviewed; 9 were fully compliant, and 2 were partially compliant. These partially compliant HIMS standards are presented in **Table 15**.

Table 15: GCTC HIMS Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
The Agency is requiring a case management system that includes Care Coordination documentation, maternity data and the ability to accept Admission/Discharge/Transfer (ADT) feeds. Failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in Sanctions (see Section II.M.2.i.).	This requirement is partially addressed in the ACHN Application process provided by GCTC. **Recommendation** GCTC should add the accuracy rate requirement to their policy.	Recommendation added to HIMS Policy and Procedure. Sent to AMA for approval.
The system must provide the Agency a monthly extract of data in the format prescribed by the Agency.	This requirement is partially addressed in the ACHN Application process provided by GCTC. GCTC provided data files demonstrating that extracts are created. **Recommendation** GCTC should add the reporting extract requirement to their policy.	Recommendation added to HIMS Policy and Procedure. Sent to AMA for approval.

Provider Participation
A total of 12 standards were reviewed; all were fully compliant.

Quality Management
A total of 42 standards were reviewed; 41 were fully compliant, and 1 was partially compliant. This partially compliant quality management standard is presented in **Table 16**.

Table 16: GCTC Quality Management Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
Composed of all participating Providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a twelve (12) month period in at least two (2) quarterly Medical Management	This requirement is addressed in Quality Improvement Program Policy No. 021, and evidence of meetings can be found in the Medical Management Meeting notes within the Quality Improvement Plan Evaluation. It is not clear, however, that all participating providers have attended	Quality Improvement Plan Evaluation FY2020 pg 22-53 contains PCP practices attendance for all quarterly Medical Management Meetings. Attendance identifies the PCP practices meeting the

Partially Compliant Standards	Findings and Recommendations for Improvement	GCTC Response and Action Plan
meetings in person and one (1) webinar/facilitation exercise with the Network(s) Medical Director.	the required number of meetings. GCTC indicated that before COVID-19 limitations, they had breakfast, lunch and dinner meetings with providers, as well as webinars. **Recommendation** GCTC should ensure that a roster for provider participation in the Medical Management meetings is developed, to ensure active participation requirements are being met.	active participation requirements.

My Care Central

Care Coordination
A total of 134 standards were reviewed; 122 were fully compliant, and 12 were partially compliant. These partially compliant care coordination standards are presented in **Table 17**.

Table 17: My Care Central Care Coordination Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
The PCCM-E shall establish processes to support Care Coordination for EIs, primarily those that are at highest risk and cost. The processes shall include, but are not limited to, the following: Reducing the potential for risks of catastrophic or severe illness;	This requirement is partially addressed in the Care Plan Policy. The Care Plan Policy outlines how to develop and implement a care plan with specific EI-centered goals; however, the Care Plan Policy does not specifically address catastrophic or severe illness. This requirement is partially addressed in the Quality Improvement Program Policy – it outlines how risk is assessed; however, the policy does not specifically address catastrophic or severe illness. **Recommendation** During the interview, the entity stated that this requirement is addressed individually for each EI; however, this should not only be demonstrated in implementation, but in the structure of the program as well. The entity should add wording to policies and procedures that address this requirement in detail.	Wording that addresses this requirement will be added to policies no later than 3/15/2021
As the EI's needs are identified or goals are met, the EI's risk level may change. The PCCM-E will complete a risk reassessment form to change the EI's	This requirement is addressed in the Risk Reassessment Policy on page 1. File Review Results	We will request that our HIMS system create an ongoing report that identifies all EIs with risk reassessments due with-in

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
risk level. At the minimum, a risk assessment must be completed every ninety (90) Calendar Days.	Of the 20 files reviewed, 11 were not applicable, 5 met the requirement, and 4 did not meet the requirement. **Recommendation** There were four files that did not meet the timeframe for this requirement; however, the entity did not agree with one of the files where the case was closed. Despite the fact that the goals were met, a risk assessment form should have still been completed in order to ensure that the case warrants closing. For this file, there was no communication with the EI's caretaker to follow-up on goals and the case was seemingly closed a month after last communication. The entity should ensure that all assessments are conducted within the required timeframe.	30 days. We will re-train staff on timelines. Please note that this timeline will be changed with the new contract amendments.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Meet regularly as outlined in Exhibit G;	This requirement is addressed in the MCT Policy on page 1 and in the Screening and Stratification Policy on pages 2 to 3. File Review Results Of the 20 files reviewed, four met the requirement, one did not meet the requirement, and 15 were not applicable. **Recommendation** The file that did not meet the requirement required a quarterly meeting, yet within a 132 day timeframe, this did not take place. The entity should ensure that the MCT is meeting within the required timeframes.	Recommendation Noted. With the new contract amendments, we are implementing a new MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings. We will also conduct ongoing training with staff about the MCT process and timeframes.
The PCCM-E will implement a program approved by the Agency to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care. The goal of the program is to reduce maternal and infant morbidity and mortality and improve birth outcomes. EIs will be notified at the time of Medicaid application of the requirement to participate and engage in the PCCM-E Maternity Care Coordination Program.	This requirement is partially addressed in the Integrated Operational Model document and EI Notification Policy. **Recommendation** The policy submitted only marginally demonstrates this requirement. More details that capture every part of the regulation are needed. Additionally, the creation of a program description would be informative. During the interview, the entity agreed that there is an opportunity to create additional material to address this requirement.	My Care will be writing a more complete Care Coordination Program overview document to address these requirements more holistically. We estimate the completion of that document no later than 6/30/2021.
The PCCM-E must advise all DHCPs and	This requirement is partially addressed in	My Care will write a new policy

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service.	the participation agreement templates and in the sample agreements provided. **Recommendation** The entity should create a policy to address this requirement.	that addresses the participation agreement process, including this requirement. We estimate completion of that document no later than 4/30/2021.
Track EIs throughout pregnancy and postpartum periods;	This requirement is addressed in the Maternity Checklist Policy on page 1. File Review Results Of the 20 files reviewed, four were applicable for a high-risk face-to-face postpartum visit. None of the four files had documentation of this visit. Ten of the files were eligible for a follow-up visit in the second/third trimester; two of these files did not have evidence of this follow-up visit. **Recommendation** The entity should ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for eligible EIs.	We will implement ongoing reporting of High Risk maternity EIs that are entering their 2nd and 3rd trimesters. We will also implement ongoing report of High Risk maternity EIs that have delivered and are due for a postpartum visit.
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must: Be patient/caregiver centered with a team approach;	This requirement is addressed in the Maternal Care Plan Policy on page 1. File Review Results Of the 20 files reviewed, 18 met the requirement and two did not meet the requirement. **Recommendation** The two files that did not meet the requirement did not appear to address EI-specific risks in the care plan documentation. During the interview, the entity acknowledged this opportunity for improvement and stated that training for care coordinators is being created to help staff improve their skills in identifying and addressing EI needs. The entity should implement further testing and review post training to ensure care plans are addressing EI needs.	We will continue to train and reinforce the importance of a patient centered and comprehensive care plans. Additional training to include appropriate documentation of service referral needs and/or refusal of services
The PCCM-E must provide Care Coordination for newborns delivered	This requirement is addressed in the Newborns with no Prenatal Care Policy on	Entity will request a ongoing HIMS report to include all EIs

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator.	page 1. File Review Results Of the 20 files reviewed, none of the files were applicable for newborn care coordination, as all 20 files had evidence of prenatal care. Eleven of the files were applicable for a delivery encounter; however, only six of these files had a delivery visit or missed delivery visit within 20 calendar days. **Recommendation** During the interview, the entity stated that the maternity files sampled were from the beginning of new enrollment upon opening. At the time, relationships with hospitals were still being developed, which is why there was a noted gap within care reflected in the review. Due to new enrollments, the entity had to conduct all reassessments and providers needed referrals, so the entity had to triage their resources appropriately. The entity should ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	that have an active Hospital Delivery Encounter Form with EIs With No Prenatal Care, so that we can actively work to enroll the newborn in care coordination. In addition, we will instruct staff to better document the details regarding why they did not have prenatal care or were not enrolled in care coordination prior to delivery. Training and reinforcement with staff to ensure those newborns are enrolled into services will continue.
EIs must be allowed to change a DHCP once without cause within the first ninety (90) Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1. **Recommendation** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy, once complete. We estimate this will be implemented no later than 4/30/2021.
The PCCM-E must inform the EI of the EI's rights to change DHCPs, with and without cause at the initial contact and at least once per year.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1 and in the screenshot provided that demonstrates verbal notification of this requirement. **Recommendation** During the interview, the entity stated	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy, once complete. We estimate this will be implemented no later than 4/30/2021.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
	that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	
The PCCM-E must provide, at the time of initial contact all required information regarding rights and responsibilities, and appropriate telephone numbers.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1. **Recommendation** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy and all materials will be available via our website or hard copy handout, once complete. We estimate this will be implemented no later than 4/30/2021.
The Medication List shall be used during the EI interview of the Health Risk and Psychosocial Assessment to enhance drug use information gathering. The caregiver or family may be present at the interview. Medication List should also include discharge instructions, PCP chart, prescription fill history, and patient report, as appropriate.	This requirement is addressed in the Care Coordinator Medication List Policy on page 2 and in the Care Plan Policy on pages 1 to 2. File Review Results Of the 20 general care coordination files reviewed, 18 met the requirement and two were not applicable. Of the 20 maternity care coordination files reviewed, 18 were not applicable, one met the requirement, and one did not meet the requirement. **Recommendation** The entity should ensure that all necessary documentation is included in an EI's record to ensure proper care coordination.	Training has been provided regarding Medication List and required documentation. Pharmacy staff has trained staff on required information for completed Med Review. Staff will continue to follow up and review MED list policy.

EI Materials
A total of 45 standards were reviewed; all were fully compliant.

EI Rights
A total of 10 standards were reviewed; all were fully compliant.

Enrollment/Disenrollment
A total of 11 standards were reviewed; all were fully compliant.

Grievances
A total of six standards were reviewed; all were fully compliant. There was a recommendation that the entity should submit all complaints and grievances to the Agency on the grievances log regardless of how the issue was triaged. My Care Central responded that they will work with the Agency to determine how grievances are classified/defined, and then report all applicable cases within the grievances log going forward.

HIMS
A total of 11 standards were reviewed; 10 were fully compliant, and 1 was partially compliant. This partially compliant HIMS standard is presented in **Table 18**.

Table 18: My Care Central HIMS Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
The PCCM-E shall have an automated system available every Business Day between the hours of 5:00 p.m. and 8:00 a.m. CT and during weekends and legal holidays. The automated system must include a voice mailbox for callers to leave messages. The PCCM-E shall ensure that the voice mailbox has adequate capacity to receive the reasonably anticipated maximum volume of messages. The PCCM-E must return messages on the next Business Day. This automated system must provide callers with operating instructions on what to do in case of an emergency which must include, at a minimum, the following information in accordance with 42 C.F.R. §438.10(g)(2)(v): The fact that the EI has a right to use any hospital or other setting for emergency care.	This requirement is partially addressed in the policy provided, which states that voicemail outgoing message directs EIs to the ER or to call 911. **Recommendation** My Care Central should add the EI right to use any hospital or other setting for emergency care to their written policy.	The verbiage will be added to the policy no later than 2/28/2021.

Provider Participation
A total of 12 standards were reviewed; all were fully compliant.

Quality Management
A total of 42 standards were reviewed; 41 were fully compliant, and 1 was partially compliant. This partially compliant quality management standard is presented in **Table 19**.

Table 19: My Care Central Quality Management Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
Composed of all participating Providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a twelve (12) month period in at least two (2) quarterly Medical Management	This requirement is addressed in the policy and procedure Regional Medical Management Committee, and evidenced within the meeting minutes (which clearly documented the roster, which included an indication of face-to-face or remote prior to COVID-19, as well as detailed meeting	1.) Starting 1st quarter of the 2021 Fiscal year, we began documenting provider participation quarterly based off of the participation requirements set forth in the RFP.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Central Response and Action Plan
meetings in person and one (1) webinar/facilitation exercise with the Network(s) Medical Director.	notes). While a monthly/quarterly participation report template was submitted, this was not populated and thus it is not possible to tell whether all providers had adequate representation at these meetings. **Recommendation** My Care Central should ensure that provider participation is logged throughout the year so that participation in at least 2 quarterly meetings and one exercise with the Network Medical Director is evidenced.	2.) Provider participation is logged and submitted to the Agency via the Monthly and Quarterly PCP and DHCP Participation reports 3.) This process will be updated within the RMMC policy no later than 2/28/2021.

My Care East

Care Coordination

A total of 134 standards were reviewed; 109 were fully compliant, and 25 were partially compliant. These partially compliant care coordination standards are presented in **Table 20**.

Table 20: My Care East Care Coordination Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
The PCCM-E shall establish processes to support Care Coordination for EIs, primarily those that are at highest risk and cost. The processes shall include, but are not limited to, the following: Reducing the potential for risks of catastrophic or severe illness;	This requirement is partially addressed in the Care Plan Policy. The Care Plan Policy outlines how to develop and implement a care plan with specific EI-centered goals; however, the Care Plan Policy does not specifically address catastrophic or severe illness. This requirement is partially addressed in the Quality Improvement Program Policy, which outlines how risk is assessed; however, the policy does not specifically address catastrophic or severe illness. **Recommendation** During the interview, the entity stated that this requirement is addressed individually for each EI within their care plans, focusing on reducing disease exacerbation; however, this should not only be demonstrated in implementation, but should also be documented within the structure of the program. The entity should add wording to policies and procedures that address this requirement	Wording that addresses this requirement will be added to policies no later than 3/15/2021.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	in detail.	
As the EI's needs are identified or goals are met, the EI's risk level may change. The PCCM-E will complete a risk reassessment form to change the EI's risk level. At the minimum, a risk assessment must be completed every ninety (90) Calendar Days.	This requirement is addressed in the Risk Reassessment Policy on page 1. File Review Results Of the 20 files reviewed, four met the requirement, one did not meet the requirement, and 15 were not applicable. **Recommendation** The identified file did not meet the required timeframe, with only one risk assessment conducted within 126 days. The entity should ensure that all assessments are conducted within the designated time period.	We will request that our HIMS system create an ongoing report that identifies all EIs with risk reassessments due with-in 30 days. We will re-train staff on timelines. Please note that this timeline will be changed with the new contract amendments.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Meet regularly as outlined in Exhibit G;	This requirement is addressed in the MCT Policy on page 1 and in the Screening and Stratification Policy on pages 2 to 3. File Review Results Of the 20 files reviewed, two met the requirement, one did not meet the requirement, and 17 were not applicable. **Recommendation** The identified file had no MCT meeting documented. The entity should ensure that an MCT is established for every EI in active care in order to ensure successful care coordination.	Recommendation Noted. With the new contract amendments, we are implementing a new MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings. We will also conduct ongoing training with staff about the MCT process and timeframes.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Include multi-disciplines;	This requirement is addressed in the MCT Policy on page 1. File Review Results Of the 20 files reviewed, two met the requirement, one did not meet the requirement, and 17 were not applicable. **Recommendation** The identified file had no MCT meeting documented. The entity should ensure that an MCT is established for every EI in active care in order to ensure successful care coordination.	Recommendation Noted. With the new contract amendments, we are implementing a new MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings. We will also conduct ongoing training with staff about the MCT process and timeframes.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The	This requirement is addressed in the MCT Policy on page 1. File Review Results Of the 20 files reviewed, two met the requirement, one did not meet the requirement, and 17 were not applicable.	Recommendation Noted. With the new contract amendments, we are implementing a new MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
MCT must: Discuss EI's needs, solutions, and potential outcomes; and	**Recommendation** The identified file had no MCT meeting documented. The entity should ensure that an MCT is established for every EI in active care in order to ensure successful care coordination.	We will also conduct ongoing training with staff about the MCT process and timeframes.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Document, in detail, issues as described above and participating staff.	This requirement is addressed in the MCT Policy on page 1. File Review Results Of the 20 files reviewed, two met the requirement, one did not meet the requirement, and 17 were not applicable. **Recommendation** The identified file had no MCT meeting documented. The entity should ensure that an MCT is established for every EI in active care in order to ensure successful care coordination.	Recommendation Noted. With the new contract amendments, we are implementing a new MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings. We will also conduct ongoing training with staff about the MCT process and timeframes.
Complete a face-to-face Health Risk and Psychosocial Assessment within ten (10) Calendar Days of discharge to ensure appropriate home-based support and services are available;	This requirement is addressed in the Transitional Care Program Policy on page 1. File Review Results Of the 20 files reviewed, two met the requirement, one did not meet the requirement, and 17 were not applicable. **Recommendation** The file identified had a risk assessment that took place 19 days after discharge. The entity should ensure that all assessments are conducted within the required timeframes.	Noted. We will retrain staff on the timelines. We will also instruct staff to document all attempts to contact the EI within the HIMS.
Implement medication reconciliation in concert with the PCP and Transitional Pharmacist within ten (10) Calendar Days of discharge;	This requirement is addressed in the Transitional Care Program Policy on page 1. File Review Results Of the 20 files reviewed, one met the requirement, two did not meet the requirement, and 17 were not applicable. **Recommendation** For one of the identified files, medication reconciliation took place 22 days after discharge, and in the other file identified, there was no evidence of medication reconciliation at all. The entity should	Noted. We will retrain staff on the timelines. We will also instruct staff to document all attempts to contact the EI and conduct the medication reconciliation within the HIMS.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	ensure that medication reconciliation is conducted at discharge to facilitate proper transitional care, and that designated timeframes are observed.	
Educate EIs regarding medical management, and provide referrals to needed resources within ten (10) Calendar Days of discharge;	This requirement is addressed in the Transitional Care Program Policy on page 1. File Review Results Of the 20 files reviewed, two met the requirement, one did not meet the requirement, and 17 were not applicable. **Recommendation** The file identified showed that the EI received education 19 days post discharge. The entity should ensure that required timeframes are observed in order to ensure successful transitional care.	Noted. We will retrain staff on the timelines. We will also instruct staff to document all attempts to contact the EI within the HIMS.
The PCCM-E will implement a program approved by the Agency to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care. The goal of the program is to reduce maternal and infant morbidity and mortality and improve birth outcomes. EIs will be notified at the time of Medicaid application of the requirement to participate and engage in the PCCM-E Maternity Care Coordination Program.	This requirement is partially addressed in the Integrated Operational Model document and EI Notification Policy. **Recommendation** The policy submitted only marginally demonstrates this requirement; however, more details that capture every part of the regulation are needed. Additionally, the creation of a program description would be informative. During the interview, the entity agreed that there is an opportunity to create additional material to address this requirement.	My Care will be writing a more complete Care Coordination Program overview document to address these requirements more holistically. We estimate the completion of that document no later than 6/30/2021.
The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service.	This requirement is partially addressed in the participation agreement templates and in the sample agreements executed. **Recommendation** The entity should create a policy to fully address this requirement.	My Care will write a new policy that addresses the participation agreement process, including this requirement. We estimate completion of that document no later than 4/30/2021
Track EIs throughout pregnancy and postpartum periods;	This requirement is addressed in the Maternity Checklist Policy on page 1. File Review Results Of the 20 files reviewed, two were applicable for a high-risk face-to-face postpartum visit, but only one of the two files had documentation of this visit. Nine of the files were eligible for a follow-up	We will implement ongoing reporting of High Risk maternity EIs that are entering their 2nd and 3rd trimesters. We will also implement ongoing report of High Risk maternity EIs that have delivered and are due for a postpartum visit.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	visit in the second/third trimester; four of these files did not have evidence of this follow-up visit. **Recommendation** The entity should ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for eligible EIs.	
Include a maternal health risk identification strategy;	This requirement is addressed in the Risk Stratification for Pregnant EIs Policy on page 1. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the requirement. **Recommendation** For this identified file, there was a delivery visit with no risk assessment or care plan, with sparse documentation; the EI's risk was deemed low, but there was no documentation to justify this. During the interview, the entity acknowledged that they were aware of this gap in care. The entity should ensure that there is a system in place to identify EIs with missing assessments and care plans, as these are critical for successful care. Additionally, documentation should be included in every EI's file to justify risk ratings.	Noted. We will conduct additional staff training addressing this issue.
Include a maternal health screening within five (5) Business Days of contact with the EI;	This requirement is addressed in the Risk Stratification for Pregnant EIs Policy on page 1. File Review Results Of the 20 files reviewed, 17 met the requirement and three did not meet the requirement. **Recommendation** Of the non-compliant three files, two files did not meet the required timeframe and one file did not have a screening in the record. The entity should ensure that there is a system in place to identify EIs missing screenings in order to conduct them as expediently as possible; proper	Noted. We have had a change in our process since the beginning of the program, and our CHWs now screen the forms. Cases are deferred after 3 unsuccessful contact attempts and the DHCP is notified to assist.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	timeframes also need to be observed for the execution of the screening.	
Include a maternal Health Risk and Psychosocial Assessment for all EIs at the first face-to-face initial assessment.	This requirement is addressed in the Risk Stratification for Pregnant EIs Policy on page 1. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the requirement. **Recommendation** For this identified file, there was a delivery visit with no assessment conducted. The entity should implement a system to identify EIs with missing assessments.	Noted. We will conduct additional staff training addressing this issue. In addition, we will ensure that our internal audits review the timely completion of all assessments
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must: Be initiated and completed by the Care Coordinator within seven (7) Business Days of the initial encounter;	This requirement is addressed in the Maternal Care Plan Policy on page 1. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the requirement. **Recommendation** For this identified file, there was a delivery visit with no care plan created, and no justification about the missing documentation. The entity should ensure that there is a system in place to identify EIs with missing care plans.	Noted. We will conduct additional staff training addressing this issue. In addition, we will ensure that our internal audits review the timely completion of all documentation
Be patient/caregiver centered with a team approach; and	This requirement is addressed in the Maternal Care Plan Policy on page 1. File Review Results Of the 20 files reviewed, 17 met the requirement and three did not meet the requirement. **Recommendation** Of the three non-compliant files, two files did not include EI-specific risks in care planning. One file did not have a care plan at all: during the interview, the entity rebutted that for delivery encounters, care plans are not necessary, however, the EI's chart began over a month before delivery, which included notes regarding enrollment around this time. The entity should ensure that there is a system in place to identify EIs with missing care	We will continue to train and reinforce the importance of a patient centered and comprehensive care plans. Additional training to include appropriate documentation of service referral needs and/or refusal of services.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	plans, and ensure that the care plans address all EI needs and EI-specific risks.	
Include the PCPs/community agencies as appropriate.	This requirement is addressed in the Maternal Care Plan Policy on page 1. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the requirement. **Recommendation** For this identified file, there was a delivery visit with no coordination with PCP. To ensure proper care coordination, the entity should include the PCP in creating care plans.	We will continue to train and reinforce the importance of a patient centered and comprehensive care plans. Additional training to include appropriate documentation of service referral needs and/or refusal of services
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator. The following services shall be provided to the newborn's mother:	This requirement is addressed in the Newborns with no Prenatal Care Policy on page 1. File Review Results Of the 20 files reviewed, none of the files were applicable for newborn care coordination, as all 20 files had evidence of prenatal care. Fourteen of the files were applicable for a delivery encounter; however, only thirteen of these files had a delivery visit or missed delivery visit within 20 calendar days. **Recommendation** The entity should ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	Entity will request an ongoing HIMS report to include all EIs that have an active Hospital Delivery Encounter Form with EIs With No Prenatal Care, so that we can actively work to enroll the newborn in care coordination. In addition, we will instruct staff to better document the details regarding why they did not have prenatal care or were not enrolled in care coordination prior to delivery. Training and reinforcement with staff to ensure those newborns are enrolled into services will continue.
Counseling on contraception and family planning services; and	This requirement is addressed in the Newborns with no Prenatal Care Policy on page 1. File Review Results Of the 20 files reviewed, 15 files met the requirement, one did not meet the requirement, and four were not applicable. **Recommendation** The file identified had missing follow-up visits, no delivery encounter, and no documentation of counseling. During the interview, the entity stated that there were multiple attempts to contact the EI,	We will continue to train and reinforce the importance of a patient centered and comprehensive care plans.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	however this is not included in the record. The entity should ensure that counseling is provided to EIs, and if there are communication issues, these need to be documented within the record.	
Counseling on appropriate postpartum care	This requirement is addressed in the Newborns with no Prenatal Care Policy on page 1. <u>File Review Results</u> Of the 20 files reviewed, 15 files met the requirement, one did not meet the requirement, and four were not applicable. **<u>Recommendation</u>** The file identified had missing follow-up visits, no delivery encounter, and no documentation of counseling. During the interview, the entity stated that there were multiple attempts to contact the EI, however, this is not included in the record. The entity should ensure that counseling is provided to EIs, and if there are communication issues, these need to be documented within the record.	We will continue to train and reinforce the importance of a patient centered and comprehensive care plans. Additional training to include appropriate documentation of service referral needs and/or refusal of services.
EIs must be allowed to change a DHCP once without cause within the first ninety (90) Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1. **<u>Recommendation</u>** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy, once complete. We estimate this will be implemented no later than 4/30/2021.
The PCCM-E must inform the EI of the EI's rights to change DHCPs, with and without cause at the initial contact and at least once per year.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1 and in the screenshot provided that demonstrates verbal notification of this requirement. **<u>Recommendation</u>** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy, once complete. We estimate this will be implemented no later than 4/30/2021.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	
The PCCM-E must provide, at the time of initial contact all required information regarding rights and responsibilities, and appropriate telephone numbers.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1. **Recommendation** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy and all materials will be available via our website or hard copy handout, once complete. We estimate this will be implemented no later than 4/30/2021.
The Medication List shall be used during the EI interview of the Health Risk and Psychosocial Assessment to enhance drug use information gathering. The caregiver or family may be present at the interview. Medication List should also include discharge instructions, PCP chart, prescription fill history, and patient report, as appropriate.	This requirement is addressed in the Care Coordinator Medication List Policy on page 2 and in the Care Plan Policy on pages 1 to 2. File Review Results Of the 20 general care coordination files reviewed, 18 met the requirement, one was not applicable, and one did not meet the requirement. Of the 20 maternity care coordination files reviewed, 16 were not applicable and four met the requirement. **Recommendation** The file identified had an incomplete medication list, as it was missing the discharge instruction, prescription fill history, and the PCP chart. During the interview, the entity reported that there have been issues obtaining discharge summaries due to the COVID pandemic. The entity should attempt to obtain full documentation whenever possible, but also document in the EI's record when issues arise.	Noted. Moving forward, we will clearly document any issues we have in receiving discharge summaries or PCP records. We will retrain staff on collecting the medication list.

EI Materials
A total of 45 standards were reviewed; all were fully compliant.

EI Rights
A total of 10 standards were reviewed; all were fully compliant.

Enrollment/Disenrollment
A total of 11 standards were reviewed; all were fully compliant.

Grievances
A total of six standards were reviewed; all were fully compliant.

HIMS
A total of 11 standards were reviewed; 10 were fully compliant, and 1 was partially compliant. This partially compliant HIMS standard is presented in **Table 21**.

Table 21: My Care East HIMS Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
The fact that the EI has a right to use any hospital or other setting for emergency care.	This requirement is partially addressed in the policy provided, which states that voicemail outgoing message directs EIs to the ER or to call 911. **Recommendation** My Care East should add the EI right to use any hospital or other setting for emergency care to their written policy.	The verbiage will be added to the policy no later than 2/28/2021.

Provider Participation
A total of 12 standards were reviewed; all were fully compliant.

Quality Management
A total of 42 standards were reviewed; 41 were fully compliant, and 1 was partially compliant. This partially compliant quality management standard is presented in **Table 22**.

Table 22: My Care East Quality Management Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
Composed of all participating Providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a twelve (12) month period in at least two (2) quarterly Medical Management meetings in person and one (1) webinar/facilitation exercise with the Network(s) Medical Director.	This requirement is addressed in the policy and procedure Regional Medical Management Committee. My Care East submitted meeting minutes (which documented very nicely the "in-person" and "WebEx" attendance), however it was unclear from these minutes and the monthly/quarterly provider participation report if each provider had adequate representation at these meetings (i.e., attended at least 2 of the meetings and 1 exercise with the Network Medical Director). During the interview, My Care East indicated that their Quality Manager reached out to all providers who have not attended a Medical Management	1.) My Care East has added a Performance Incentive Plan (PIP) goal for all care coordinators to conduct 4- 6 Outreach calls/visits to their assigned Providers per quarter. During these calls/visits, care coordinators will educate them on requirements related to active participation, as well as how attendance in the Medical Management meetings affects the quality bonus or provider participation rates. 2.) My Care Easts Medical Director, QCM and ED will also outreach to providers

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care East Response and Action Plan
	meeting. Further, the entity will add a performance goal for care coordinators that include provider outreach to bolster participation in these meetings. **Recommendation** My Care East should continue to work with providers to educate them on the requirements related to active participation, as well as how attendance in the Medical Management meetings affects the quality bonus or provider participation rates.	throughout each quarter and let them know where they stand on meeting the participation requirements, so that Providers will have adequate time to meet the requirements. 3.) This process will be updated within the RMMC policy no later than 2/28/2021.

My Care Northwest

Care Coordination
A total of 134 standards were reviewed; 118 were fully compliant, and 16 were partially compliant. These partially compliant care coordination standards are presented in **Table 23**.

Table 23: My Care Northwest Care Coordination Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Northwest Response and Action Plan
The PCCM-E shall establish processes to support Care Coordination for EIs, primarily those that are at highest risk and cost. The processes shall include, but are not limited to, the following: Reducing the potential for risks of catastrophic or severe illness;	This requirement is partially addressed in the Care Plan Policy. The Care Plan Policy outlines how to develop and implement a care plan with specific EI-centered goals; however, the Care Plan Policy does not specifically address catastrophic or severe illness. This requirement is partially addressed in the Quality Improvement Program Policy – it outlines how risk is assessed; however, the policy does not specifically address catastrophic or severe illness. **Recommendation** During the interview, the entity responded that the care plan is structured to address and monitor risks, and that the nature of patient-centered care planning is meant to prevent catastrophic or severe illness; additionally, the entity supplemented that the quality improvement plan is meant to track EIs to further reduce those risks. The entity should add to their policies specific wording that addresses this requirement.	Wording that addresses this requirement will be added to policies no later than 3/15/2021
EIs identified in the health risk screening and stratification as medium risk or high risk must receive a face-to-face Health	This requirement is addressed in the Health Risk Screening and Stratification Policy on page 1. File Review Results	Recommendation Noted. We will include this as part of our internal audit checklist, starting 4/1/2021.

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Northwest Response and Action Plan
Risk and Psychosocial Assessment conducted by a Care Coordinator, Behavioral Health Nurse or a Transitional Care Nurse.	Of the 20 files reviewed, 17 met the requirement, two did not meet the requirement, and one was not applicable. **Recommendation** During the interview, the two files that were deemed non-compliant were identified to be active family planning cases, and the entity stated that family planning cases do not require the same stipulations as general care coordination cases; however, Exhibit J mandates family planning cases to conduct the Health Risk and Psychosocial Assessments. The entity should ensure that all required screenings and assessments are conducted appropriately.	
As the EI's needs are identified or goals are met, the EI's risk level may change. The PCCM-E will complete a risk reassessment form to change the EI's risk level. At the minimum, a risk assessment must be completed every ninety (90) Calendar Days.	This requirement is addressed in the Risk Reassessment Policy on page 1. File Review Results Of the 20 files reviewed, six met the requirement, two did not meet the requirement, and 12 were not applicable. **Recommendation** Of the two files that did not meet compliance, one file had evidence of a risk reassessment that took place 146 days after the initial assessment. In the other file, 115 days passed between risk assessments, but during the interview, the entity had reported difficulty contacting the EI; upon re-review, there was only one missed call attempt on the record. The entity should ensure that risk assessments take place within the required time frame, and to document any difficulties contacting the EI.	We will request that our HIMS system create an ongoing report that identifies all EIs with risk reassessments due with-in 30 days. We will re-train staff on timelines. Please note that this timeline will be changed with the new contract amendments.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Meet regularly as outlined in Exhibit G;	This requirement is addressed in the MCT Policy on page 1 and in the Screening and Stratification Policy on pages 2 to 3. File Review Results Of the 20 files reviewed, four met the requirement, three did not meet the requirement, and 13 were not applicable. **Recommendation** For all three files that did not demonstrate compliance, MCT meetings were not conducted according to the schedule stipulated by Exhibit G, based on risk scores. The entity should ensure that the MCT meets within the required timeframes.	Recommendation Noted. With the new contract amendments, we are implementing a new MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings. We will also conduct ongoing training with staff about the MCT process and timeframes.
The PCCM-E will implement a	This requirement is partially addressed in the	My Care will be writing a more

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program approved by the Agency to integrate and manage all maternal health Care Coordination including family planning, interconception care, prenatal care, and postnatal care. The goal of the program is to reduce maternal and infant morbidity and mortality and improve birth outcomes. EIs will be notified at the time of Medicaid application of the requirement to participate and engage in the PCCM-E Maternity Care Coordination Program.	Integrated Operational Model document and EI Notification Policy. **Recommendation** The policy submitted only marginally demonstrates this requirement; more details that capture every part of the regulation are needed. Additionally, the creation of a program description would be informative. During the interview, the entity agreed that there is an opportunity to create additional material to address this requirement.	complete Care Coordination Program overview document to address these requirements more holistically. We estimate the completion of that document no later than 6/30/2021.
The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service.	This requirement is partially addressed in the participation agreement templates and in the agreements executed with ECM Health Group, OBGYN Association of NW AL, and Winfield Ob/Gyn. **Recommendation** The entity should create a policy to address this requirement	My Care will write a new policy that addresses the participation agreement process, including this requirement. We estimate completion of that document no later than 4/30/2021.
Track EIs throughout pregnancy and postpartum periods;	This requirement is addressed in the Maternity Checklist Policy on page 1. File Review Results Seven of the 20 files reviewed were applicable for a high risk postpartum encounter, but only three of these files had evidence of this visit. Thirteen of the files were eligible for a follow-up visit in the second/third trimester; however, two of these files did not have evidence of this follow-up visit. **Recommendation** The entity should ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for eligible EIs.	We will implement ongoing reporting of High Risk maternity EIs that are entering their 2nd and 3rd trimesters. We will also implement ongoing report of High Risk maternity EIs that have delivered and are due for a postpartum visit.
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must: Be initiated and completed by the Care Coordinator within seven (7) Business Days of the initial encounter;	This requirement is addressed in the Maternal Care Plan Policy on page 1. File Review Results Of the 20 files reviewed, 19 met the requirement and 1 did not meet the requirement. **Recommendation**	Entity will continue to adhere to an internal policy of care plan completed within five days of enrollment. Additional training and reinforcement regarding timelines will be provided to all CC.

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	During the interview, the file identified to be non-compliant was discussed and the entity stated that there had been no time to complete the Care Plan, as care coordination services commenced only two weeks before the delivery; however, this requirement stipulates a stricter timeframe of seven business days for the initiation and completion of a Care Plan. The entity should ensure that Care Plans are executed in a timely manner.	
Be patient/caregiver centered with a team approach; and	This requirement is addressed in the Maternal Care Plan Policy on page 1. File Review Results Of the 20 files reviewed, 15 met the requirement and five did not meet the requirement. **Recommendation** Of the five files that did not demonstrate compliance, one file did not have a Care Plan at all and four files documented a variety of health issues, chronic conditions, and mental health issues that were not addressed. The entity should ensure that all EI needs are addressed to inform a thorough Care Plan.	Entity will continue to train and reinforce the importance of a patient centered and comprehensive care plans. Additional training to include appropriate documentation of service referral needs and/or refusal of services.
Include the PCPs/community agencies as appropriate.	This requirement is addressed in the Maternal Care Plan Policy on page 1. File Review Results Of the 20 files reviewed, 17 files met the requirement, one did not meet the requirement, and two were not applicable. **Recommendation** The EI in the non-compliant file had a mental health issue that was not addressed – there was no outreach to resources and no coordination of care with mental health services. To ensure proper care coordination, the entity should include PCP and community agencies in Care Plan creation and implementation.	We will continue to train and reinforce the importance of a patient centered and comprehensive care plans. Additional training to include appropriate documentation of service referral needs and/or refusal of services.
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator.	This requirement is addressed in the Newborns with no Prenatal Care Policy on page 1. File Review Results Of the 20 files reviewed, there was one file that did not have notation of whether the EI received prenatal care, and so it could not be determined if newborn care coordination was required. Seventeen of the files were applicable for a delivery encounter; however, only 16 of these files had a delivery visit or missed delivery encounter within	We will request an ongoing HIMS report to include all EIs that have an active Hospital Delivery Encounter Form with EIs With No Prenatal Care, so that we can actively work to enroll the newborn in care coordination. In addition, we will instruct staff to better document the details regarding why they did not have prenatal

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	20 calendar days. **Recommendation** The entity should ensure that newborn care coordination is conducted for all EIs with a newborn delivery who did not receive prenatal care. EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	care or were not enrolled in care coordination prior to delivery. Training and reinforcement with staff to ensure those newborns are enrolled into services will continue.
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator. The following services shall be provided to the newborn's mother: Counseling on appropriate postpartum care.	This requirement is addressed in the Newborns with no Prenatal Care Policy on page 1. File Review Results Of the 20 files reviewed, 15 met the requirement, two did not meet the requirement, and three were not applicable. **Recommendation** There was no evidence of postpartum care counseling for two of the files. The entity should ensure that counseling is conducted appropriately for maternal care coordination.	We will continue to train and reinforce the importance of a patient centered and comprehensive care plans. Additional training to include appropriate documentation of service referral needs and/or refusal of services.
EIs must be allowed to change a DHCP once without cause within the first ninety (90) Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1. **Recommendation** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy, once complete. We estimate this will be implemented no later than 4/30/2021.
The PCCM-E must inform the EI of the EI's rights to change DHCPs, with and without cause at the initial contact and at least once per year.	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1 and in the screenshot provided that demonstrates verbal notification of this requirement. **Recommendation** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	My Care is in process of developing materials to address this requirement in a written format. This will also be added to our policy, once complete. We estimate this will be implemented no later than 4/30/2021.
The PCCM-E must provide, at the time of initial contact all required information regarding	This requirement is partially addressed in the DHCP Selection, Notification, Change, and Compliance Policy on page 1.	My Care is in process of developing materials to address this requirement in a written

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Northwest Response and Action Plan
rights and responsibilities, and appropriate telephone numbers.	**Recommendation** During the interview, the entity stated that verbal notification of this requirement is provided to EIs. In order to fully address this requirement, materials communicating this regulation must be provided to the EI. The entity should provide this information on their website as well as in written documents to the EI.	format. This will also be added to our policy and all materials will be available via our website or hard copy handout, once complete. We estimate this will be implemented no later than 4/30/2021.
The Medication List shall be used during the EI interview of the Health Risk and Psychosocial Assessment to enhance drug use information gathering. The caregiver or family may be present at the interview. Medication List should also include discharge instructions, PCP chart, prescription fill history, and patient report, as appropriate.	This requirement is addressed in the Care Coordinator Medication List Policy on page 2 and in the Care Plan Policy on pages 1 to 2. File Review Results Of the 20 general care coordination files reviewed, 16 met the requirement and two did not meet the requirement. Of the 20 maternity care coordination files reviewed, four met the requirement and 16 were not applicable. **Recommendation** There was no Medication List for the two files that did not demonstrate compliance. The entity should ensure that the Medication List is included to enhance drug use information gathering.	We will continue to train and reinforce Medication List compliance with a focus on having CCs document the review of the HIMS Medication claims feed.

EI Materials
A total of 45 standards were reviewed; all were fully compliant.

EI Rights
A total of 10 standards were reviewed; all were fully compliant.

Enrollment/Disenrollment
A total of 11 standards were reviewed; all were fully compliant.

Grievances
A total of six standards were reviewed; all were fully compliant. There was a recommendation for the entity to submit all complaints and grievances to the Agency on the grievances log regardless of how the issue was triaged. My Care stated they will work with the Agency to determine how grievances are classified/defined, and then report all applicable cases within the grievances log going forward.

HIMS
A total of 11 standards were reviewed; 10 were fully compliant, and 1 was partially compliant. This partially compliant HIMS standard is presented in **Table 24**.

Table 24: My Care Northwest HIMS Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Northwest Response and Action Plan
The fact that the EI has a right to use any hospital or other setting for emergency care.	This requirement is partially addressed in the policy provided, which states that voicemail outgoing message directs EIs to the ER or to call 911. **Recommendation** My Care NW should add the EI right to use any hospital or other setting for emergency care to their written policy.	The verbiage will be added to the policy no later than 2/28/2021.

Provider Participation
A total of 12 standards were reviewed; all were fully compliant.

Quality Management
A total of 42 standards were reviewed; 41 were fully compliant, and 1 was partially compliant. This partially compliant quality management standard is presented in **Table 25**.

Table 25: My Care Northwest Quality Management Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	My Care Northwest Response and Action Plan
The PCCM-E must establish and is responsible for a Region Medical Management Committee which satisfies the following requirements: Composed of all participating Providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a twelve (12) month period in at least two (2) quarterly Medical Management meetings in person and one (1) webinar/facilitation exercise with the Network(s) Medical Director.	This requirement is addressed in the policy and procedure Regional Medical Management Committee, and evidenced within the meeting minutes. While a monthly/quarterly participation report template was submitted, this was not populated and thus it is not possible to tell whether all providers had adequate representation at these meetings. **Recommendation** My Care NW should ensure that provider participation is logged throughout the year so that participation in at least two quarterly meetings and one exercise with the Network Medical Director is evidenced.	1.) Starting 1st quarter of the 2021 Fiscal year, we began documenting provider participation quarterly based off of the participation requirements set forth in the RFP. 2.) Provider participation is logged and submitted to the Agency via the Monthly and Quarterly PCP and DHCP Participation reports 3.) This process will be updated within the RMMC policy no later than 2/28/2021.

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Care Coordination
A total of 134 standards were reviewed; 116 were fully compliant, and 18 were partially compliant. These partially compliant care coordination standards are presented in **Table 26**.

Table 26: NACC Care Coordination Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
As the EI's needs are identified or goals are met, the EI's risk level may change. The PCCM-E will complete a risk reassessment form to change the EI's risk level. At the minimum, a risk assessment must be completed every ninety (90) Calendar Days.	This requirement is addressed in the 90 Day Reassessment Policy and Procedure. File Review Results Of the 20 files reviewed, 16 met the requirement, one did not meet the requirement, and three were not applicable. **Recommendation** Initially during the interview, IPRO had identified the non-compliant file as not having completed the risk assessment within the required timeframe. At the time, the entity had indicated that the case had been closed, so the assessment was not conducted. The Agency clarified that the EI must be reassessed in order to see if goals are met and that closing the case is warranted. Upon additional review post-interview, the entity stated that the case was deferred and closed after loss of contact; however, there is no documentation of attempts to contact the EI. The entity should ensure that risk assessments are conducted within the required timeframe, which could determine if goals have been met and that the case can be closed. Further, when an EI is unable to be reached, the entity should document all contact attempts to ensure due diligence is met.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained on Risk Assessment requirements and mandatory documentation of all attempts to contact EIs. NACC developed an audit tool specifically targeting all items cited in the audit. For A minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Meet regularly as outlined in Exhibit G;	This requirement is addressed in the Multidisciplinary Care Team Policy and Procedure. File Review Results Of the 20 files reviewed, four met the requirement, two did not meet the requirement, and 14 were not applicable. **Recommendation** (applies to all of the following MCT requirements) There was continued discussion between the entity and IPRO post-interview to discuss the identified files that did not demonstrate compliance. Although the entity did provide some clarity as to why certain files had been closed before an MCT could meet because goals had been achieved, there were still remaining issues where the entity's response did not justify a change of determination for	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained all current MCT Requirements including conducting regularly scheduled MCTs and ensuring a MCT for any patient for which it is deemed beneficial. Careful review of case prior to closure and documentation of all contact attempts were reinforced as well. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator.

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
	these files. One file had been closed due to loss of contact, however that history of failed outreach had not been documented. Another file had been closed with seemingly no reason, despite goals not having been met, as well as the EI being readmitted. The entity should ensure that closing of cases are warranted and fully reviewed before action, and that all outreach attempts are documented if communication with the EI is proving difficult. One file was closed because the singular goal the coordinator had set had been accomplished; however, the other issues clearly stated throughout the file were not addressed, nor was follow-up conducted. The case seemed to be closed expediently despite how the EI could have benefited from an MCT. Although the review determination for this file was ultimately changed to non-applicable to reflect the most basic properties of this requirement, there is an opportunity to analyze how care plan goals are created, which would impact MCT involvement.	These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will to review/retrain on deficiencies a minimum of quarterly.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Include multi-disciplines;	This requirement is addressed in the Multidisciplinary Care Team Policy and Procedure. <u>File Review Results</u> Of the 20 files reviewed, four met the requirement, two did not meet the requirement, and 14 were not applicable.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained on all current MCT Requirements including ensuring MCTs include appropriate multi-disciplines. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director.

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
		NACC will review/retrain on deficiencies a minimum of quarterly.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Discuss EI's needs, solutions, and potential outcomes;	This requirement is addressed in the Multidisciplinary Care Team Policy and Procedure. <u>File Review Results</u> Of the 20 files reviewed, four met the requirement, two did not meet the requirement, and 14 were not applicable.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained on all current MCT Requirements including mandatory discussion of EI's needs, solutions, and potential outcomes. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
The MCT shall meet at an appropriate location or venue in the Region such as the PCCM-E's office, hospital, community mental health center, clinical practice or clinical group practice, or an academic health center. The participation may be by telephone. The MCT must: Document, in detail, issues as described above and participating staff.	This requirement is addressed in the Multidisciplinary Care Team Policy and Procedure. <u>File Review Results</u> Of the 20 files reviewed, four met the requirement, two did not meet the requirement, and 14 were not applicable.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained all current MCT Requirements including mandatory documentation, in detail, of all issues and participating staff. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator.

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
		These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
Consultation to the MCT regarding behavioral health issues or topics and resources in the area;	This requirement is addressed in the North Alabama Community Care Behavioral Health Program Description. <u>File Review Results</u> Of the 20 files reviewed, 2 met the requirement, 1 did not meet the requirement, and 17 were not applicable. **<u>Recommendation</u>** There was one file that did not meet the requirement, in which there was a noted behavioral health issue yet consultation regarding this was not noted with the MCT. The entity should ensure that the MCT is consulted for all aspects of the EI's needs, including behavioral health, in order to fully integrate and coordinate care.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained on all current MCT Requirements. Mandatory requirements that all needs/issues, including behavioral health when indicated, be addressed were reviewed and reinforced. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
Transitional Care Process. The Transitional Care Nurses and/or Transitional Care Team will establish processes to assist EIs in their transition from a facility to the community setting to	This requirement is partially addressed in the Transitional Care Program description which includes review of daily hospital census reports with a timeframe of once per week at a minimum. **<u>Recommendation</u>**	NACC has updated language to reflect review of census one time daily in the Transition of Care Program description. NACC will update policy and

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
include, but not be limited to, the following: Reviewing daily census at inpatient or residential settings to identify EIs needing support at discharge;	The entity should change the wording of the policy to reflect the frequency dictated in the requirement, as the entity had acknowledged during the interview.	procedure to reflect frequency dictated in the RFP requirement and submits to the Alabama Medicaid Agency on or before March 5, 2021.
Complete a face-to-face Health Risk and Psychosocial Assessment within ten (10) Calendar Days of discharge to ensure appropriate home-based support and services are available;	This requirement is addressed in the Transitional Care Program description. File Review Results Of the 20 files reviewed, 7 met the requirement, 12 were not applicable and 1 did not meet the requirement. **Recommendation** The entity should ensure that all assessments are conducted within the required timeframes.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained on mandatory requirements that all assessments must be conducted within required timeframes. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
Implement medication reconciliation in concert with the PCP and Transitional Pharmacist within ten (10) Calendar Days of discharge;	This requirement is addressed in the Transitional Care Program description. File Review Results Of the 20 files reviewed, 7 met the requirement, 12 were not applicable and 1 did not meet the requirement. **Recommendation** The entity should ensure that medication reconciliation is conducted within required timeframes to ensure proper transitional care.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained on the required timeframes for medication reconciliation to ensure proper transitional care. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
		areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
Educate EIs regarding medical management, and provide referrals to needed resources within ten (10) Calendar Days of discharge;	This requirement is addressed in the Transitional Care Program description. <u>File Review Results</u> Of the 20 files reviewed, 7 met the requirement, 12 were not applicable and 1 did not meet the requirement. **<u>Recommendation</u>** The entity should ensure that the EI is properly educated and provided referrals within required timeframes to ensure proper transitional care.	On Monday, January 25th, NACC's audit results were reviewed with the General Care Coordination staff. Care Coordinators were retrained on the importance of providing applicable education to EIs and referrals to needed resources within ten (10) Calendar Days of discharge. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director.
Track EIs throughout pregnancy and postpartum periods;	This requirement is addressed in the North Alabama Community Care Maternity Care Coordination Program Description. <u>File Review Results</u> Of the 20 files reviewed, seven were applicable for a high-risk face-to-face postpartum visit, yet only three had documentation of this visit. Ten of the files were eligible for a follow-up visit in the second/third trimester; two of these files did not have evidence of this follow-up visit.	On February 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement that post- partum visits must be conducted on all high risk pregnancies. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
	Recommendations The entity should ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for eligible EIs.	conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
Include a maternal health screening within five (5) Business Days of contact with the EI;	This requirement is addressed in the Maternity Care Coordination Policy and Procedure. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the requirement. **Recommendation** The file that did not meet the requirement had a screening that occurred months after initial contact. The entity should ensure that all timeframes are met.	On February 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement that a maternal health screening must be conducted within five (5) business days of contact with the EI. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must: Be initiated and completed by the Care Coordinator within seven (7) Business Days of the	This requirement is addressed in the Maternity Care Coordination Policy and Procedure. File Review Results Of the 20 files reviewed, 17 met the requirement and three did not meet the	On February 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement that care plans must be completed within seven (7)

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
initial encounter;	requirement. **Recommendation** The three files that were non-compliant did not have care plans. The entity should ensure that Care Coordinators are properly trained to execute the creation of the care plan within the required timeframe, as this is a central part to the success of care coordination and the pregnancy as a whole.	business days of the initial encounter and that is critical to the success of care coordination and the pregnancy as a whole. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must: Be patient/caregiver centered with a team approach;	This requirement is addressed in the Maternity Care Coordination Policy and Procedure. File Review Results Of the 20 files reviewed, 13 met the requirement and seven did not meet the requirement. **Recommendation** Of the seven files identified, two files had no care plan and risks were not fully addressed in five files. During the interview, the entity had acknowledged the primary issue to be inadequate documentation by Care Coordinators and had already taken steps to retrain their staff. The entity should employ additional testing and further review to determine the success of this intervention.	On February 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement that care plans must be patient/caregiver centered with a team approach. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
		quarterly.
The PCCM-E must develop a maternal health Care Plan for all pregnant EIs. The Care Plan must: Include the PCPs/community agencies as appropriate.	This requirement is addressed in the Maternity Care Coordination Policy and Procedure. File Review Results Of the 20 files reviewed, 17 met the requirement and three did not meet the requirement. **Recommendation** Of the three files identified, two had no care plans and one indicated DHR involvement as the EI did not have custody, yet there was no coordination noted. The entity should train staff to better detect when additional support from providers or outer agencies should be included.	On February 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement Care Plans must include PCPs/community agencies as appropriate. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator.	This requirement is addressed in the Maternity Care Coordination Policy and Procedure. File Review Results Fourteen of the files were applicable for a delivery encounter; however, only nine of these files had a delivery visit or missed delivery visit within 20 calendar days. **Recommendation** The entity should ensure that EIs eligible for a delivery encounter receive a delivery visit or missed delivery visit within 20 calendar days.	On February, 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement that NACC must provide a delivery visit or missed delivery visit within 20 calendar days. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
		improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator. The following services shall be provided to the newborn's mother: Counseling on contraception and family planning services;	This requirement is addressed in the Transition from Maternity to Non-Maternal Health Care Coordination Policy and Procedure. File Review Results Of the 20 files reviewed, 19 met the requirement and one did not meet the requirement. **Recommendation** The entity should ensure that counseling is conducted appropriately for maternal health care coordination.	On February 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement that counseling on contraception and family planning services must be provided to EIs. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits. Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.
The PCCM-E must provide Care Coordination for newborns delivered with no prenatal care. Care Coordination for newborns who did not benefit from pre-natal care will receive a face-to-face inpatient delivery encounter by a Care Coordinator. The following services shall be provided to the newborn's mother: Counseling on appropriate postpartum care.	This requirement is addressed in the North Alabama Community Care Maternity Care Coordination Program Description. File Review Results Of the 20 files reviewed, 18 met the requirement, one did not meet the requirement, and one was not applicable. **Recommendation** The entity should ensure that counseling is conducted appropriately for maternal health care coordination.	On February 1, 2021, NACC Maternity Care Coordinators were provided audit results and information on the requirement that counseling on appropriate postpartum care must be provided to EIs. NACC developed an audit tool specifically targeting all items cited in the audit. For a minimum of six (6) months, NACC plans to conduct random monthly chart reviews targeting the deficient areas for each care coordinator. These will coincide with random full chart audits.

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
		Care Coordinators with trends of continued deficiencies will be placed on a performance improvement plan and closely monitored by manager and clinical director. NACC will review/retrain on deficiencies a minimum of quarterly.

EI Materials

A total of 45 standards were reviewed; 43 were fully compliant, and 2 were partially compliant. These partially compliant EI materials standards are presented in **Table 27**.

Table 27: NACC EI Materials Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
The PCCM-E must provide the Agency with a written description of all planned health education activities and targeted implementation dates at a frequency and in a format determined by the Agency.	The requirement is addressed in the NACC Proposed Health Education Activities Tool however, does not include "targeted implementation dates at a frequency and in a format determined by the Agency." **Recommendation** NACC should ensure their policies are updated to include this requirement.	NACC updated its Health Education Proposed Activities to include implementation dates and will submit to the Alabama Medicaid Agency on or before March 5, 2021.
In addition to the requirements of Section II.W Information Requirements of this RFP, the PCCM-E may only use electronic methods of communication with an EI if: a. The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication; b. The EI has requested or approved electronic transmittal; c. The identical information is available in written format upon request; d. Language and alternative format accommodations are available; and e. All Health Insurance Portability and Accountability Act (HIPAA) requirements are satisfied with respect to PHI.	Requirements (b) and (c) are addressed in the 2019 NACC Enrollee Rights and EI Guidelines for Non-English and Disabled EI however requirements (a) and (d) are not addressed in these policies or in the "Notices" section on the website. **Recommendation** NACC should ensure their policies are updated to include the missing requirements.	NACC updated its Enrollee policy to include State Contract Requirements Federal Regulations 438.208. The updated policy will be submitted to the Alabama Medicaid Agency on or before March 8, 2021. On February 4, 2021, NACC added Agency approved language regarding text and email communication to its website Notices.

EI Rights
A total of 10 standards were reviewed; all were fully compliant.

Enrollment/Disenrollment
A total of 11 standards were reviewed; all were fully compliant.

Grievances
A total of six standards were reviewed; all were fully compliant. There was a recommendation that the entity submit all complaints and grievances to the Agency on the grievances log regardless of how the issue was triaged. NACC reviewed this issue with care coordination staff and will proceed with reporting all official complaints along with grievances.

HIMS
A total of 11 standards were reviewed; 10 were fully compliant, and 1 was partially compliant. This partially compliant HIMS standard is presented in **Table 28**.

Table 28: NACC HIMS Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
The Agency is requiring a case management system that includes Care Coordination documentation, maternity data and the ability to accept Admission/Discharge/Transfer (ADT) feeds. Failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in Sanctions (see Section II.M.2.i.).	A systems design document was provided. NACC provided RMEDE screen shots. During the interview it was learned that there are automated edits in RMEDE which create limits to constrain entry to comply with accuracy. In addition, NACC conducts audits to compare the medical records to the data in the HIMS. This includes maternity and pharmacy data. There is a comparison of pharmacy data to patient's verbal report of what they are taking. **Recommendation** It is recommended that the University of Southern Alabama update RMEDE documents with the accuracy rate requirement or add it to an internal policy. NACC could consider capturing their data validation process in a policy and procedure as another best practice.	The following language concerning internal Data Integrity audits has been added to the policy Tool 10_II.1.12.d_Quality Improvement Program and Structure_7-12-19: North Alabama Community Care will use the RMEDE HIMS system and the Tableau Reporting software to perform internal data integrity audits on a quarterly basis to include: Maternity Data Fields Pharmacy Medication Reconciliation

Provider Participation
A total of 12 standards were reviewed; all were fully compliant.

Quality Management
A total of 42 standards were reviewed; 40 were fully compliant, and 2 were partially compliant. These partially compliant quality management standards are presented in **Table 29**.

Table 29: NACC Quality Management Partially Compliant Standards

Partially Compliant Standards	Findings and Recommendations for Improvement	NACC Response and Action Plan
The PCCM-E's most current Quality Improvement Plan evaluation for the previous calendar year;	This requirement is partially evidenced within the Quality Improvement Annual Work Plan. There is an opportunity to evaluate aspects of quality outside of the quality measures (chart audits, QIPs, data collection/HIMS, grievances, etc.). **Recommendation** NACC should ensure that all aspects of their QI program are evaluated each year, including (but not necessarily limited to) chart audit results, QIPs, grievances, etc.	The Following Sections have been added to the Policy and Procedure titled Tool 10_II.1.12.f_Quality Improvement Annual Work Plan_7-12-19-V1: Quality Improvement Projects Care Coordination Documentation Audits Grievances and Complaints Medical Management Meeting
[The Medical Management Committee is] composed of all participating Providers who must have at least one representative (PCP, Physician Assistant, or Nurse Practitioner) from its medical practice to participate over a twelve (12) month period in at least two (2) quarterly Medical Management meetings in person and one (1) webinar/facilitation exercise with the Network(s) Medical Director.	This requirement is addressed in policy Tool 10_II.I.12.l_Quality Improvement MMM, and evidenced within the Master MMM PMP Participation Report (23 unique practice sites, out of the 149 participating providers, were not in compliance). During the interview, NACC indicated that in order to bolster participation, providers that did not attend 1st quarter meeting were reached out to by phone or email. **Recommendation** NACC should continue their outreach efforts to providers to ensure they meet the minimum attendance requirements to ensure active participation status.	The Following language has been added to the Policy and Improvement titled Tool 10_II.1.12.1_Quality Improvement MMM_6-7-19 and to the Tool titled Tool 10_II.1.12.d_Quality Improvement Program and Structure_7-12-19 After each quarter's meetings are complete, North Alabama Community Care will summarize the attendance and note those PCP practices not in attendance. Those missing practices will be contacted by either the Medical Director / QI staff by telephone and/or by fax. North Alabama Community care will continue our outreach efforts to providers to ensure they meet the minimum attendance requirements to ensure active participation status.

Validation of Quality Improvement Projects

Each ACHN entity is required to develop and implement QIPs to assess and improve processes of care with the desired result of improving outcomes of care. The projects are focused on the health care needs that reflect the demographic characteristics of the ACHN entities' membership, the prevalence of disease, and the potential risks of the disease. QIP topics were selected by AMA. An assessment is conducted for each project upon proposal submission, and again for interim and final remeasurement, using a tool developed by IPRO and consistent with CMS EQR protocols. Update reports are provided quarterly, and assessed by IPRO and AMA. QIP proposals were submitted November 2019, with re-submissions requested, and final review and approval by March 2020. Brief summaries of these QIPs are presented below. The interim measurement period (calendar year [CY] 2020) will be reported in June 2021 and incorporated into next year's Annual Technical Report.

ACN Mid-State

QIP: Adverse Birth Outcomes

ACN Mid-State is targeting EIs at high risk for adverse maternal outcomes by focusing on chronic conditions such as hypertension and diabetes in pregnant women and EIs of childbearing age (defined by the entity as those 18–44 years of age). The performance indicator for the project is the percentage of live deliveries in the measurement year that weighed less than 2500 grams, as outlined in **Table 30**.

Table 30: ACN Mid-State Adverse Birth Outcomes QIP Performance Indicator

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of live deliveries in the measurement year that weighed less than 2500 grams	9.71% Numerator: 326 Denominator: 3,354	9.8%

ACN: Alabama Care Network; QIP: quality improvement project; CY: calendar year.

ACN Mid-State has identified poorly managed comorbidities as a barrier to healthy birth outcomes, in addition to social and environmental factors, as well as lack of adequate preconception care. To address these barriers, the entity has focused their efforts on implementing the use of in-house hypertension/diabetes monitoring, providing blood pressure monitors to hypertensive EIs, performing a screening for social determinants of health for EIs that have delivered a low birth-weight baby and connected to community resources, and engaging postpartum EIs in family planning. Intervention tracking measures have not been reported by the entity to date, given the changes that were made in several interventions; however, they will be provided going forward, and reviewed to assess intervention progress and provide additional insight into potential gaps in care.

QIP: Childhood Obesity

ACN Mid-State is targeting EIs 3–11 years of age with a BMI > 85th percentile, with the goal of reducing the percentage of children with an overweight or obese diagnosis. There are four performance indicators for the project, reflected in **Table 31**.

Table 31: ACN Mid-State Childhood Obesity QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of annual BMI assessments completed for EIs age 3–19 during the measurement year	44.03% Numerator: 31,899 Denominator: 72,454	60.0%
The percentage of EIs age 3–6 had an annual Well Visit during the measurement year	62.22% Numerator: 12,282 Denominator: 19,741	79.6%
The percentage of EIs age 7–11 had an annual Well Visit during the measurement year	50.24% Numerator: 12,102 Denominator: 24,086	R: 82.3%
The percentage of EIs, age 3–11 with diagnosis of overweight or obese during the measurement year	39.25% Numerator: 8,200 Denominator: 20,890	R: 1.0 % reduction

ACN: Alabama Care Network; QIP: quality improvement project; CY: calendar year; BMI: body mass index; EI: eligible individual.

The ACHN identified a lack of parental awareness of long-term health consequences of missed well-child visit, as well as a lack of healthy food and physical activity among children, as key drivers of childhood obesity within their EI population. ACN Mid-State has targeted EIs with a mailing campaign, wherein letters are sent and a follow-up phone call is made to educate parents on the importance of the well-child visit, and to help with scheduling a visit with the child's provider. Additionally, the ACHN has implemented their Healthy Eating Active Living (HEAL) program for EIs with a BMI between

the 85th and 95th percentiles. Lastly, ACN Mid-State has been providing MyPlate materials to EIs for nutrition education, as well as jump ropes and Frisbees to promote physical activity. Intervention tracking measures have not been reported by the entity to date; however, they will be provided going forward, and reviewed to assess intervention progress and provide additional insight into potential gaps in care.

QIP: Substance Use Disorder

ACN Mid-State is targeting EIs who were newly prescribed Medication Assisted Therapy (MAT) within the last 6 months, as well as pregnant EIs who were identified with a history of substance use disorder (SUD), or with active SUD. There are four performance indicators for the project, reflected in **Table 32**.

Table 32: ACN Mid-State Substance Use Disorder QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
Percentage of EIs engaged with Peer Specialist to increase patient engagement and retention in SUD treatment.	Not available (new measure)	15.0%
Percentage of EIs age 18–64 with a new episode of AOD abuse or dependence who engaged in AOD treatment	1.43% Numerator: 106 Denominator: 7419	41.1%

ACN: Alabama Care Network; QIP: quality improvement project; CY: calendar year; EI: eligible individual; SUD: substance use disorder; AOD: alcohol or other drug.

ACN Mid-State has identified management of comorbid medical conditions as a barrier to SUD treatment adherence. Furthermore, the ACHN has identified an opportunity to address a lack of support for SUD recovery, as well as EI non-compliance with their follow-up appointments. ACN Mid-State is utilizing AMA data to identify and outreach EIs with SUD for care coordination (to assist with primary/mental health care as well as connection to community resources), referrals to peer support specialists, and appointment coordination for those with a new MAT prescription. Additionally, the ACHN is referring pregnant EIs (i.e., those identified at assessment by maternity care coordinator with history/active SUD) to peer support, or to the Children's Policy Council for a plan of safe care. Intervention tracking measures have not been reported by the entity to date; however, they will be provided going forward, and reviewed to assess intervention progress and provide additional insight into potential gaps in care.

ACN Southeast

QIP: Adverse Birth Outcomes

ACN Southeast is targeting all pregnant EIs, as well as DHCPs and PCPs, in order to encourage visit compliance. There are three performance indicators for the project, reflected in **Table 33**.

Table 33: ACN Southeast Adverse Birth Outcome QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of pregnant EIs who have a prenatal visit in the first trimester	73.7% Numerator: 4,210 Denominator: 5,872	77.3%
The percentage of live births weighing < 2500 grams	9.9% Numerator: 321 Denominator: 3,240	9.1%
The percent of infants ages 0–15 months who have 6 or more well-child visits	73.9% Numerator: 3,126 Denominator: 2,311	77.6%

ACN: Alabama Care Network; QIP: quality improvement project; CY: calendar year; EI: eligible individual.

Access to care in the first trimester, low birth weight infants, knowledge of safe sleep, and knowledge of well-child visits have been identified as barriers by the ACHN. In order to address these barriers, ACN Southeast has initiated outreach to DHCP offices and EIs to schedule an initial visit within the first trimester; issued an incentive delivery package at delivery for EIs who attend at least 80% of prenatal visits, postpartum visit, and all care coordination visits; referred pregnant EIs with hypertension or diabetes to their internal bio-monitoring program; distributed safe sleep information to caregivers of EIs 0–6 months of age; and provided targeted case management to EIs 0–15 months of age. Intervention tracking measures have been recorded for several interventions, and demonstrate a consistent increase in the percentage of initial visits scheduled with DHCP offices (70.9% in Q1 to 77.4% in Q4); an improvement in the percentage of EIs who qualify for the incentive package (0% in the first two quarters to 24.3% and 20.7% in Q3 and Q4, respectively); and in referral to bio-monitoring, demonstrating that 45.2% of EIs completed bio-monitoring after launch in Q3 and 28.2% in Q4. Intervention tracking measures also demonstrated a steady decline in the percentage of EIs with hypertension or diabetes that deliver after 37 weeks (83.3% in Q1 to 70.1% in Q4), as well as an increase in the percentage of live births weighing less than 2500 grams born to EIs with hypertension or diabetes (low of 14.7% in Q2 and high of 20.4% in Q4).

QIP: Childhood Obesity

ACN Southeast is targeting EIs 3–6 years of age in order to promote well-child visits and improve outcomes among those with a BMI > 85th percentile. There are two performance indicators for the project, reflected in **Table 34**.

Table 34: ACN Southeast Childhood Obesity QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate[1]
The percentage of EIs 3–6 years of age with a well-child visit	72.7% Numerator: 10,691 Denominator: 14,696	76.3%
The percentage of EIs 3–6 years of age with a BMI > 85th percentile	13.5% Numerator: 2,280 Denominator: 17,344	25.7%

ACN: Alabama Care Network; QIP: quality improvement project; CY: calendar year; EI: eligible individual; BMI: body mass index.
[1] The baseline rate for BMI > 85th percentile of 13.5% (CY 2019) is lower than the goal rate for 2021 due to BMI not being required in billing claims by the Agency prior to October 2019. Thus, the baseline rate for BMI > 85th percentile in 3–6 year olds appears low due to under reporting in 2019. The target rate for 2021 was set based on data collected during CY 2020.

ACN Southeast identified poor choices, limited resources for nutrition education, and lack of knowledge of benefits on breastfeeding and childhood obesity as barriers. In order to address these barriers, the ACHN has distributed MyPlate educational materials, provided gardening materials and seeds to children in pre-K, kindergarten, and first grade, and provided education and support to encourage breastfeeding in infants 0–6 months of age. The first two interventions (the MyPlate and gardening initiatives) began in November 2020, and tracking measures demonstrate that there remains much opportunity to continue the distribution of MyPlate educational materials (evidenced by only 2.1% of EIs with BMI > 85th percentile ages 3–6 who received education in Q4) and an opportunity to expand the percentage of schools that received gardening materials (14.5% in Q4).

QIP: Substance Use Disorder

ACN Southeast is targeting EIs 18 years of age and older with a diagnosis of alcohol or other drug (AOD) abuse or dependence. There is one performance indicator for the project, reflected in **Table 35**.

Table 35: ACN Southeast Substance Use Disorder QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of EIs with an SUD diagnosis who receive treatment in measurement year	3.3% Numerator: 647 Denominator: 19,429	3.6%

ACN: Alabama Care Network; QIP: quality improvement project; CY: calendar year; EI: eligible individual; SUD: substance use disorder.

Cost of placement in non-billing SUD treatment facilities, transportation to treatment programs, and identification of EIs with SUD were cited as barriers. To address these barriers, ACN Southeast has proposed funding non-billing treatment facilities, arranging transportation when non-emergency transport is unavailable, and partnering with SpectraCare to add peer support specialists in their region. Intervention tracking measures have not been reported by the entity to date, given the changes that were made to the scope of this project and to the interventions; however they will be provided going forward, and reviewed to assess intervention progress and provide additional insight into potential gaps in care.

Gulf Coast Total Care

QIP: Adverse Birth Outcomes
Gulf Coast Total Care (GCTC) is targeting EIs with a critical risk, which they defined as an individual with a previous pre-term birth and/or a diagnosis of hypertension or diabetes. There are three performance indicators for the project, reflected in **Table 36**.

Table 36: GCTC Adverse Birth Outcome QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of live births weighing < 2500 grams	10.4% Numerator: 450 Denominator: 4,325	9.7%
The percentage of pregnant EIs who have a prenatal visit in the first trimester	39.1% Numerator: 1,521 Denominator: 3,889	74.2%
The percentage of EIs defined as critical risk, who completed 37 weeks of gestation	43.8% Numerator: 7 Denominator: 16	50.0%

GCTC: Gulf Coast Total Care; QIP: quality improvement project; CY: calendar year; EI: eligible individual.

GCTC cited the identification of EIs with one of the critical risk diagnoses as a barrier. In terms of data collection processes to address this barrier, the entity has indicated they are utilizing the assessment carried out by the maternity care coordinator. The care coordinator then confirms EI self-reporting with DHCP records and Alabama Medicaid claims data. Once EIs are identified, GCTC focuses their efforts around bio-monitoring and enrollment of EIs into the Today's Mom program. Intervention tracking measures demonstrate an opportunity to improve EI compliance with bio-monitoring (all EIs that have been identified as critical risk agreed to bio-monitoring; however, only 19% on average were compliant at least 50% of the time).

QIP: Childhood Obesity
GCTC is targeting EIs 7–11 years of age with an overweight or obese diagnosis (defined by ICD codes Z68.53 or Z68.54). There are three performance indicators for the project, reflected in **Table 37**.

Table 37: GCTC Childhood Obesity QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of EIs 3–17 years of age that have an annual BMI assessment completed	62.2% Numerator: 30,750 Denominator: 49,443	75.0%
The percentage of EIs 7–11 years of age with a diagnosis code of overweight or obese (ICD Z68.53 or Z68.54)	45.4% Numerator: 6,629 Denominator: 14,608	44.4%

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of EIs 7–11 years of age that had an annual PCP visit	89.1% Numerator: 16,760 Denominator: 18,801	90.3%

GCTC: Gulf Coast Total Care; QIP: quality improvement project; CY: calendar year; EI: eligible individual; BMI: body mass index; ICD: International Classification of Disease; PCP: primary care provider.

GCTC has identified several barriers, including practice inability to review EIs in terms of diagnosis codes (providers unaware of distribution of overweight/obese in their practice), lack of physical activity and EI/parent knowledge regarding diet/nutrition/exercise, and underutilization of PCPs for annual visit for children 7–11 years of age. The ACHN has evaluated the percentage of children in the southwest region with their BMI assessed who had an overweight/obese diagnosis to determine the extent of the public health issue (42.0% as of Q4 2020). Of those identified, the ACHN has proposed to work with PCPs to refer these EIs to care coordination, and then track the percentage that enrolled in care coordination and became involved in the 14,000 step challenge (including a pedometer and tracking chart provided by GCTC) or Teen Cuisine program (a cooking and nutrition education curriculum available through the Alabama Cooperative Extension System). Furthermore, the ACHN seeks to support and assist PCPs in contacting and scheduling appointments for EIs 7–11 years of age that are due or past due for an annual PCP visit. Intervention tracking measures have not been reported by the entity to date, given the changes that were made to the scope of this project and to the interventions; however, they will be provided going forward, and reviewed to assess intervention progress and provide additional insight into potential gaps in care.

QIP: Substance Use Disorder

GCTC is focusing its efforts on EIs with a new episode of alcohol or other drug use (AOD), specifically opioid-related, and EIs with their first Medication Assisted Treatment (MAT) prescription fill. There are three performance indicators for the project, reflected in **Table 38**.

Table 38: GCTC Substance Use Disorder QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of EIs 18 years of age and older with a new episode (no prior claim in past 60 days) of AOD (opioid-related, defined by ICD-F11) or first MAT prescription fill that enroll and remain in active Care Coordination for at least 120 days	N/A	50.0%
The percentage of EIs 18 years of age and older with a first MAT prescription filled (no prior claim in past 60 days) and initiates counseling/ behavioral therapies within 60 days of first fill	N/A	20.0%
The percentage of eligible providers that participated/completed Opioid Use Disorder (OUD) Educational Outreach and Survey that report increased knowledge/ understanding of OUD, prescribing guidelines, treatment options and community resources	N/A	50.0%

GCTC: Gulf Coast Total Care; QIP: quality improvement project; CY: calendar year; EI: eligible individual; AOD: alcohol or other drug use; ICD: International Classification of Disease; MAT: Medication Assisted Treatment; OUD: Opioid Use Disorder; N/A: not applicable.

GCTC identified barriers including a high incidence of recidivism without appropriate support navigating the healthcare system, and PCP reluctance to treat SUD due to lack of training and expertise regarding treatment modalities. To address, the ACHN has developed a procedure where a certified recovery support specialist (CRSS) will perform outreach within 24 hours of receipt of referral to EIs that have a new episode of AOD or have received their first MAT prescription. The CRSS will assist EIs in enrolling in care coordination and completing a placement assessment. Furthermore, the CRSS will assist EIs with accessing outpatient treatment through barrier assessment and support. GCTC is also conducting educational outreach to PCPs to improve their comfort level in managing EIs with AOD. The Medical Director, Pharmacy

Manager, and/or Quality Manager provides training on pathophysiology of OUD, prescribing guidelines, MAT options, quality measures, and community resources. Intervention tracking measures have not been reported by the entity to date; however, it is expected that they will be provided going forward, and will be reviewed to assess intervention progress and provide additional insight into potential gaps in care.

My Care Central

QIP: Adverse Birth Outcomes

To address adverse birth outcomes, My Care Central is focusing their efforts on family planning and school-based sexual education. There are two performance indicators for the project, reflected in **Table 39**.

Table 39: My Care Central Adverse Birth Outcomes QIP Performance Indicators

Indicator	Baseline (CY 2019)	Target
The number students enrolled in the targeted high school that complete the Making Proud Choices curriculum	0	300 students by end of school year
The number of EIs who attend women's health appointments at Baptist Health Family Medicine	0	200

QIP: quality improvement project; CY: calendar year; EI: eligible individual.

In response to the barriers of lack of knowledge of the importance of reproductive wellness, and lack of knowledge related to adverse birth outcomes related to sexually transmitted infections (STIs), My Care Central has implemented an evidence-based sexual/reproductive health curriculum in a regional high school and has partnered with Baptist Health Family Medicine to ensure women's access to screening and other preventive health measures. Intervention tracking measures demonstrate a small percentage of students participating in the curriculum; however, of those students who did participate, 84.2% demonstrated an improved post-test score (compared with their pre-test score). In terms of efforts around women's health, My Care Central has successfully had over 40% of EIs complete their cervical cancer screening with Baptist Health Family Medicine to date (since intervention initiation in quarter 2 of 2020).

QIP: Childhood Obesity

My Care Central is targeting pregnant women and EIs 0–15 months of age in an effort to prevent childhood obesity among their population. There are three performance indicators for the project, reflected in **Table 40**.

Table 40: My Care Central Childhood Obesity QIP Performance Indicators

Indicator	Baseline Rate	Target Rate
The percentage of EIs that initiate breastfeeding in the hospital post-delivery	67.7%[1]	70%
The percentage of pregnant EIs enrolled in The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) during the prenatal period	52.2%[2]	59.1%
The percentage of EIs 0–15 months of age who have 6 or more well-child visits	60.3%[3]	61.8%

QIP: quality improvement project; EI: eligible individual; WIC: Women, Infants, and Children.

[1] This rate reflects the percentage of Alabama newborns ever breastfed, per the ACHN's research.

[2] This rate reflects the percentage of WIC participants in Alabama in 2014

[3] This rate reflects calendar year 2019 ACHN data

My Care Central identified low breastfeeding rates, decreased utilization of WIC in pregnancy, and lack of understanding of the importance of the well-child visit as key drivers and barriers to preventing childhood obesity. In response, the ACHN has employed nurses to provide in-home breastfeeding education and support, improved early prenatal access to WIC, and provided education on the importance of the well-child visit in the first 15 months of life. Intervention tracking

measures indicate that all EIs that were enrolled in the Strong Momma program and delivered to-date initiated breastfeeding at the hospital. While data was not yet available, the ACHN is also collecting information related to the percentage of EIs that were still breastfeeding 30 or more days after initiation. Tracking measures also demonstrate that My Care Central is making progress enrolling eligible women in WIC before 28 weeks gestation (46% in Q3 2020 and 72% in Q4). The percentage of children who turn 15 months during the measurement year will be reviewed to evaluate how many had at least 6 well-child visits from 0–15 months of age.

QIP: Substance Use Disorder

My Care Central is targeting all EIs with n SUD diagnosis to connect them with peer support specialists and improve their access to treatment. There are three performance indicators for the project, reflected in **Table 41**.

Table 41: My Care Central Substance Use Disorder QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of EIs with an SUD diagnosis who initiated treatment within 14 days of diagnosis	34.4%	41.0%
The percentage of EIs receiving peer support services	N/A	To be decided
The percentage of EIs who initiated treatment and had 2 or more additional services within 30 days of initial visit	3.4%	10.3%

QIP: quality improvement project; CY: calendar year; EI: eligible individual; SUD: substance use disorder; N/A: not applicable.

My Care Central identified two primary barriers, including a lack of masters-level health professionals to perform the Advanced Placement Assessment (APA), and insufficient EI transportation to treatment facilities. To address, the ACHN is working to increase the ability of a mental health professional to initiate treatment by providing APA in the targeted region, and connecting EIs with transportation and other services offered by peer support specialists. According to intervention tracking measures, the percentage of APAs completed has remained at about 32% over the three quarters since intervention initiation. The percentage of EIs who initiated treatment has remained at less than 4%.

My Care East

QIP: Adverse Birth Outcomes

My Care East is focusing on smoking cessation and EI compliance with prenatal and postpartum visits in order to mitigate adverse birth outcomes. There are three performance indicators for the project, reflected in **Table 42**.

Table 42: My Care East Adverse Birth Outcomes QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of women who smoke during pregnancy	26.4% Numerator: 1,112 Denominator: 4,209	23.8%
The percentage of live births weighing less than 2,500 grams	8.8% Numerator: 128 Denominator: 1,474	8.7%
The percentage of EIs who had a postpartum visit on or between 21 and 56 days after delivery	68.1% Numerator: 813 Denominator: 1,247	72.9%

QIP: quality improvement project; CY: calendar year; EI: eligible individual.

My Care East identified lack of support to quit, access to quit services, and education about unsafe treatment as barriers to smoking cessation. In order to address, the ACHN is increasing support, resources, and education through incentivizing EIs to complete a smoking cessation program through the mobile app Quit Genius. Of those pregnant EIs referred to the app in 2020, 38% enrolled in Q3 and 42% in Q4, with 31% completing the program in Q3 and 30% in Q4.

Of those who completed the program, 31% remained smoke free 4 weeks after quit date in Q3, while 33% remained smoke free in Q4. In order to bolster prenatal and postpartum care, My Care East initiated an incentive program, which rewards EIs with gift cards if they attend a prenatal care appointment in the first trimester, and/or a postpartum care appointment 21–56 days following delivery. While 100% of DHCPs were educated about My Care East's incentive program, less than 20% of EIs collected their gift card for a prenatal visit in the first trimester or a postpartum visit in the 21–56 days following delivery; however, there has been improvement seen quarter-to-quarter in this effort.

QIP: Childhood Obesity

My Care East is targeting three high-risk engaged pediatric practices in DeKalb, Calhoun, and Tallapoosa counties, as well as two Title I schools, in order to mitigate childhood obesity. There is one performance indicator for the project, reflected in **Table 43**.

Table 43: My Care East Childhood Obesity QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of children ages 3–17 years of age who had an outpatient visit with a PCP/OBGYN and had evidence of BMI documentation during the measurement year	6.7%	28.4%

QIP: quality improvement project; CY: calendar year; PCP: primary care provider; OBGYN: obstetrician/gynecologist; BMI: body mass index.

My Care East identified several barriers, including parental compliance with well-child visits, poor diet/nutrition/physical activity, and lack of education around healthy eating habits. To address, the ACHN is providing incentives for EIs that attend well-child visits and participate in nutrition and physical activity counseling, implementing the Healthy Eating and Acting Living (HEAL) Program in physical education classes for the two selected Title I schools in My Care East's region, and partnering with the University of Alabama (UAB) to provide registered dieticians to offer telehealth counseling sessions to children 6–12 years of age with a BMI > 85th percentile. Intervention tracking measures indicate 100% of targeted pediatric providers received education about the well-child visit incentives for EIs. The percentage of EIs that attended their well-child visit over the first year of the project remained relatively constant (approximately 20% each quarter); however, the percentage of EIs that collected their incentive gift card steadily rose (from 1% in Q1 2020 to 24% in Q3 2020). Forty percent (40%) of elementary schools in St. Clair and Tallapoosa counties enrolled in the HEAL Program; however, other intervention tracking measures around this intervention (as well as the partnership with UAB dieticians) have not yet been collected. It is expected that they will be provided going forward, and will be reviewed to assess intervention progress and provide additional insight into potential gaps in care.

QIP: Substance Use Disorder

My Care East is targeting all EIs with an SUD diagnosis to connect them with peer support specialists and improve their access to treatment. There are two performance indicators for the project, reflected in **Table 44**.

Table 44: My Care East Substance Use Disorder QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
Percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis	33.1% Numerator: 268 Denominator: 903	36.3%
Percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit	3.8% Numerator: 24 Denominator: 903	6.4%

QIP: quality improvement project; CY: calendar year; AOD: alcohol or other drug use.

My Care East identified several barriers, including lack of transportation, support, and knowledge of resources; lack of assessment providers in the East region; and siloed community involvement and resources. To address, the ACHN has implemented the use of peer support specialists in partnership with Recovery Outreach and Support Services (ROSS), implemented the use of My Care East master's-level social workers (MSWs) to conduct timely adult placement assessments (APAs) to improve entry into substance treatment facilities after detox, and has plans to establish an SUD task force to improve community capacity to identify and connect recipients to substance use resources. Intervention tracking measures indicate that an increasing percentage of EIs with an active SUD diagnosis have been connected with peer support and have been connected to the ROSS helpline. Furthermore, tracking measures demonstrate that 100% of MSWs have been trained to conduct the APAs, and all EIs with MSW-completed APAs have entered into an SUD treatment center. While the SUD task force has been placed on hold due to COVID-19 restrictions, all 11 organizations that have been asked to participate have agreed. Going forward, My Care East plans to place MSWs in emergency departments, as well as pursue the SUD task force.

My Care Northwest

QIP: Adverse Birth Outcomes

My Care Northwest is targeting pregnant EIs as well as women of childbearing age to improve receipt of prenatal/postpartum care and contraception use, respectively. There are two performance indicators for the project, reflected in **Table 45**.

Table 45: My Care Northwest Adverse Birth Outcomes QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of EIs with a live birth that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment	62.1% Numerator: 597 Denominator: 970	65.5%
The percentage of EIs with a live birth that had a postpartum visit 21–56 days after delivery	62.1% Numerator: 597 Denominator: 970	65.5%

QIP: quality improvement project; CY: calendar year, EI: eligible individual.

My Care Northwest identified the lack of education on the importance of prenatal care and postpartum visits and unplanned pregnancy as barriers to address to mitigate adverse birth outcomes. The ACHN has collaborated with Nurse Family Partnership to provide education to EIs regarding the importance of prenatal and postpartum visits. Given that face-to-face discussion has not always been possible due to the restrictions posed by COVID-19, the ACHN has pivoted towards providing handouts to members to educate them on prenatal/postpartum visits, as well as the various types of contraceptive methods. Intervention tracking measures indicate that the majority of pregnant EIs have received education regarding prenatal care visits, with 100% receiving postpartum care education, and 100% receiving education on contraception. Tracking measures also demonstrate that the usage of long acting reversible contraception (LARC) has increased for adult EIs between October and November of 2020 (44% to 55%, respectively), and for the 5 teenagers represented, has declined from 100% to 60% between October and November of 2020.

QIP: Childhood Obesity

My Care Northwest is targeting children, community agencies, and providers to provide EIs with education on ways to change their diets to incorporate healthy food selections and being more active. There is one performance indicator for the project, reflected in **Table 46**.

Table 46: My Care Northwest Childhood Obesity QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of children ages 3 to 17 who had nutritional and physical activity counseling documented during the measurement year	4.4% Numerator: 1,181 Denominator: 10,143	15.7%

QIP: quality improvement project; CY: calendar year.

My Care Northwest identified several barriers, including lack of education on healthy eating habits, lack of knowledge on the importance of yearly well-child visits, and lack of knowledge of community resources. To address, the ACHN has partnered with the Auburn Extension Office to provide nutritional classes via Zoom, and has made it part of their procedure to identify EIs with a past-due well-child visit and assist them with scheduling an appointment with their PCP. Furthermore, the ACHN will have their registered dietician work with community agencies to improve knowledge of available community resources, develop a "cheat sheet" for providers to assist them with coding BMI correctly, and partner with Alabama Cooperative Extension Office to provide education to improve healthy eating habits and promote middle schoolers to become more active. Intervention tracking measures demonstrate the need for increased participation into the nutritional classes, as well as well-child visits. Intervention tracking measures have not been collected for the interventions that started later in the project year, but it is the expected that the ACHN will provide them going forward, and they will be reviewed to assess intervention progress and provide additional insight into potential gaps in care.

QIP: Substance Use Disorder

My Care Northwest is targeting EIs with an SUD diagnosis, and seeks to improve initiation and engagement in treatment among this population. There are two performance indicators for the project, reflected in **Table 47**.

Table 47: My Care Northwest Substance Use Disorder QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
The percentage of EIs age 18 and older with a new episode of AOD abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis	40.0% Numerator: 322 Denominator: 804	43.8%
The percentage of EIs age 18 and older with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit	5.5% Numerator: 44 Denominator: 804	6.9%

QIP: quality improvement project; CY: calendar year; EI: eligible individual; AOD: alcohol or other drug.

My Care Northwest has identified lack of trained peer support specialists (PSSs) in their region, lack of APA providers, and lack of transportation providers as barriers. To address, the ACHN has sought to increase the number of PSSs through a partnership with ROSS, and has provided training to their MSWs on how to complete APAs. Furthermore, the ACHN has begun addressing the transportation barrier by having PSSs provide this service to EIs. The only tracking measure that has been evaluated to date is the percentage of EIs who were connected with PSS to assist with treatment; this measure demonstrates that while there is room for improvement, between 30% and 75% of members (month over month beginning in May 2020) have received assistance from PSS. It is expected that My Care Northwest will provide tracking measures for each intervention going forward, and they will be reviewed to assess intervention progress and provide additional insight into potential gaps in care.

North Alabama Community Care

QIP: Adverse Birth Outcomes

North Alabama Community Care (NACC) is focusing their efforts on EIs with a BMI greater than or equal to 30.0 in order to mitigate poor birth outcomes. There are three performance indicators for the project, reflected in **Table 48**.

Table 48: NACC Adverse Birth Outcomes QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
Percentage of pregnant EIs identified as having a BMI greater than or equal to 30.0 at their first prenatal visit receiving nutritional and healthy lifestyle counseling to decrease infant mortality and adverse outcomes	N/A	50.0%
Percentage of pregnant EIs that fail their GTT receiving nutritional and healthy lifestyle counseling to decrease infant mortality and adverse outcomes	N/A	50.0%
Percentage of pregnant EIs identified as having a BMI greater than or equal to 30.0 at their first prenatal visit and/ or EIs that fail their GTT enrolling in Plan First services after delivery	N/A	50.0%

NACC: North Alabama Community Care; QIP: quality improvement project; CY: calendar year; EI: eligible individual; BMI: body mass index; GTT: glucose tolerance test.

NACC identified several key drivers associated with mitigating adverse birth outcomes, including the maintenance of a healthy weight and lifestyle throughout pregnancy, and promotion of inter-conception care. The ACHN has developed interventions that target the identification of EIs who fail their glucose tolerance test (GTT) or who have a BMI greater than or equal to 30.0 at their initial prenatal visit. The ACHN then provides education about physical activity, smoking cessation and breastfeeding, and enrollment into Plan First Services. Intervention tracking measures demonstrate that NACC has been successful in nutrition counseling for women who either were identified as having failed their GTT, or identified as having a BMI greater than or equal to 30.0. Furthermore, the ACHN was successful in mitigating excessive weight gain during pregnancy in those with a high BMI, and also helping to facilitate smoking cessation in the two pregnant EIs that were identified. There is an opportunity for continued focus on breastfeeding education and support, given only one of six women continued breastfeeding from delivery through the postpartum visit (it should be noted that only one month of results were available at the time of this report; thus, the ACHN is encouraged to continue tracking their efforts around breastfeeding to understand if intervention effective).

QIP: Childhood Obesity

NACC is targeting EIs 3–6 years of age, as well as pregnant EIs, in order to reduce the prevalence of childhood obesity. There are three performance indicators for the project, reflected in **Table 49**.

Table 49: NACC Childhood Obesity QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
Percentage of EIs ages 3–6 with documentation of BMI in their medical record	89.5%	60.0%
Percentage of EIs ages 3–6 with a BMI between 85%–94%	16.0%	15.3%
Percentage of first time pregnant EIs that are breastfeeding at postpartum visit	31.3%	25.0%

NACC: North Alabama Community Care; QIP: quality improvement project; CY: calendar year; EI: eligible individual; BMI: body mass index.

The ACHN identified several barriers, including lack of PCP/pediatrician commitment to identifying childhood obesity, EI knowledge of nutrition and healthy lifestyles, and lack of breastfeeding promotion. In order to address, NACC has begun educating PCPs and pediatricians on the correct collection and reporting of BMI, and requesting referrals from these providers for EIs 3–6 years of age with a BMI between 85% and 94% to NACC for counseling. Case Management assesses these EIs for readiness for change, and group sessions managed by dietician, community health workers, and extension services that focus on child nutrition, increasing physical activity and reducing screen time are made available. Furthermore, the dietician, community health workers, and extension services manage food box distribution to these EIs. NACC's intervention targeting pregnant women focuses on Maternity Care Coordinators providing education about the benefits of breastfeeding with first time pregnant EIs; these EIs are then offered coordination with local lactation support services. Intervention tracking measures demonstrate that the percentage of EPSDT claims for EIs ages 3–6 with BMI classification diagnosis codes has steadily increased since the inception of the project (from 9.9% in January 2020 to 61.3% in August 2020). Data have been limited for the tracking measures that assess the other interventions; however, it is the expectation that NACC will provide these going forward, and they will be reviewed to assess intervention progress and provide additional insight into potential gaps in care.

QIP: Substance Use Disorder

NACC is targeting EIs 13 years of age and older with an SUD diagnosis, as well as providers, to improve access to treatment and recovery services. There is one performance indicator for the project, reflected in **Table 50**.

Table 50: NACC Substance Use Disorder QIP Performance Indicators

Indicator	Baseline Rate (CY 2019)	Target Rate
Percentage of EIs age 13 years and older with a new episode of SUD diagnosis receiving substance use disorder treatment	40.2%	40.5%

NACC: North Alabama Community Care; QIP: quality improvement project; CY: calendar year; EI: eligible individual; SUD: substance use disorder.

NACC identified several barriers, including lack of MAT-certified physicians, identifying EIs with substance use disorders, identifying the support needs of EIs with a substance use disorder diagnosis, and low-Risk EIs and adolescents being overlooked for interventions. In order to address, the ACHN has initiated provider group training sessions via GoTo Meeting (to educate on the referral process to identify EIs in need of brief intervention for SUD). The brief intervention is completed by NACC staff to educate on the consequences of substance use and encourage healthy lifestyle choices. Further targeting providers, the ACHN has implemented an incentive program to promote MAT certification. Lastly, NACC has coordinated with ROSS to address the support needs of EIs with SUD and complete referrals to residential facilities for treatment. Intervention tracking measures are not available to date, given the changes in the project due to COVID-19 restrictions. It is expected that NACC will provide these measures going forward, and they will be reviewed to assess intervention progress and provide additional insight into potential gaps in care.

Appendix A: Systems Performance Review

Objectives

Each annual detailed technical report must contain data collected from all mandatory EQR activities. Federal regulations at 42 CFR 438.358 delineate that a review of an MCE's compliance with standards established by the state to comply with the requirements of § 438 Subpart D and the quality assessment and performance improvement requirements described in § 438.330 is a mandatory EQR activity. Furthermore, this review must be conducted within the previous three-year period, by the state, its agent, or the EQRO.

Annually, AMA evaluates the ACHN entities' performance against contract requirements and state and federal regulatory standards through IPRO, its EQRO contractor.

In order to determine which regulations must be reviewed annually, IPRO performs an assessment of the ACHN entities' performance on each of the federal managed care regulations over the prior three-year period. Given that 2020 was the first year of SPR, all applicable regulations were subject to review.

The SPR for the review period October1 2019–September 30, 2020, conducted in December 2020, addressed contract requirements and regulations within the following categories:

- Care Coordination
- EI Materials
- EI Rights
- Enrollment/Disenrollment
- Grievances
- Provider Participation
- Health Information Management Systems
- Quality Management

Data collected from each ACHN entity submitted during the pre-interview phase, during the day of interviews, or in follow-up were considered in determining the extent to which the entity was in compliance with the standards. Further, descriptive information regarding the specific types of data and documentation reviewed is provided in the **Description of Data Obtained** section below, and in the **Systems Performance Review** section of this report.

Technical Methods of Data Collection

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCEs. For each set of standards reviewed, IPRO prepared standard-specific review tools with standard-specific elements (i.e., sub-standards). The tools include the following:

- statement of federal regulation and related federal regulations;
- statement of state regulations;
- statement of state and ACHN contract requirement(s);
- suggested evidence;
- prior results;
- ACHN entity evidence;
- reviewer determination;
- descriptive reviewer findings and comments related to findings; and
- ACHN entity response and action plan.

In addition, where applicable (e.g., EI grievances and care coordination), file review worksheets were created to facilitate complete and consistent file review.

Reviewer findings formed the basis for assigning preliminary and final determinations. The standard determinations used are listed in **Table A.1**.

Table A.1: Standard SPR Determinations

Level of Compliance	Meaning
Full compliance	ACHN entity has met or exceeded the standard.
Partial compliance	ACHN entity has met some requirements of the standard, but is deficient in some areas that must be remediated.
Non-compliance	ACHN entity has not met the standard.

SPR: systems performance review; ACHN: Alabama Coordinated Health Network.

The list of elements due for review and the related review tools were shared with AMA and each ACHN entity.

Pre-interview Activities: Prior to the day of interviews, an introduction letter was sent to the ACHN entities, and documentation along with eligible population listings for file reviews was requested.

The documentation request is a listing of pertinent documents for the period of review, such as policies and procedures, sample contracts, program descriptions, work plans, and various program reports.

The eligible population request is a request for case listings for file reviews, e.g., for EI grievances, a listing of grievances received by the ACHN entity for a selected time period; or, for care coordination, a listing of members enrolled in care coordination during a selected time period. From these listings, IPRO selected a random sample of files for review.

Additionally, IPRO began its desk review, or offsite review, when the documentation and case files were received from the ACHN entities. Prior to the review, a notice was sent to the ACHN entities including a confirmation of the virtual review dates, an introduction to the review team members, the review agenda, and an overall timeline for SPR activities.

Virtual Review Activities: The reviews commenced with an opening conference, where staff was introduced, and an overview of the purpose and process for the review, including the agenda, was provided. Following the opening conference, staff interviews were conducted to clarify and confirm findings from the pre-interview phase. When appropriate, walk-throughs or demonstrations of work processes were conducted. The review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed, and the next steps in the review process.

Description of Data Obtained

As noted in **Pre-interview Activities**, in advance of the review, IPRO requested documents relevant to each standard under review to support each ACHN entity's compliance with federal and state regulations and contract requirements. This included items such as: policies and procedures; sample contracts; annual QI program description, work plan, and annual evaluation; EI and provider handbooks; participation reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis, and follow-up. Additionally, as noted in **Virtual Review Activities**, staff interviews and demonstrations were conducted on the day of interviews. Supplemental documentation was also requested for areas where IPRO deemed it necessary to support compliance. Further detail regarding specific documentation reviewed for each standard for the 2020 review is included in the **Systems Performance Review** section of this report.

Data Aggregation and Analysis

Post-interview Activities: Following the virtual review, the ACHN entities were provided with a limited time period to submit additional documentation while IPRO prepared the preliminary review findings. As noted earlier, each standard reviewed was assigned a level of compliance ranging from full compliance to non-compliance. The review determination was based on IPRO's assessment and analyses of the evidence presented by the ACHN entity. For standards where an ACHN entity was less than fully compliant, IPRO provided in the review tool a narrative description of the evidence reviewed and reason for lack of full compliance. Each ACHN entity was provided with the preliminary findings with the opportunity to submit a response and additional information for consideration. IPRO reviewed any responses submitted by the ACHN entity and made final review determinations.

Appendix B: Validation of Quality Improvement Projects

Objectives

ACHN entities implement QIPs to assess and improve processes of care, and as a result improve outcomes of care. The goal of QIPs is to achieve significant and sustainable improvement in health outcomes and processes. While regulations do not require PCCM entities to conduct QIPs, states may require them to do so. It is recommended that if states do require their PCCM entities to carry out QIPs, then they should consider validating those projects. AMA requires their PCCM entities to carry out QIPs, and IPRO has been tasked with the validation of those QIPs, to ensure methodological soundness of design and conduct, and evaluate the improvement in care and provide confidence in these reported improvements.

QIPs were reviewed according to the CMS protocol *Validation of Performance Improvement Projects.* The first process outlined in this protocol is assessing the methodology for conducting the QIP. This process involves the following 10 elements:

- review of the selected study topic(s) for relevance of focus and for relevance to the ACHN entity's enrollment;
- review of the study question(s) for clarity of statement;
- review of selected study indicator(s), which should be objective, clear and unambiguous and meaningful to the focus of the QIP;
- review of the identified study population to ensure it is representative of the ACHN entity enrollment and generalizable to the ACHN entity's total population;
- review of sampling methods (if sampling used) for validity and proper technique;
- review of the data collection procedures to ensure complete and accurate data were collected;
- assessment of the improvement strategies for appropriateness;
- review of the data analysis and interpretation of study results;
- assessment of the likelihood that reported improvement is "real" improvement; and
- assessment of whether the ACHN entity achieved sustained improvement.

Following the review of the listed elements, the review findings are considered to determine whether or not the QIP findings should be accepted as valid and reliable.

Technical Methods of Data Collection

The methodology for validation of the QIPs was based on the CMS protocol. Each QIP was reviewed using this methodology upon proposal submission. Upon first remeasurement and each remeasurement thereafter, each of the 10 protocol elements is considered.

Description of Data Obtained

Each QIP was validated using the ACHN entity's QIP project reports, and in collaboration with AMA's data and analytics team. Data obtained at the proposal stage included baseline, benchmark, and goal rates.

Data Aggregation and Analysis

Each applicable protocol element necessary for a valid QIP is documented within this report. Analysis includes review of the study topic, questions, indicators, target population, data collection procedures, and interventions. Sampling was not applicable within any of the QIPs.

Upon final reporting, a determination will be made as to the overall credibility of the results of each QIP, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility of the QIP results is at risk.
- The validation findings generally indicate that the credibility of the QIP results is not at risk. Results must be interpreted with some caution. Processes that put the conclusions at risk will be enumerated.
- There are one or more validation findings that indicate a bias in the QIP results. The concerns that put the conclusion at risk will be enumerated.

Alabama Medicaid Agency

Plan First Program

Section 1115 Demonstration Waiver

Annual Monitoring Report

Demonstration Year 20

October 1, 2019 through September 30, 2020

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Introduction:

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

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

On June 15, 2017, Medicaid submitted a request to extend the demonstration for a five-year period with no program changes. CMS is approving this extension request through September 30, 2022, as agreed upon with the State, to realign Plan First's annual demonstration cycles back to the original date of implementation. The Special Terms and Conditions (STCs), accompanying the CMS approval letter, permit section 1115 demonstration authority for the Plan First demonstration through September 30, 2022. The program's overall goal is to reduce unintended pregnancies.

CMS and Medicaid expect that this demonstration program will promote the Medicaid program objectives by:

- Increasing the enrollment of women eligible for Plan First, with a focus to reduce race/ethnicity and geographic disparities in enrollment;
- Maintaining a high level of awareness of the Plan First program among enrollees;
- Increasing the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and subsequent years;
- Increasing the portion of Plan First enrollees who receive tobacco cessation services or nicotine replacement products;
- Maintaining birth rates among Plan First participants that are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration; and,
- Increasing enrollment of men eligible for Plan First and undergoing vasectomy services.

ANNUAL MONITORING REPORT
ALABAMA MEDICAID AGENCY
1115 PLAN FIRST DEMONSTRATION WAIVER

State: Alabama
Demonstration Reporting Period: October 1, 2019 - September 30, 2020
Demonstration Year: 20
Demonstration Approval Period: November 27, 2017 through September 30, 2022

A. EXECUTIVE SUMMARY

The Plan First Program was 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 through 55, and males ages 21 or older for vasectomy related services only. Plan First enrollees are also eligible to receive tobacco cessation counseling and products provided by the Alabama Department of Public Health through a partnership with the Alabama Medicaid Agency. 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. However, due to the current Public Health Emergency (PHE) declared in March 2020, verbal consent for services has been accepted when needed. 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
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 Alabama Medicaid application. Income is verified at the 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 Alabama Medicaid application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at the initial application and re-verified at recertification 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 must apply using a simplified Plan First application (Form 357). 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. Medicaid 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 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**.**

The Alabama Medicaid Plan First 1115 Demonstration Waiver was renewed in November 2017, and the renewed waiver specified six goals for evaluation. This Annual Monitoring report contains information for Demonstration Year (DY) 20, October 1, 2019, through September 30, 2020, representing the Demonstration's various operational areas and the State's analysis of program data collected for the demonstration year. This report also includes findings related to trends and issues that have occurred over the demonstration year, including progress on addressing any issues affecting access, quality, or costs.

PROGRAM UPDATES

1. Current Trends or Significant Program Changes from Previous Demonstration Years

a. Operational / Administrative Changes

- Family Planning care coordination was transitioned from the Alabama Department of Public Health (ADPH) to Alabama Coordinated Health Networks (ACHNs) in October 2019. ACHNs receive monthly assignment file reports of all eligible Plan First/Family Planning eligible individuals (EIs). Care Coordinators utilize these reports to attempt outreach to EIs and to offer Family Planning Care Coordination services.

b. Narrative on any demonstration changes, such as changes in enrollment, service utilization, and provider participation. Discussion of any action plan, if applicable.

Services and Enrollment

- Medicaid began allowing dual enrollment for care coordination services. However, family planning services can only be provided to maternity EIs the month of delivery and after to facilitate early engagement with the family planning service options, this allows family planning care coordination to begin at the hospital after the birth and this helps in the continuity of care and positively impacts enrollment.

- Medicaid approved with oversight from the Agency, the Waiver submitted by the ACHNs requesting that Associate Degree Nurses (ADNs) be allowed to provide transitional care services.

Provider Participation

Currently, all counties have public provider options for Plan First services. Plan First providers enrolled in Alabama have increased to 1,906 as of October 1, 2020.

c. Audits

During this past demonstration year, Alabama Medicaid completed 99 audits of family planning care coordination services for Plan First Providers enrolled in the Medicaid Plan First Program. Findings were identified, and education was provided.

To accomplish the Waiver requirements, Alabama Medicaid performed the following monitoring and quality functions:

- Reviewed utilization reports from claims data to monitor trends and utilization
- Reviewed care coordinator activity summary reports
- Reviewed summary reports from UAB
- Monitored complaints and grievances to an acceptable resolution
- Added claims system edits and audits to prevent duplication of payments

Additionally, each ACHN conducted self-audits during this past demonstration year related to the Plan First services provided.

ACHN	**Self-Audits During Past Demonstration Year**

North Alabama Community Care (NACC)	The Family Planning Supervisor completed internal audits on a monthly basis to include auditing a minimum of 1 to 2 eligible individual's (EIs) case files per Family Planning Care Coordinator.
Alabama Care Network Mid-State (ACN-M)	Sixty-five total self-audits were conducted on a monthly basis.
Alabama Care Network Southeast (ACNS)	Approximately 5% of newly enrolled family planning charts were self-audited on a monthly basis.
Gulf Coast Total Care (GCTC)	Each Family Planning Care Coordinator has 1-2 new family planning cases audited monthly, which equates to a total of approximately 6% of newly enrolled family planning charts.
My Care Alabama Northwest (MCANW)	Seventy-five self-audits were conducted during this past demonstration year. Each Associate and the Supervisors conducted audits on randomly chosen EIs on a weekly basis.
My Care Alabama Central (MCAC)	Eighty-eight total self-audits were conducted on a weekly basis.
My Care Alabama East (MCAE)	One hundred thirty-nine total self-audits were conducted on a weekly basis.

POLICY ISSUES AND CHALLENGES

1. **Narrative of any operational challenges or issues the state has experienced.**

- The COVID-19 PHE took effect in March 2020, which significantly impacted the provider's ability to provide in-person Family Planning/Plan First services.
    - At least one ACHN reported an impact on numbers of strictly family planning only service referrals from the FQHCs to ACHNs due to activities transitioning to remote/telephonic activities and providers placing limits on the number of patients being seen in the clinics per day.
    - The Agency's need to shift to the allowance of telephonic service delivery instead of the required face-to-face visit(s) for both care coordination services and contraceptive visits.

- Collaboration between the Alabama Department of Public Health (ADPH) and Alabama Coordinated Health Networks (ACHNs) has been a struggle.
    - Some ACHNs were not allowed access into the health departments.
    - ADPH did not send family planning care coordination referrals or provide ACHN contact information to the EIs.

2. Narrative of any policy issues the state is considering, including pertinent legislative/budget activity, and potential demonstration amendments.

There are not any policy issues the state is considering, including pertinent legislative/budget activity, or potential demonstration amendments at this time.

3. Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

- In response to the COVID-19 pandemic, ADPH began providing Plan First recipients Family Planning services telephonically in March 2020. With the deferment of the physical exam component, telephone visits were available when clinically appropriate for recipients who preferred not to come into a county health department to receive Family Planning services. However, ADPH is also scheduling clinic appointments for patients who desire an in-person visit and/or those whose deferred physical exams are due, per ADPH Family Planning Clinic Protocol.
- Effective March 18, 2020, Medicaid did not terminate individuals from Medicaid coverage during the PHE if they were enrolled in the program in March 2020 or became enrolled during the PHE, unless the individual voluntarily terminated eligibility or was no longer a resident of the state.

B. UTILIZATION MONITORING

Addressed in Goal 1. Addressing Disparities in Enrollment Section of the report

C. PROGRAM OUTREACH AND EDUCATION

General Outreach and Awareness
Alabama Coordinated Health Networks (ACHNs):

ACHN	Strategies	Effectiveness
Alabama Care Network Mid-State (ACN-M)	Care Coordinators were provided a list of eligible individuals (EIs), otherwise known as recipients eligible for family planning	Successfully connecting with EIs for Family Planning services has been a challenge. , the deferral rate for family planning outreach was 80%.

	services. Calls were made to eligible EIs. ACN-M educated DHCPs and provided information about ACN-M's family planning care coordination services.	
Alabama Care Network Southeast (ACNS)	Care Coordinators were provided a list of EIs who were eligible for family planning services. Calls were made to eligible EIs. For EIs could not be reached due to an outdated phone number or unable to be contacted due to an outdated phone number or voicemail set up, letters were mailed to offer family planning care coordination services. ACNS also met with the Medicaid eligibility workers in the Auburn office. They agreed to attach a family planning business card to new Family Planning recipient letters with our contact information. ACNS had two meetings during the fiscal year with delivering health care providers in the region and provided information about our family planning care coordination services.	Cold calls to eligible EIs were not very successful. In December, 100 EIs were called to outreach for family planning care coordination. The results were: • Four appointments made, • Seven EIs refused services, • 52 voicemails left (0 callbacks), and; • 37 calls were either incorrect phone numbers, or voicemail was full. Due to the low success rate, ACNS did not continue to pursue cold calls for outreach. Family Planning letters offering services were somewhat successful as ACNS did receive calls from EIs who had received the outreach letters. ACNS did receive calls from new Family Planning EIs that resulted from the business card attached to their award letter. ACNS plans to reach out to additional eligibility offices to send more business cards along with the family planning award letters. The outreach to ACNS's delivering healthcare providers has been helpful - especially from the providers who offer family planning services to EIs.

		ACNS's enrollment rate was approximately 31.6% of the EIs contacted by either phone or mail.
My Care Alabama Northwest (MCANW)	Plan First outreach and provider education is addressed during quarterly Medical management Meetings. **MCANW's** Medical Director updates the Network with any Plan First Medicaid ALERTS. Attempts to engage ADPH were made early on, but they were not successful. EI outreach is provided using MCANW marketing materials based at ADPH lobbies, PCP and Pediatrician offices, FQHCs, DHCP offices, faith-based organizations, and Pregnancy Centers. MCANW also works with the board members and CAC to Network in dispersing information regarding Plan First services and the ACHN requirements.	All quality partners and ACHN providers are encouraged to support the PF program and the enrollment of all eligible individuals. MCANW has discussed developing specific PF services materials in an effort to reach the targeted population. Attempts to engage ADPH were done early on, but attempts were unsuccessful in receiving referrals on those receiving clinical services at the Health departments. If EIs are not enrolled, it will continue to be an MCANW priority to have PF educational materials distributed amongst the Region. Some pregnancy centers in the Region will not allow birth control literature to be distributed, this is a barrier that limits education to EIs.
North Alabama Community Care (NACC)	Family Care Coordinator mailed introductory outreach letters to Family Planning only EIs attributed to Central North. Three pads of 100 informational tear-offs were provided to each county health department in NACC's region to reach potential Family Planning EIs. Tear-offs were made available in both English and Spanish.	Emphasis was heavily placed on continued collaboration and partnership with all local health departments and primary care providers (to include gynecological providers). This was extremely vital to NACC's overall outreach for Plan First/Family Planning services to all women and men eligible for coverage. NACC's continued efforts will help to improve access to services, including care coordination. NACC's hope is that that they continue to expand and improve outreach across all service counties to Eligible Individuals (EIs) and

		potential EIs. Thus by continuing to work closely with Maternity Care Coordinators per contacting EIs who have delivered (before or after delivery) to offer to complete Family Planning Risk Screenings and Family Planning Enrollments at such encounters, either telephonically or via face-to-face engagement; and by intentionally reviewing on a consistent basis EI Medicaid Assignment Files so to contact (by phone or outreach letters) eligible women and men to share about Plan First/Family Planning services, to include facilitation of referrals for care coordination and utilization of smoking cessation products and other relatable services.
Gulf Coast Total Care (GCTC)	All maternity EIs received education on the Family Planning care coordination program and was reflected in their maternity care plan. All DHCP offices received information regarding the Family Planning care coordination program offered by GCTC and the referral process for identified EIs. Care coordinators placed outreach phone calls to newly awarded Plan First recipients in an attempt to enroll in services. All maternity EIs were given a Plan First education brochure at the maternity follow-up encounter.	GCTC feels that their efforts of outreach currently available to have been effective. All maternity EIs are given information regarding family planning services multiple times throughout their pregnancy. It appears that GCTC have had an increase in EIs accepting services, specifically those that are transitioning from maternity services. The outreach to DHCPs within GCTC's region has been very helpful in helping to secure needed service referrals. As for "cold call" outreach from the list of newly assigned Plan First recipients, GCTC found those have not been as successful as GCTC would have liked. GCTC had a very low success rate in reaching the EIs due to incorrect phone numbers and addresses. Additionally, when able to reach the EIs, many declined services from cold call lists alone. GCTC have found EIs are more receptive when we have been able to work in partnership with their primary

		family planning medical service provider, and the provider had first discussed the topic of care coordination services. Unfortunately, in seven of GCTC's eight-county region, family planning services are primarily provided by ADPH, from which GCTC have been unsuccessful thus far in receiving family planning care coordination referrals or active family planning management listings.
My Care Alabama Central (MCAC)	MCAC has conducted numerous outreach activities to providers and local community organizations. MCAC are continuously educating PCPs, including pediatricians and DHCPs, on family planning services and how our care coordinators can assist them with their patients. GCTC does this individually and through medical management meetings. MCAC also targets community organizations such as pregnancy centers to educate on family planning services. MCAC continues to struggle with referrals from the Health Departments who hold most of the Plan First EIs.	Pediatrician outreach has proven the most effective. These providers need services for their adolescent patients. Pregnancy centers have been a great source of referrals also. The pregnancy centers are happy to be able to provide resources to EIs whose pregnancy test is negative. MCAC continuously finds that EIs still have not heard of the ACHN program or MCAC. A lesson learned is to provide more EI outreach from the ACHNs and Medicaid. Attempts to collaborate and engage ADPH for the betterment of shared patients have proven unsuccessful despite numerous attempts.
My Care Alabama East (MCAE)	MCAE has conducted numerous outreach activities to providers and local community organizations. We are continuously educating PCPs, including pediatricians and DHCPs, regarding family planning services and how our care coordinators can assist them with their patients.	All quality partners and ACHN providers are educated and encouraged to support the Plan First program and the enrollment of all eligible individuals. My Care Alabama has discussed developing specific family planning services materials in an effort to reach the targeted population.

	Plan First outreach and provider education is also addressed during quarterly Medical Management Meetings. MCAE continues to struggle with referrals from the Health Department who provides services to the majority of the Plan First EIs.	MCAE continuously finds that EIs still have not heard of the ACHN program or MCAE, creating initial skepticism that must be overcome. Navigating how to provide additional EI outreach from the ACHNs and Medicaid has been a lesson learned.

Alabama Medicaid Agency:

The PT+3 Partnership hotline number previously operated by the Alabama Department of Public Health (ADPH) transferred to Medicaid. A log of all calls is maintained in Medicaid's Communications Division. Future outreach activities will include, but are not limited to:

- Continued promotion of long-acting reversible contraception (LARCs);
- Statewide academic detailing effort to promote smoking cessation among women of childbearing age to Plan First providers (began December 2018);

General outreach will be directed to all potentially eligible women to include basic information about applying for the program and accessing services.

Updates, links, fact sheets, and other sources of information about family planning services are accessible online to recipients and providers. This information can be found on Medicaid's website at http://www.medicaid.alabama.gov/ and ADPH's website at http://alabamapublichealth.gov/.

D. PROGRAM INTEGRITY

During this past Demonstration Year, the Program Integrity Division did not submit any audit findings to the Plan First Unit.

E. GRIEVANCES AND APPEALS

There were no complaints or grievances received during this reporting period.

F. ANNUAL POST AWARD PUBLIC FORUM

Plan First Program 1115 Waiver Extension Post Award Public Forum
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama
May 1, 2020
Questions and Answers

There were no questions at the Annual Plan First Public Forum held on May 1, 2020.

G. BUDGET NEUTRALITY

1. Budget Neutrality Workbook

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

Without-Waiver Total Expenditures								
			18	**19**	**20**	**21**	**22**	**TOTAL**
Hypothetical Per Capita	-	-						
Family Planning	1	**Total**	$ 23,475,183	$ 22,851,782	$ 23,646,661	$ 22,851,782	$ 22,851,782	
		PMPM	$26.76	$26.76	$26.76	$26.76	$26.76	
		Mem-Mon	877,249	853,953	883,657	853,953	853,953	

Tobacco Cessation	2	**Total**	$ 261	$ 128	$ 272	$ 128	$ 128	
		PMPM	$0.50	$0.50	$0.50	$0.50	$0.50	
		Mem-Mon	522	255	543	255	255	
TOTAL			**$23,475,444**	**$22,851,910**	**$23,646,933**	**$22,851,910**	**$22,851,910**	**$115,678,106**

With-Waiver Total Expenditures								
			18	**19**	**20**	**21**	**22**	**TOTAL**
Hypothetical Per Capita								
Family Planning	1	**Total**	$22,803,379	$23,635,913	$11,490,506	$13,431,624	$14,671,498	
		PMPM						
		Mem-Mon						
Tobacco Cessation	2	**Total**	$9,446	$7,077	$9,058	$9,193	$9,193	
		PMPM						
		Mem-Mon						
TOTAL			**$ 22,812,825**	**$ 23,642,990**	**$ 11,499,564**	**$ 13,440,817**	**$ 14,680,691**	**$ 86,076,887**

NOTE: 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 October 2017 – September 2020 time periods for DY 2017 and DY 2020

Budget Neutrality Summary

	18	**19**	**20**	**21**	**22**
Cumulative Target Percentage (CTP)	2.0%	1.5%	1.0%	0.5%	
Cumulative Budget Neutrality Limit (CBNL)	$ 23,475,444	$ 46,327,354	$ 69,974,287	$ 92,826,197	$ 115,678,106
Allowed Cumulative Variance (= CTP X CBNL)	$ 469,509	$ 694,910	$ 699,743	$ 464,131	$ -
Actual Cumulative Variance (Positive = Overspending)	$ (662,619)	$ 128,461	$ (12,018,908)	$ (21,430,001)	$ (29,601,219)

Is a Corrective Action Plan needed?					

Note 1: Used the historical expenditures and member months from 2012-2016
Note 2: Actual member months and total expenditures have been entered for the October 2017 – September 2020 time periods for DY 2018, DY2019, and DY2020.

2. There was no variance noted in the estimated budget.

H. DEMONSTRATION EVALUATION ACTIVITIES AND INTERIM FINDINGS

SUMMARY OF THE PROGRESS OF EVALUATION ACTIVITIES

Evaluation Progress: The current reporting period (October 1, 2019, through September 30, 2020) is the third year of the evaluation for the five-year demonstration. The University of Alabama at Birmingham (UAB) evaluation team is completed their analysis of the enrollment data and claims for family planning services and births for this evaluation year. The team has also begun data collection for the beneficiary surveys. NOTE: This is a partial report due to evaluation design changes approved by CMS in March 2021 and the Agency's inability to have all needed data prior to April 30, 2021, due date established by CMS at that time.

Evaluation Goal 1 – Addressing Disparities in Enrollment

The program goal is to enroll into Plan First 80% of eligible women between ages 19 and 40 across all racial/ethnic groups and geographic areas.

Hypotheses: We anticipate that the composition of the enrolled population will be demographically similar to the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we anticipate lower enrollment rates among older women compared to younger women.

Findings as of April 2021: Enrollment in Plan First remains significantly below the goal of 80% of eligible women. Enrollment declined 12.5% between DY 19 and DY 20. This was primarily due to a 53% decline in new enrollees. Many new enrollees in Plan First are flips from other Medicaid eligibility categories, particularly SOBRA coverage during pregnancy. Changes in enrollment and disenrollment policies in place in 2020 in response to the PHE Maintenance of Effort requirements are likely explanations for much of this change in enrollment.

Table 1.1. Estimates of low-income women eligible for and enrolled in Plan First, by age, race, and public health district. (Enrollment and Census data)

		Enrolled in Plan First in DY 19	Enrolled in Plan First DY 20	Change in percent of population enrolled DY 19-DY 20
	ACS Population Estimate	**N (% Enrollees of low-income population in 2019)**	**N (% Enrollees of low-income population in 2020)**	**%**
TOTAL	**N**			
	353,394	103,275 (29.2)	90,318 (25.6)	-12.5
Age, years				
19-24[a]	93,937 (26.6)	27,597 (26.8)	24,434 (27.1)	-11.5
24-44	188,070 (53.2)	70,961 (68.9)	61,576 (68.2)	-13.2
45-54	71,387 (20.2)	4,663 (4.3)	4,308 (4.8)	-7.6
Race				
White	172,797 (48.9)	37,558 (36.4)	32,784 (36.3)	-12.7
Black	149,569 (42.3)	55,168 (53.4)	47,912 (53.1)	-13.2
Hispanic	20,047 (5.7)	2,169 (2.1)	2,018 (2.2)	-7.0
Asian/Pacific Islander	4,242 (1.2)	470 (0.5)	405 (0.5)	-13.8
American Indian	1,986 (0.6)	317 (0.3)	293 (0.3)	-7.6
Other race/ethnicity/unknown	4,436 (1.3)	7,593 (7.4)	6,906 (7.1)	-9.1
ACHN Regions[b]				
Central	38,691 (11.0)	14,775 (14.3)	12,763 (14.1)	-13.6
East	44,143 (12.5)	12,992 (12.6)	10,982 (12.2)	-15.5
Gulf/Southwest	53,081 (15.0)	19,254 (18.6)	16,929 (18.7)	-12.1
Mid-state	65,502 (18.6)	14,943 (14.5)	13,459 (14.9)	-9.9
Northeast	58,059 (16.5)	11,863 (11.5)	10,535 (11.7)	-11.2
Northwest	46,933 (13.3)	14,187 (13.7)	12,542 (13.9)	-11.6
Southeast	46,419 (13.2)	15,256 (14.8)	13,108 (14.5)	-14.1

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

[b]ACHN region population estimates were calculated using the Census Vintage 2019 county population estimates, ages 18-24 with 30% poverty estimate https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-detail.html

Table 1.2. Changes in re-enrollment rates from previous year (Enrollment data)

	Enrolled in DY19			Enrolled in DY20			% change DY19 to DY20		
	Total	**Returning**	**New**	**Total**	**Returning**	**New**	**Total**	**Returning**	**New**
TOTAL	103,275	68,837	34,438	90,318	73,950	16,368	-12.5%	7.4%	-52.5%
Age, years									
19-24	27,597	16,439	11,158	24,434	18,767	5,667	-11.5%	14.2%	-49.2%
25-34	49,885	34,150	15,735	42,450	34,748	7,702	-14.9%	1.8%	-51.1%
35-44	21,076	14,767	6,309	19,126	16,618	2,508	-9.3%	12.5%	-60.2%
45-54	4,663	3,427	1,236	4,308	3,817	491	-7.6%	11.4%	-60.3%
Race‡									
White	37,558	24,900	12,658	32,784	26,404	6,380	-12.7%	6.0%	-49.6%
Black	55,168	37,300	17,868	47,912	39,613	8,299	-13.2%	6.2%	-53.6%
Hispanic	2,169	1,412	757	2,018	1,558	460	-7.0%	10.3%	-39.2%
Asian /Pacific Islander	470	326	144	405	337	68	-13.8%	3.4%	-52.8%
American Indian	317	210	107	293	241	52	-7.6%	14.8%	-51.4%
Other or unknown race/ ethnicity	7,599	4,694	2,905	6,906	5,797	1,109	-9.1%	23.5%	-80.8%
ACHN Region									
Central	14,775	10,111	4,664	12,763	10,538	2,225	-13.6%	4.2%	-52.3%
East	12,992	8,493	4,499	10,982	8,870	2,112	-15.5%	4.4%	-53.1%
Gulf	19,254	12,609	6,645	16,929	13,911	3,018	-12.1%	10.3%	-54.6%
Mid-state	14,943	10,064	4,879	13,459	11,037	2,422	-9.9%	9.7%	-50.4%

	Enrolled in DY19			Enrolled in DY20			% change DY19 to DY20		
	Total	**Returning**	**New**	**Total**	**Returning**	**New**	**Total**	**Returning**	**New**
Northeast	11,863	8,064	3,799	10,535	8,478	2,057	-11.2%	5.1%	-45.9%
Northwest	14,187	9,591	4,596	12,542	10,348	2,194	-11.6%	7.9%	-52.3%
Southeast	15,256	9,908	5,348	13,108	10,768	2,340	-14.1%	8.7%	-56.2%

Survey data for Table 1.3, report on barriers to enrollment from the disenrollee survey, is not yet available.

Evaluation Goal 2 – Maintaining High Level of Awareness of Plan First

The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be aware that they are enrolled in the program.

Hypotheses: Since Plan First is a well-established program, we expect that the majority of women enrolled will have heard of it and will be aware that they are enrolled.

Survey data to assess this program goal is not yet available.

Evaluation Goal 3 – Increasing Family Planning Service Use among Plan First Enrollees

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

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

Claims data showing previous use of LARC and showing DY 20 use of care coordination services is not yet available.

Evaluation Goal 4 – Increasing Use of Smoking Cessation Modalities

Smoking cessation coverage has been available in Plan First since 2012. The program goal is to have 85% of smokers receiving these services.

Hypothesis: Data from recent surveys of Plan First enrollees indicate that approximately 25% are smokers. We expect that the majority of enrolled smokers will report that their

health care provider advised them to quit smoking and about half will report they were provided with information about smoking cessation services.

Survey data for Table 4.1, the content of smoking cessation discussions at family planning visits, is not yet available.

This provisional table 4.2 assumes that the same proportion of individuals used services in DY 20 as in DY 19 (34%), and the same portion of these service users are smokers as found in DY 19 (22.8%). Based on these provisional assumptions, only half a percent of clinical service users had a claim filed for an NRT product.

Table 4.2. Smoking cessation based on claims

	DY 18		DY 19		DY 20	
	N	%	N	%		
Plan First service users	39,196	--	35,180	--	31,267*	--
Estimated number of smokers (based on survey data)	9,485	24.2	8,021	22.8	7,129	22.8*
Service users with claims for covered NRT products (% of estimated number of smokers)	102	1.1%	63	0.8%	38	0.5%

* estimate

Evaluation Goal 5 – Maintaining Low Birth Rates among Plan First Service Users

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

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

This section reports birth rates from the previous demonstration year to allow time for pregnancies starting during the demonstration year, to be counted through the following year. Birth rates remain much lower with the Plan First program than estimated to be, based on pre-program birth rates. Birth rates were lower for clinical service users than for enrollees who did not use services. Birth rates were slightly higher in DY 19 than they had been in DY 18.

In Demonstration Year 19, there were 103,281 enrollees. Of these, 291 were pregnant at enrollment.

Table 5.1 Birth rates for enrollees and service users, Demonstration Year Previous to Current One (Claims data)

	Number Enrollees	**Number of Births**	**Births/1000**
		Assuming pre-waiver fertility levels*	
All enrollees	**103,281**	**16,484**	**159.6**
		Actual births after enrollment	
All enrollees not pregnant at enrollment	**102,990**	**5,257**	**51.0**
Service Users not pregnant at first visit	**35,173**	**1,725**	**49.0**
Non-service users not pregnant at enrollment	**67,817**	**3,532**	**52.1**

* Adjusted for age and race

Table 5.2 Estimated and actual birth rates to women enrolled in Plan First (Claims data)

	Estimated birth rate if fertility rates continued at pre-waiver levels*	**Actual birth rates all enrollees – pregnancies starting during DY**	**Actual birth rates service users – pregnancies starting during DY**	**Actual birth rates non-service users – pregnancies starting during DY**
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9
DY15	196.7	62.7	61.0	63.9
DY16	182.4	60.9	63.1	59.0
DY17	176.9	46.4	34.5	53.6
DY18	160.2	42.4	40.8	43.1

	Estimated birth rate if fertility rates continued at pre-waiver levels*	Actual birth rates <u>all enrollees</u> – pregnancies starting during DY	Actual birth rates <u>service users</u> – pregnancies starting during DY	Actual birth rates <u>non-service users</u> – pregnancies starting during DY
DY19	159.6	51.0	49.0	52.1

*Adjusted for age and race

Evaluation Goal 6 – Increase Male Enrollment and Vasectomy Service Use

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

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

Male enrollment in Plan First increased almost 10% (9.8%) between DY 19 and DY 20. Claims data are not yet processed to calculate actual vasectomy rates.

Table 6.1. Percentage of men enrolled who obtained a vasectomy through Plan First (Claims and enrollment data)

	DY 19		DY 20		% Change DY 19 - DY 20	
	Enrolled N	Obtained vasectomy N (%)*	Enrolled N	Obtained vasectomy N (%)*	Enrolled %	Obtained vasectomy %
TOTAL	1,500	14 (0.9)	1,647			
Race						
White	905	14 (1.5)	988			
Black	382	0 (0.0)	448			
Hispanic	37	0 (0.0)	45			
Asian/Pacific Islander	16	0 (0.0)	16			
American Indian	14	0 (0.0)	12			
Other race/ethnicity	146	0 (0.0)	138			
Care Coordination						

	DY 19		DY 20		% Change DY 19 - DY 20	
	Enrolled N	**Obtained vasectomy N (%)***	**Enrolled N**	**Obtained vasectomy N (%)***	**Enrolled %**	**Obtained vasectomy %**
Received care coordination	21	5 (23.8)	N/A			
Did not receive care coordination	1479	9 (0.6)	N/A			
ACHN Regions						
Central	145	1 (0.7)	145			
East	230	8 (3.5)	234			
Gulf	266	1 (0.4)	317			
Mid-state	221	0 (0.0)	258			
Northeast	268	0 (0.0)	288			
Northwest	170	2 (1.2)	191			
Southeast	200	2 (13.3)	214			

* Row percentages

Survey data for Table 6.2, experience with vasectomy services, is not yet available.

Challenges

Beneficiary satisfaction surveys: In this second evaluation year, UAB planned to conduct two surveys with women about their experiences with Plan First: a survey of 800 women currently enrolled in the program and a survey of 300 women who are no longer enrolled. Data collection for the surveys began later than anticipated due to delays in obtaining enrollee contact information. To date, the University of Alabama at Birmingham evaluation team has completed 514 enrollee surveys (64% of the target sample) with 604 refusals and 75 surveys with women who are no longer enrolled (25% of the target sample). UAB anticipates data collection will be complete within 6 to 8 weeks.

Evaluation Staff

The University of Alabama at Birmingham evaluation team is the independent contractor that conducts the evaluation of the Plan First Program.

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

KAY IVEY
Governor

Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Commissioner

July 29, 2021

Ms. Stephanie A. Bryan
Tribal Chair and CEO
Poarch Band of Creek Indians
5811 Jack Springs Road
Atmore, Alabama 36502

Re: Tribal Consultation for Proposed Renewal of Section 1115 Demonstration

Dear Ms. Bryan:

As directed by the Tribal Consultation Section 1902(a) (73) of the Social Security Act and Federal Regulation, this notice to the Tribal Government is hereby given to notify the tribe of the Alabama Medicaid Agency's (Alabama Medicaid) intent to renew the Family Planning Section §1115 Demonstration Waiver which governs the provision of family planning services under the Plan First Program. The proposed effective dates for the Waiver extension are October 1, 2022 through September 30, 2027. The Waiver application is seeking continued flexibility in administering and managing the Plan First Program delivery model for the provision of family planning services to eligible individuals. It is designed to reduce unintended pregnancies and improve the well-being of women, men, and infants in Alabama. Alabama Medicaid does not anticipate a change in expenditures due to this Demonstration extension request.

A copy of the public notice and the 1115 Demonstration application have been included for your reference. Digital copies of these and addition documents can be found on Alabama Medicaid's website at the following link:

http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx.

Written comments concerning the §1115 Demonstration Waiver will be accepted starting July 30, 2021 and are due August 30, 2021 at 5PM (CST). Send comments to the following e-mail address: bakeba.raines@medicaid.alabama.gov or mailed to Bakeba Raines, Director, Managed Care Operations Division, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103-5624. Comments can also be submitted via email to PublicComment@Medicaid.Alabama.gov or mailed to Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624.

In addition to the 30-day public comment period, Alabama Medicaid will also host two public hearings in which the Tribal Government may provide verbal comments directly to the Agency. The public hearings will be held on the following dates and times:

Wednesday, August 18, 2021, 11:00 AM-12:00 PM (CST) **Virtual webinar presentation** (login instructions will be posted on the Medicaid website)	**Wednesday, August 25, 2021, 10:00 AM - 11:00 AM (CST)** **Virtual webinar presentation** (login instructions will be posted on the Medicaid website)

Medicaid will be presenting on the renewal at the public hearings. Dial-in instructions will be posted on Medicaid's website at: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx.

All written comments will be available for review by the public during normal business hours at the above address. Prior to finalizing the proposed waiver, Alabama Medicaid will consider all comments received during the public comment period, both written and verbal. The comments will be summarized and addressed in the final draft of the waiver to be submitted to CMS.

If you have any questions or concerns, please contact me at (334) 242-5630.

Sincerely,

[redacted]

Bakeba C. Raines
Director
Managed Care Operations Division
Alabama Medicaid Agency

Cc: Cristi Malone (via cmalone@pci-nsn.gov)
Terry Sweat (via tsweat@pci-nsn.gov)

ALABAMA MEDICAID AGENCY

1115(a) Demonstration Waiver
Plan First Program

Six-Month Post Award Public Forum
Questions And Responses
Date: Tuesday, May 1, 2018 Time: 10:00 a.m.
501 Dexter Ave; Montgomery, Alabama

During the May 1, 2018, Six-Month Post Award Public Forum related to the 1115(a) Demonstration Waiver for the Plan First Program several questions were asked. Below are the Agency's responses.

- **Question (Meredith Adams –ADPH):** When you all met with the Maternity Contractors, how did it go to encourage referrals?
- **Response**: We recommend the Primary Contractor to pull out information and put in a separate folder, then reintroduce the information to the recipient at another visit. And they can follow up with the recipient pertaining to the information by a phone call to asked how you read over the education material are there any questions one may have. A follow up meeting will be held with the Contractors concerning to the referrals.

- **Question (Matt Holdbrooks- Kid One Transport):** For clarification sake, can you share some of the Primary Contractors?
- **Response:** There are Contractors intercedes that receive contracts throughout Alabama except 2 counties and they are, District 10 and District 12 previous Gift Of Life (GOL), but they did not renew their contract. Some of the Contractors are District 5, 10, 11, 12, 13, 16, and 17.

- **Question (Matt Holdbrooks- Kid One Transport):** What are the primary issues with barriers?
- **Response-** One barrier we believe the recipients are not checking the box on the application, or if they roll over from SOBRA they are getting missed. Another barrier is our LARC (Long- Acting Reversible Contraceptive) usage. The LARC are not being utilized as we would like it to. Dr. White has sent out a survey to try to identify those barriers as to why the recipient are not using the services. We have also found there is a lack of knowledge of Family Planning (FP) services. If it's a SOBRA, which is a pregnant woman, they are automatic go to FP services. Other problems other than FP are not covered. Anyone that receive a sterilization, they are not available for FP services. FP do not pay for NET(non-emergency transportation). Recipient has to be between the ages pf 19-55.

- **Comment (Matt Holdbrooks- Kid One Transport):** Rural area's may be far challenging.

1115 (a) Medicaid Family Planning Demonstration Waiver Plan First Program Annual Public Forum

Presented by the Managed Care Operations Division

Plan First Program Unit

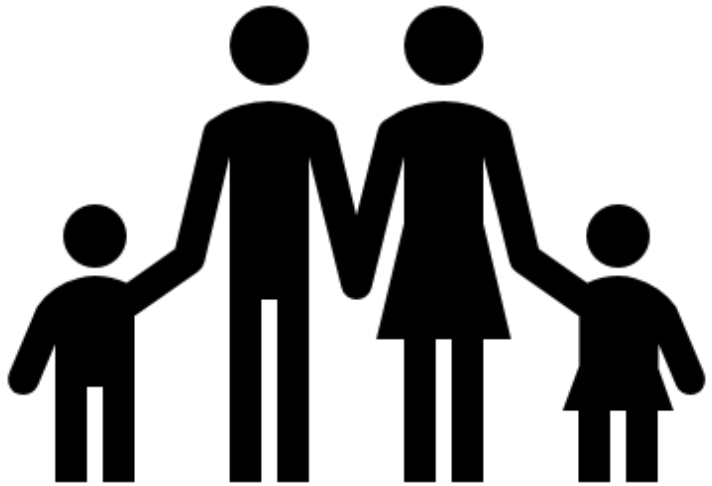
Julie Gilliland, RN, BSN, CPN

Program Manager, Family Planning/ Plan First Programs

Managed Care Operations Division

Objective of Public Forum

- To afford providers, recipients and other interested individuals the opportunity to provide comments on the progress of the Plan First Section 1115(a) Demonstration Waiver

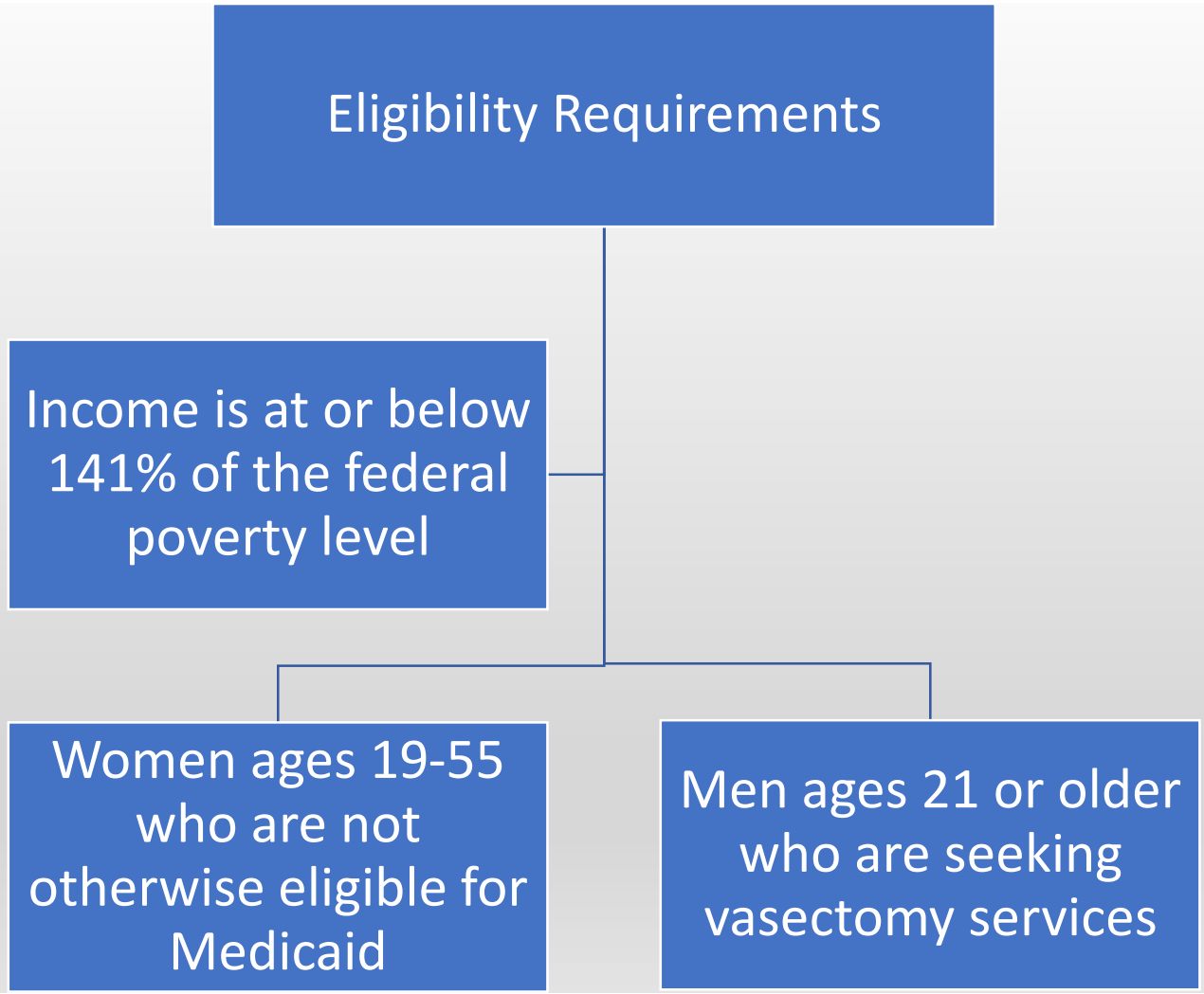


What is Plan First?

- A federally approved Research and Demonstration Waiver for family planning services. The principle objective of Plan First is to prevent or delay pregnancy as well as, to improve the well-being of Alabama's children and families by extending Medicaid eligibility for family planning services to eligible women/men.

- The waiver was originally approved in 2000 and was renewed by Centers for Medicare and Medicaid (CMS) on November 27, 2017. The current waiver will expire on September 30, 2022.

Who is Eligible?



Types of services covered under the Plan First Program

- Office visits
- Labs
- Contraceptives (pills, patches, rings, LARCs, injections)
- Care coordination
- STD/STI testing and counseling
- Tubal ligations
- Vasectomy/ Vasectomy related services
- Smoking Cessation Services (Nicotine Replacement Therapy (NRT) and Quit Line)

Progress of the Waiver

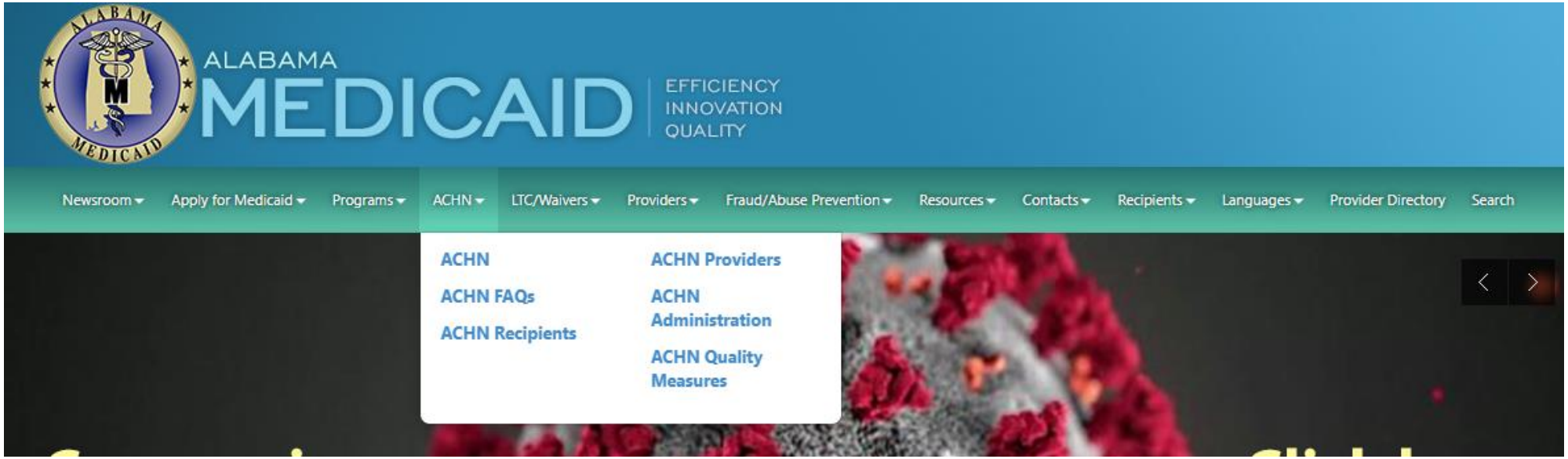
- Currently in the fourth demonstration year (DY 21) of the current waiver renewal period.
- As of March 31, 2021, there are 70,994 individuals enrolled in the Plan First program and 78,349 claims have been filed and paid since October 1, 2020.
- Currently, all counties have public provider options for Plan First services. Plan First providers enrolled in Alabama have increased from 1802 in October 2019 to 1906 in October 2020.
- Male enrollment in Plan First increased almost 10% (9.8%) between DY 19 and DY 20.
- Birth rates remain much lower with the Plan First program than they were estimated to be, based on pre-program birth rates.

Progress of the Waiver

- Family Planning care coordination was transitioned from Alabama Department of Public Health (ADPH) to Alabama Coordinated Health Networks (ACHNs) in October 2019.
- ACHNs receive monthly assignment file reports of all eligible Plan First/Family Planning eligible individuals (EIs).
- Care Coordinators utilize these reports to attempt outreach to EIs and to offer Family Planning Care Coordination services.

Alabama Coordinated Health Network (ACHN)

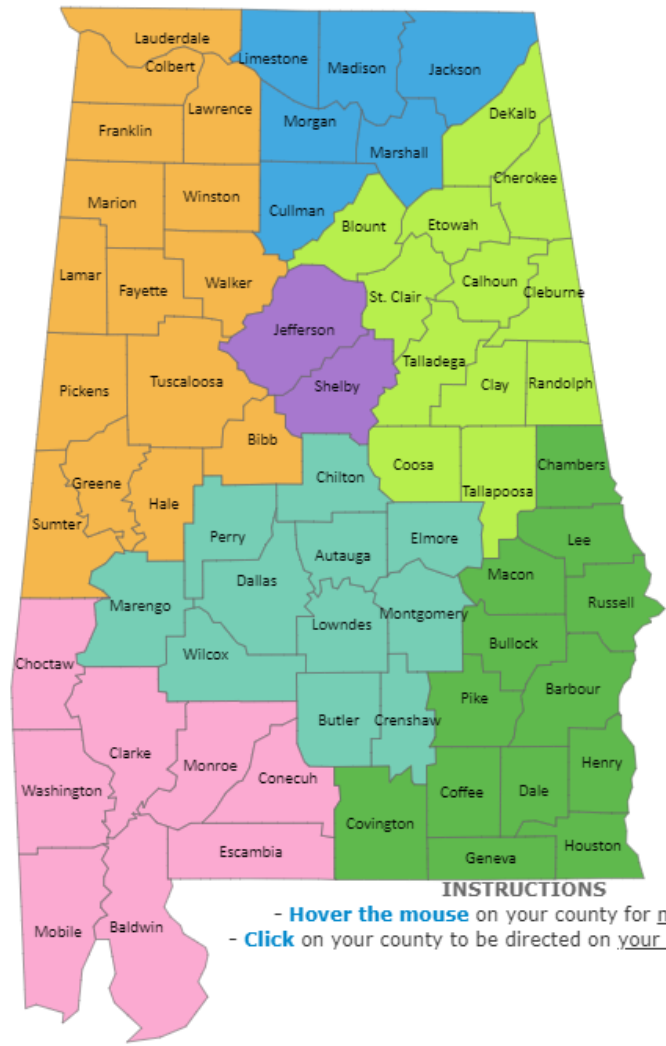
- Visit www.Medicaid.Alabama.gov and select the ACHN tab.



- Select either ACHN Recipients or ACHN Providers for information.

ACHN Contact Information

There are currently seven ACHN regions operating in Alabama. Please find the ACHN contact information for your region using the map below.



INSTRUCTIONS

- **Hover the mouse** on your county for more details
- **Click** on your county to be directed on your region's website

Uncheck "All" and
Select Your County

- ☑ (All)
- ☑ Autauga
- ☑ Baldwin
- ☑ Barbour
- ☑ Bibb
- ☑ Blount

OR

Uncheck "All" and
Select Your Region

- ☑ (All)
- ☑ Alabama Care Network Mid-Sta...
- ☑ Alabama Care Network Southe...
- ☑ Gulf Coast Total Care
- ☑ My Care Alabama Central
- ☑ My Care Alabama East

ACHN Regions

- Alabama Care Network Mid-State
- Alabama Care Network Southeast
- Gulf Coast Total Care
- My Care Alabama Central
- My Care Alabama East
- My Care Alabama Northwest
- North Alabama Community Care

Additional Information About The Plan First Program

- A copy of the approved Section 1115 Demonstration Waiver Extension Application and other information about Plan First may be found on the website at: https://medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx
- A copy of the Request for the Proposal for the Alabama Coordinated Health Networks (ACHN) may be found on the website at:

https://medicaid.alabama.gov/documents/2.0_Newsroom/2.4_Procurement/2.4.1_Consolidated/2.4.1.4_2019/2.4.1.4_2019-ACHN_RFP_ALL.pdf

Medicaid Staff

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Attendance

If you are a participant on the webinar, please **type your name in the chat box** to record your attendance.

If you are a participant by phone, please email Public.Comment@Medicaid.Alabama.gov to record your attendance.

We will now begin the **comment segment**.

Comments ??

Alabama Medicaid Agency

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334-242-5000 1-800-362-1504

STEPHANIE MCGEE AZAR
Commissioner

PUBLIC NOTICE

SUBJECT: NOTICE OF INTENT TO SUBMIT A FAMILY PLANNING SECTION §1115 DEMONSTRATION WAIVER EXTENSION PROPOSAL

The Alabama Medicaid Agency (Medicaid) is proposing to extend its Family Planning Section §1115 Demonstration Waiver. Pursuant to 42 C.F.R. § 431.408, notice is hereby given that Medicaid will provide the public the opportunity to review and provide input on the Demonstration Waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS). This notice provides details about the Waiver submission and serves to open the 30-day public comment period, which closes on Monday, August 30, 2021, at 5:00 PM (CST). Medicaid does not anticipate a change in expenditures due to this Waiver extension.

In addition to the 30-day public comment period in which the public will be able to provide written comments to the Agency via the U.S. Postal Service or electronic mail, Medicaid will also host two public hearings in which the public may provide verbal comments directly to the Agency. The public hearings will be held on the following dates and times:

Wednesday, August 18, 2021, 11:00 AM-12:00 PM (CST) (login instructions will be posted on the Medicaid website)	**Wednesday, August 25, 2021, 10:00 AM -11:00 AM (CST)** (login instructions will be posted on the Medicaid website)

Medicaid will be presenting on the renewal at the public hearings. All information regarding the Demonstration Waiver, including a full public notice, the Waiver application, dial-in instructions for the public hearings, and other documentation regarding the proposal are available at:: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx.

WAIVER PROPOSAL SUMMARY

The Plan First Program is a program designed to extend family planning and birth control services to expanded eligibility groups in Alabama. Approved in July 2000 and implemented in October 2000, the Plan First Program operates under a federally-approved Demonstration Waiver granted by CMS. The Plan First Demonstration Waiver has allowed Medicaid to provide family planning services to over 300,000 male and female recipients in Alabama. Beginning October 2019, the seven Alabama Coordinated Health Network (ACHN) organizations took responsibility for providing all case management and care coordination services for Plan First.

The §1115 Demonstration Waiver extension is seeking continued flexibility in administering and managing family planning services to eligible individuals under the Plan First Program delivery model. The delivery model is designed to reduce unintended pregnancies and improve the well-being of women, men, and infants in Alabama. Males ages 21 or older meeting the eligibility guidelines can only receive vasectomies, vasectomy-related services, and care coordination services.

IMPLEMENTATION

The Medicaid Plan First Program began on October 1, 2000. The demonstration has been consistently extended since that date. On June 15, 2017, Alabama submitted a request to extend the demonstration for a five-year period with no program changes. CMS approved this extension request through September 30, 2022, as agreed upon with the state, to realign Plan First's annual demonstration cycles back to the original date of implementation. During this renewal, the ACHNs began providing all case management and care coordination services for Plan First. Previously the Alabama Department of Public Health provided these services, usually in combination with family planning services in Title X clinics. Also during this renewal, CMS altered some policies for Medicaid coverage during the COVID-19 (coronavirus) pandemic, beginning in March 2020. Enrollees who would typically enter Plan First from maternity care coverage under SOBRA retained their SOBRA coverage until the end of the public health emergency period. Some services, particularly case management, and care coordination, were provided telephonically rather than face-to-face.

GOALS & OBJECTIVES

The Alabama Medicaid Agency seeks to accomplish the following goals/objectives for the Demonstration Waiver:

(1) Increase the portion of women eligible for Plan First who enroll and reduce racial/ethnic and geographic disparities in enrollment.

(2) Maintain a high level of awareness of the Plan First Program.

(3) Increase Family Planning Service Use among Plan First Enrollees.

(4) Increase use of smoking cessation modalities.

(5) Maintain low birth rates among Plan First users.

(6) Increase male enrollment and vasectomy service use.

ELIGIBILITY

Childbearing women, ages 19-55, and males ages 21 or older meeting the income limit at or below 141% of the Federal Poverty Level (FPL) may qualify for services under this Waiver. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

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

Group 1

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 must apply using a simplified shortened application. 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 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.

ENROLLMENT & FISCAL PROJECTIONS

It is anticipated that enrollment in the Plan First Program will fluctuate for a variety of reasons. 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. In addition, once a recipient receives sterilization, he/she is no longer eligible to receive family planning services under this Demonstration Waiver.

The following tables illustrate the State's enrollment projections by total member months and historical expenditures.

Enrollment Projections

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

ELIGIBILITY GROUP DY 22	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 23	DY 24	DY 25	DY 26	DY 27	TOTAL WW
Family Planning **Pop Type: Hypothetical**							
Eligible Member Months	0.0%	853,953	853,953	853,953	853,953	853,953	4,269,765
PMPM Cost	0.0%	$ 26.76	$ 26.76	$ 26.76	$ 26.76	$ 26.76	$ 26.76
Total Expenditure		$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 114,258,911
Tobacco Cessation **Pop Type: Hypothetical**							
Eligible Member Months		853,953	853,953	853,953	853,953	853,953	
PMPM Cost		$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 0.50	
Total Expenditure		$ 426,977	$ 426,977	$ 426,977	$ 426,977	$ 426,977	$ 2,134,883
Exp Pop 1 **Pop Type: Expansion**							
Eligible Member Months							
PMPM Cost							
Total Expenditure		$ -	$ -	$ -	$ -	$ -	$ -
Exp Pop 2 **Pop Type: Expansion**							
Eligible Member Months							
PMPM Cost							
Total Expenditure		$ -	$ -	$ -	$ -	$ -	$ -

NOTES

1 - 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.

2 - With Waiver equals Without Waiver.

Historical Expenditures

		2017	2018	2019	2020	2021
Family Planning	Total Exp	$ 27,327,762	$ 23,475,183	$ 22,851,782	$ 22,222,762	$ 22,851,782
	PMPM	$ 26.01	$ 26.76	$ 26.76	$ 26.76	$ 26.76
	Mem-Mon	1,050,567	877,249	853,953	830,447	853,953
Tobacco Cessation	Total Exp		$ 261.00	$ 127.50	$ 123.00	$ 127.50
	PMPM		$ 0.50	$ 0.50	$ 0.50	$ 0.50
	Mem-Mon		522	255	246	255
Total		**$ 27,327,762**	**$ 23,475,444**	**$ 22,851,910**	**$ 22,222,885**	**$ 22,851,910**

ANNUAL CHANGE

		2017	2018	2019	2020	2021
Family Planning	Total Exp		-14%	-3%	-3%	3%
	PMPM		3%	0%	0%	0%
	Mem-Mon		-16%	-3%	-3%	3%
Tobacco Cessation	Total Exp			-51%	-4%	4%
	PMPM			0%	0%	0%
	Mem-Mon			-51%	-4%	4%

Note: For 2017, Family Planning and Tobacco Cessation were combined when calculating total expenditures and member months

BENEFITS

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

a) FDA-approved methods of contraception; and vasectomy services for men;

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

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

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

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

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

Individuals eligible under this demonstration are also eligible to receive smoking cessation services and products as authorized in Alabama's approved Medicaid State Plan. Smoking cessation services and products are being authorized under this section 1115 demonstration as a separate service provided in addition to family planning services. Tobacco cessation services will be reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate.

MEMBER COST-SHARING

Recipients are exempt from co-payment requirements for family planning services. There are no co-payments on prescription drugs or supplies that are designated as family planning.

HYPOTHESES & EVALUATION

This Section §1115 Demonstration Waiver will investigate the following research hypotheses related to each program goal:

Goal	Hypothesis	Selected Outcome Measures & Analytic Measures	Data Sources	Evaluation Approach
Increase the portion of women eligible for Plan First who enroll and reduce racial/ethnic and geographic disparities in enrollment. The program goal is to enroll into Plan First 80% of eligible women between ages 19 and 40 across all racial/ethnic groups and geographic areas.	We anticipate that the composition of the enrolled population will be demographically similar to the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we	Analyze eligibility and enrollment outcomes	• Eligibility and enrollment data • Recipient survey data • ACHN case management data	• Conduct analysis of eligibility and enrollment data (ethnic backgrounds and geographical areas for Plan First recipients) • Analyze recipient responses to survey questions • Conduct analysis of ACHN case management data (ethnic backgrounds and geographical areas for Plan First recipients)

	anticipate lower enrollment rates among older women compared to younger women.			
Maintain a high level of awareness of the Plan First Program among enrollees. The program goal is that 90% of surveyed enrollees will have heard of the Plan First Program and 85% will be aware that they are enrolled in the program.	Since Plan First is a well-established program, we expect that the majority of women enrolled will have heard of it and will be aware that they are enrolled.	Analyze recipient outreach and education outcomes and utilization trends	• Eligibility and enrollment data • Recipient survey data • Claims utilization	• Conduct analysis of eligibility and enrollment data (how did the recipient hear about and/or enroll in the Plan First program) • Analyze recipient responses to survey questions • Conduct analysis of ACHN case management data (did the recipient receive eligibility assistance from the ACHN)
Increase Family Planning service use among Plan First enrollees. The program goal is to achieve 70% in the initial year and increase service use to 60% in subsequent years.	Based on prior evaluations of Plan First, we expect service use to be more common among younger women than among older women since younger women tend to rely on shorter-acting hormonal methods for contraception and are recommended for routine STI and cervical cancer screening, both of which require more regular contact with providers. Because Plan First offers no-cost contraception, we	Analyze recipient utilization	• Claims utilization • Recipient survey data • ACHN case management data	• Analyze claims history to capture utilization of services • Analyze recipient survey responses • Conduct analysis of ACHN case management data (did the recipient utilize Plan First care coordination services with the ACHN)

	also expect more than half of women using services to have a claim for a moderate or highly effective contraceptive method.			
Increase use of smoking cessation modalities.	Data from recent surveys of Plan First enrollees indicate that approximately 25% are smokers. We expect that the majority of enrolled smokers will report that their health care provider advised them to quit smoking and about half will report they were provided with information about smoking cessation services.	Analyze recipient outreach and education outcomes	• Recipient survey data • Claims utilization (diagnoses & procedure code data)	• Analyze recipient survey responses • Analyze claims history to capture diagnoses and medical history
Maintain low birth rates among Plan First service users. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.	Based on prior evaluations of Plan First, we hypothesize that the birth rate among program participants will be less than the expected birth rate in the absence of the program. We also anticipate that birth rates will be lower among women who used Plan First services than those who enrolled but did not have a clinical encounter.	Analyze recipient utilization, diagnoses	• Claims utilization (diagnoses & procedure code data) • Health outcomes data	• Analyze claims history to capture diagnoses and medical history
Increase male enrollment and vasectomy service use. Our goal is that the number of men enrolled in Plan First for	We anticipate that men's use of vasectomy services will increase over time and that first, those who receive care coordination services will be more likely to	Analyze recipient utilization	• Claims utilization (diagnoses & procedure code data)	• Analyze claims history to capture diagnoses and medical history • Conduct analysis of ACHN case management data

vasectomies and vasectomy-related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year. We will evaluate this goal based on the number of men enrolled and claims for care coordination and vasectomies.	obtain a vasectomy through Plan First than those who do not receive care coordination.		• ACHN case management data • Health outcomes data • Recipient survey data • Eligibility and enrollment data	(did the male recipient utilize Plan First care coordination services with the ACHN) • Analyze recipient survey responses • Conduct analysis of eligibility and enrollment data (how did the male recipient hear about and/or enroll in the Plan First program)

WAIVER & EXPENDITURE AUTHORITIES

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

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

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

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

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

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

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

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

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

To the extent necessary to allow the state to offer the Demonstration population a benefit package consisting only of family planning services and family planning-related services.

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

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

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

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

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

To the extent necessary to enable the state to use Express Lane eligibility determinations and redeterminations, for the Demonstration populations.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

All information regarding the Demonstration Waiver, including this full public notice, an abbreviated public notice, the Waiver application, and other documentation regarding the proposal are available at: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx.

A copy of the draft Demonstration renewal application will also be available upon request for public review at each county office of the Department of Human Resources and the State Office of the Alabama Medicaid Agency.

Written comments concerning the §1115 Demonstration Waiver should be submitted on or before 5:00 p.m. on Monday, August 30, 2021, to the following e-mail address: PublicComment@Medicaid.Alabama.gov or mailed hardcopy to Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624. All written comments will be available for review by the public during normal business hours at the above address. Prior to finalizing the proposed Waiver, Medicaid will consider all of the public comments received during the public comment period, both written and verbal. The comments will be summarized and addressed in the final draft of the Waiver to be submitted to CMS.

[redacted]

Stephanie McGee Azar
Commissioner

Alabama Medicaid Agency

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STEPHANIE MCGEE AZAR
Commissioner

PUBLIC NOTICE

NOTICE OF INTENT TO SUBMIT A FAMILY PLANNING SECTION §1115 DEMONSTRATION WAIVER EXTENSION PROPOSAL-ADDITIONAL PUBLIC HEARING DATES

The Alabama Medicaid Agency (Medicaid) is proposing to extend its Family Planning Section §1115 Demonstration Waiver. Pursuant to 42 C.F.R. § 431.408, notice is hereby given that Medicaid will provide the public the opportunity to review and provide input on the Demonstration Waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS). This notice provides details about the Waiver submission and serves to extend the public comment period originally set to expire on August 30, 2021. The Agency has extended the comment submission date to Monday, November 1, 2021, at 5:00 PM (CST). Medicaid does not anticipate a change in expenditures due to this Waiver extension.

In addition to the public comment period in which the public will be able to provide written comments to the Agency via the U.S. Postal Service or electronic mail, Medicaid will also host two additional public hearings in which the public may provide verbal comments directly to the Agency. The public hearings will be held on the following dates and times:

Date	Time	To Join Online	To Join by Phone
Tuesday, October 5, 2021	12:00 p.m. - 1:00 p.m.	https://algov.webex.com/algov/j.php?MTID=m3574da5a54a1a26b18a3c7ae91e30c4e Meeting number (access code): 1776 35 4888 Meeting password: Medicaid1	Dial: 1-415-655-0001 (US Toll) Access Code: 1776 35 4888 Attendee number: enter #
Thursday, October 7, 2021	4:00 p.m. - 5:00 p.m.	https://algov.webex.com/algov/j.php?MTID=me8f59784b1e03abd0334b4a79e1113ae Meeting number (access code): 1778 05 0502 Meeting password: Medicaid1	Dial: 1-415-655-0001 (US Toll) Access Code: 1778 05 0502 Attendee number: enter #

Medicaid will be presenting on the renewal at the public hearings. These public hearings will be similar to the public hearings held on August 18, 2021 and August 25, 2021. All information regarding the Demonstration Waiver, including this full public notice, the Waiver application, dial-in instructions for the public hearings, and other documentation regarding the proposal are available at: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx.

WAIVER PROPOSAL SUMMARY

The Plan First Program is a program designed to extend family planning and birth control services to expanded eligibility groups in Alabama. Approved in July 2000 and implemented in October 2000, the Plan First Program operates under a federally-approved Demonstration Waiver granted by CMS. The Plan First Demonstration Waiver has allowed Medicaid to provide family planning services to over 300,000 male and female recipients in Alabama. Beginning October 2019, the seven Alabama Coordinated Health Network (ACHN) organizations took responsibility for providing all case management and care coordination services for Plan First.

The §1115 Demonstration Waiver extension is seeking continued flexibility in administering and managing family planning services to eligible individuals under the Plan First Program delivery model. The delivery

model is designed to reduce unintended pregnancies and improve the well-being of women, men, and infants in Alabama. Males ages 21 or older meeting the eligibility guidelines can only receive vasectomies, vasectomy-related services, and care coordination services.

IMPLEMENTATION

The Medicaid Plan First Program began on October 1, 2000. The demonstration has been consistently extended since that date. On June 15, 2017, Alabama submitted a request to extend the demonstration for a five-year period with no program changes. CMS approved this extension request through September 30, 2022, as agreed upon with the state, to realign Plan First's annual demonstration cycles back to the original date of implementation. During this renewal, the ACHNs began providing all case management and care coordination services for Plan First. Previously the Alabama Department of Public Health provided these services, usually in combination with family planning services in Title X clinics. Also during this renewal, CMS altered some policies for Medicaid coverage during the COVID-19 (coronavirus) pandemic, beginning in March 2020. Enrollees who would typically enter Plan First from maternity care coverage under SOBRA retained their SOBRA coverage until the end of the public health emergency period. Some services, particularly case management, and care coordination, were provided telephonically rather than face-to-face.

GOALS & OBJECTIVES

The Alabama Medicaid Agency seeks to accomplish the following goals/objectives for the Demonstration Waiver:

Objective 1. Increase the enrollment of women eligible for Plan First and reduce racial/ethnic and geographic disparities in enrollment.

Goal: The program goal is to enroll 80% of eligible women under age 40 into Plan First.

Objective 2. Maintain a high level of awareness of the Plan First Program.

Goal: The program goal is that 90% of surveyed enrollees will have heard of Plan First and 85% will be aware that they are enrolled in the program.

Objective 3. Increase Family Planning Service use among Plan First enrollees.

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

Objective 4. Increase use of smoking cessation modalities.

Goal: The program goal is to have 85% of smokers receiving these services. Smoking cessation related coverage has been available in Plan First since 2012.

Objective 5. Maintain low birth rates among Plan First users.

Goal: Maintain birth rates among Plan First participants that are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

Objective 6. Increase male enrollment and vasectomy service use.

Goal: The goal is that the number of men enrolled in Plan First for vasectomies and vasectomy related covered services will increase by 10% annually; 85% of male Plan First enrollees will receive care coordination services; and 75% of male enrollees will undergo the procedure within the enrollment

year. This goal will be evaluated based on the number of male enrollees, claims for care coordination and sterilizations performed statewide.

ELIGIBILITY

Childbearing women, ages 19-55, and males ages 21 or older meeting the income limit at or below 141% of the Federal Poverty Level (FPL) may qualify for services under this Waiver. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

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

Group 1

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 must apply using a simplified shortened application. 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 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.

ENROLLMENT & FISCAL PROJECTIONS

It is anticipated that enrollment in the Plan First Program will fluctuate for a variety of reasons. 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. In addition, once a recipient receives sterilization, he/she is no longer eligible to receive family planning services under this Demonstration Waiver.

The following tables illustrate the State's enrollment projections by total member months and historical expenditures.

Enrollment Projections

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

ELIGIBILITY GROUP	DY 22	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 23	DY 24	DY 25	DY 26	DY 27	TOTAL WW
Family Planning								
Pop Type:	**Hypothetical**							
Eligible Member Months		0.0%	853,953	853,953	853,953	853,953	853,953	4,269,765
PMPM Cost		0.0%	$ 26.76	$ 26.76	$ 26.76	$ 26.76	$ 26.76	$ 26.76
Total Expenditure			$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 22,851,782	$ 114,258,911
Tobacco Cessation								
Pop Type:	**Hypothetical**							
Eligible Member Months			853,953	853,953	853,953	853,953	853,953	
PMPM Cost			$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 0.50	
Total Expenditure			$ 426,977	$ 426,977	$ 426,977	$ 426,977	$ 426,977	$ 2,134,883
Exp Pop 1								
Pop Type:	**Expansion**							
Eligible Member Months								
PMPM Cost								
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -
Exp Pop 2								
Pop Type:	**Expansion**							
Eligible Member Months								
PMPM Cost								
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -

NOTES
1 - 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.
2 - With Waiver equals Without Waiver.

Historical Expenditures

		2017	2018	2019	2020	2021
Family Planning	Total Exp	$ 27,327,762	$ 23,475,183	$ 22,851,782	$ 22,222,762	$ 22,851,782
	PMPM	$ 26.01	$ 26.76	$ 26.76	$ 26.76	$ 26.76
	Mem-Mon	1,050,567	877,249	853,953	830,447	853,953
Tobacco Cessation	Total Exp		$ 261.00	$ 127.50	$ 123.00	$ 127.50
	PMPM		$ 0.50	$ 0.50	$ 0.50	$ 0.50
	Mem-Mon		522	255	246	255
Total		**$ 27,327,762**	**$ 23,475,444**	**$ 22,851,910**	**$ 22,222,885**	**$ 22,851,910**

ANNUAL CHANGE

		2017	2018	2019	2020	2021
Family Planning	Total Exp		-14%	-3%	-3%	3%
	PMPM		3%	0%	0%	0%
	Mem-Mon		-16%	-3%	-3%	3%
Tobacco Cessation	Total Exp			-51%	-4%	4%
	PMPM			0%	0%	0%
	Mem-Mon			-51%	-4%	4%

Note: For 2017, Family Planning and Tobacco Cessation were combined when calculating total expenditures and member months

BENEFITS

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

a) FDA-approved methods of contraception; and vasectomy services for men;

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

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

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

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

Individuals eligible under this demonstration are also eligible to receive smoking cessation services and products as authorized in Alabama's approved Medicaid State Plan. Smoking cessation services and products are being authorized under this section 1115 demonstration as a separate service provided in addition to family planning services. Tobacco cessation services will be reimbursable at the state's regular FMAP rate.

MEMBER COST-SHARING

Recipients are exempt from co-payment requirements for family planning services. There are no co-payments on prescription drugs or supplies that are designated as family planning.

HYPOTHESES & EVALUATION

This Section §1115 Demonstration Waiver will investigate the following research hypotheses related to each program goal:

Goal	Hypothesis	Selected Outcome Measures & Analytic Measures	Data Sources	Evaluation Approach
Increase the enrollment of women eligible for Plan First and reduce racial/ethnic and geographic disparities in enrollment. The program goal is to enroll 80% of eligible women under age 40 into Plan First.	We anticipate that the composition of the enrolled population will be demographically similar to the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we anticipate lower enrollment rates among older women compared to younger women.	Analyze eligibility and enrollment outcomes	• Eligibility and enrollment data • Recipient survey data • ACHN case management data	• Conduct analysis of eligibility and enrollment data (ethnic backgrounds and geographical areas for Plan First recipients) • Analyze recipient responses to survey questions • Conduct analysis of ACHN case management data (ethnic backgrounds and geographical areas for Plan First recipients)
Maintain a high level of awareness of the	Since Plan First is a well-established program, we expect	Analyze recipient outreach and	• Eligibility and	• Conduct analysis of eligibility and enrollment data

Plan First Program among enrollees. The program goal is that 90% of surveyed enrollees will have heard of the Plan First Program and 85% will be aware that they are enrolled in the program.	that the majority of women enrolled will have heard of it and will be aware that they are enrolled.	education outcomes and utilization trends	enrollment data • Recipient survey data • Claims utilization	(how did the recipient hear about and/or enroll in the Plan First program) • Analyze recipient responses to survey questions • Conduct analysis of ACHN case management data (did the recipient receive eligibility assistance from the ACHN)
Increase Family Planning service use among Plan First enrollees. The program goal is to achieve 70% in the initial year and increase service use to 60% in subsequent years.	Based on prior evaluations of Plan First, we expect service use to be more common among younger women than among older women since younger women tend to rely on shorter-acting hormonal methods for contraception and are recommended for routine STI and cervical cancer screening, both of which require more regular contact with providers. Because Plan First offers no-cost contraception, we also expect more than half of women using services to have a claim for a moderate or highly effective contraceptive method.	Analyze recipient utilization	• Claims utilization • Recipient survey data • ACHN case management data	• Analyze claims history to capture utilization of services • Analyze recipient survey responses • Conduct analysis of ACHN case management data (did the recipient utilize Plan First care coordination services with the ACHN)
Increase use of smoking cessation modalities. The program goal is to have 85% of	Data from recent surveys of Plan First enrollees indicate that approximately 25% are smokers. We expect that the majority of	Analyze recipient outreach and education outcomes	• Recipient survey data • Claims utilization (diagnoses	• Analyze recipient survey responses • Analyze claims history to capture diagnoses and medical history

smokers receiving these services. Smoking cessation related coverage has been available in Plan First since 2012.	enrolled smokers will report that their health care provider advised them to quit smoking and about half will report they were provided with information about smoking cessation services.		& procedure code data)	
Maintain low birth rates among Plan First users. The program goal is to Maintain birth rates among Plan First participants that are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.	Based on prior evaluations of Plan First, we hypothesize that the birth rate among program participants will be less than the expected birth rate in the absence of the program. We also anticipate that birth rates will be lower among women who used Plan First services than those who enrolled but did not have a clinical encounter.	Analyze recipient utilization, diagnoses	• Claims utilization (diagnoses & procedure code data) • Health outcomes data	• Analyze claims history to capture diagnoses and medical history
Increase male enrollment and vasectomy service use. The program goal is that the number of men enrolled in Plan First for vasectomies and vasectomy-related covered services will increase by 10% annually, 85% of male Plan First	We anticipate that men's use of vasectomy services will increase over time and that first, those who receive care coordination services will be more likely to obtain a vasectomy through Plan First than those who do not receive care coordination.	Analyze recipient utilization	• Claims utilization (diagnoses & procedure code data) • ACHN case management data • Health outcomes data • Recipient survey data	• Analyze claims history to capture diagnoses and medical history • Conduct analysis of ACHN case management data (did the male recipient utilize Plan First care coordination services with the ACHN)

enrollees will receive care coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year. We will evaluate this goal based on the number of men enrolled and claims for care coordination and vasectomies.			• Eligibility and enrollment data	• Analyze recipient survey responses • Conduct analysis of eligibility and enrollment data (how did the male recipient hear about and/or enroll in the Plan First program)

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

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To the extent necessary to allow the state to offer the Demonstration population a benefit package consisting only of family planning services and family planning-related services.

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

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

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

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

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[redacted]

Stephanie McGee Azar
Commissioner

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STEPHANIE MCGEE AZAR
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PUBLIC NOTICE

NOTICE OF INTENT TO SUBMIT A FAMILY PLANNING SECTION §1115 DEMONSTRATION WAIVER EXTENSION –ADDITIONAL PUBLIC HEARING DATES

The Alabama Medicaid Agency (Medicaid) is proposing to extend its Family Planning Section §1115 Demonstration Waiver. Pursuant to 42 C.F.R. § 431.408, notice is hereby given that Medicaid will provide the public the opportunity to review and provide input on the Demonstration Waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS). The proposed effective dates for the Waiver extension are October 1, 2022 through September 30, 2027. The Waiver application is seeking continued flexibility in administering and managing the Plan First program delivery model for the provision of family planning services to eligible individuals. It is designed to reduce unintended pregnancies and improve the well-being of women, men, and infants in Alabama. Medicaid does not anticipate a change in expenditures due to this Demonstration extension request.

This notice provides details about the Waiver submission and serves to open the 30-day public comment period. The Agency opened a public comment period on July 30, 2021 with comments due on August 30, 2021. The Agency has extended the comment submission date to Monday November 1, 2021 at 5:00 PM (CST). In addition to the 30-day public comment period in which the public will be able to provide written comments to the Agency via the U.S. Postal Service or electronic mail, Medicaid will also host two additional public hearings in which the public may provide verbal comments directly to the Agency. The public hearings will be held on the following dates and times:

Date	Time	To Join Online	To Join by Phone
Tuesday, October 5, 2021	12:00 p.m. - 1:00 p.m.	https://algov.webex.com/algov/j.php?MTID=m3574da5a54a1a26b18a3c7ae91e30c4e Meeting number (access code): 1776 35 4888 Meeting password: Medicaid1	Dial: 1-415-655-0001 (US Toll) Access Code: 1776 35 4888 Attendee number: enter #
Thursday, October 7, 2021	4:00 p.m. - 5:00 p.m.	https://algov.webex.com/algov/j.php?MTID=me8f59784b1e03abd0334b4a79e1113ae Meeting number (access code): 1778 05 0502 Meeting password: Medicaid1	Dial: 1-415-655-0001 (US Toll) Access Code: 1778 05 0502 Attendee number: enter #

Medicaid will be presenting on the renewal at the public hearings. The additional public hearings will be similar to the public hearings held on August 18, 2021 and August 25, 2021. All information regarding the Demonstration Waiver, including a full public notice, the Waiver application, dial-in instructions for the public hearings, and other documentation regarding the proposal are available at:

http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx.

A copy of the draft Demonstration renewal application will also be available upon request for public review at each county office of the Department of Human Resources and the State Office of the Alabama Medicaid Agency.

Written comments concerning the §1115 Demonstration Waiver should be submitted on or before 5:00 p.m. on Monday November 1, 2021 to the following e-mail address: publiccomment@medicaid.alabama.gov or mailed hardcopy to: Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624. All written comments will be available for review by the public during normal business hours at the above address. Prior to finalizing the proposed Waiver, Medicaid will consider all of the public comments received during the public comment period, both written and verbal. The comments will be summarized and addressed in the final draft of the Waiver to be submitted to CMS.

Stephanie McGee Azar
Commissioner

Alabama Medicaid Agency
Family Planning Services/Plan First Program
Family Planning Section 1115(a) Demonstration Waiver Extension Request

Public Forums
Public Comments and Agency Responses

Date	Attendees Number	Public Comment(s)	Agency Response(s)
8/18/21	17	If a patient has an implanted contraceptive at this time will it be covered if they had to go into a procedure now?	Routine removal (nonsurgical) of implanted contraceptives is covered. Surgical removal in an office or outpatient hospital setting is only currently covered for IUDs.
		We are having issues with patients that are having devices removed getting pregnant and then wanting a new device after delivery to getting paid.	For claims related issues, please contact Gainwell Technologies' Provider Assistance Center at 1-800-688-7989 (toll-free). A representative is available Monday-Friday from 8 a.m. to 5 p.m. Central Time. (This is the Agency's fiscal agent.) To view the policy related to these types of services, visit the Alabama Medicaid Provider Manual, Appendix C: Family Planning, Section C.11.4. Alabama Medicaid Provider Manual Link: https://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals.aspx
Date	**Attendees Number**	**Public Comment(s)**	**Agency Response(s)**
8/25/21	8	I am writing to kindly ask the State of Alabama to re-consider the public comment deadline for the upcoming Family Planning Section 1115 Demonstration Waiver Extension.	The public comment period has been extended to October 31, 2021.

		Several of our stakeholders have expressed that they need time to consult with leaders in the community. These types of round-table discussions take time to draft and polish. The 8/30/2021 deadline does not yield enough time for us to do so. We value the time of our representatives and giving us an extension will allow us to properly prepare so that everyone's time is respected - and above all else - so that we can contribute meaningfully to an imperative discussion. Please consider this as formal request to extend the comment deadline.	
Date	**Attendees Number**	**Public Comment(s)**	**Agency Response(s)**
10/5/21	4	No comments	N/A
Date	**Attendees Number**	**Public Comment(s)**	**Agency Response(s)**
10/7/21	0	No comments	N/A