Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness

Alabama Medicaid Agency

Mid-Point Assessment

Report prepared by the Public Consulting Group

Report Submittal Date: July 18, 2025

Project # 11-W-00371/4

PUBLIC CONSULTING GROUP

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EXECUTIVE SUMMARY

Introduction

This Mid-Point Assessment (MPA) assesses the state of Alabama's progress towards achieving the milestones associated with their Section 1115 IMD Waiver for SMI, approved on May 20, 2022 by the Centers for Medicare and Medicaid Services (CMS). The 1115 waiver grants federal expenditure authority for services provided to Medicaid beneficiaries during short term stays for acute care in Institutions for Mental Disease (IMDs). The MPA covers approximately the first two and a half years of the demonstration period.

Milestone Risk Assessment and Recommendations

The Independent Evaluator (IE) analyzed and synthesized critical metrics, implementation plan action items, state-specific data, and stakeholder feedback to determine the state's risk of not achieving the following demonstration milestones:

1. Milestone 1: Ensuring quality of care in psychiatric hospitals and residential settings
2. Milestone 2: Improving care coordination and transitions to community-based care
3. Milestone 3: Increasing access to continuum of care including crisis stabilization services
4. Milestone 4: Earlier identification and engagement in treatment including through increased integration

The IE determined that Alabama is at **low risk of not achieving milestone 1.** 100% of critical metric goals are met and 100% of implementation plan action items associated with the measure are complete. Although the milestone is considered to be at low risk, the IE recommends the state consider measuring progress using a **different monitoring metric that will more accurately capture the state's progress** on this milestone, considering data collection and data quality challenges with the current critical metric.

The IE found that the state is at **medium risk for not achieving milestone 2**, with only 40% of critical metric goals met and 60% of implementation action items complete at the mid-point. Recommendations are focused on **working with SMI/SED providers to improve follow-up** processes after hospitalizations and ED visits for beneficiaries with SMI/SED.

The state is at **low risk of not achieving milestone 3 and milestone 4**. Alabama is performing well on both milestones, with 100% of critical metric goals met. The IE does not have recommendations for improvements on these milestones at the time of this report.

SMI/SED Provider Capacity and Recommendations

The IE examined provider availability assessment (PAA) data to evaluate the state's capacity to provide SMI/SED services to Medicaid beneficiaries. PAA data reflected that availability of Medicaid-enrolled providers (including individual providers as well as a range of facility types) remained stable or increased from baseline to mid-point, coinciding with a decrease in Medicaid beneficiaries with SMI as a result of Medicaid redetermination following the end of the COVID-19 PHE. Methodological and data quality issues were noted with the PAA data, however, and the IE recommends that the state strengthen their approach to documenting methodology and consistent data collection for the PAA tool to be most effective for the remainder of the demonstration. Additionally, stakeholder feedback and state-specific data indicates that Alabama has made significant investments in provider capacity since 2022. The opening of new crisis centers, development of mobile-crisis response teams, and a statewide effort to advance the Certified Community Behavioral Health Clinic (CCBHC) model is not necessarily reflected in the PAA data. The IE acknowledges this **overall progress in provider capacity** in the state.

A. GENERAL BACKGROUND INFORMATION

A.1. DEMONSTRATION NAME, TIMING, AND CONTEXT

On May 20, 2022, the Centers for Medicare and Medicaid Services (CMS) approved the Alabama Medicaid Agency's application for a Section 1115 Institutions for Mental Disease (IMD).[1] Waiver for Serious Mental Illness (SMI). The five-year waiver period was approved for implementation starting on May 20, 2022, and concluding on May 19, 2027, under the authority of Section 1115(a) of the Social Security Act. The new Section 1115(a) demonstration grants federal expenditure authority for services provided to Medicaid beneficiaries during short term stays for acute care in IMDs and waives the statewideness provision in Section 1902(a) of the Social Security Act in order to reimburse short term psychiatric stays in an underserved area of the state.

Historically, IMD stays have been excluded from the Medicaid program, but states have received federal expenditure authority for stays in IMDs through Section 1115 waivers. In November of 2018, CMS issued guidance outlining how states could receive expenditure authority for short-term stays in IMDs for individuals with SMIs and SEDs.[2] Alabama previously participated in CMS's three-year Emergency Psychiatric Demonstration (MEPD), which provided funding for short-term stays in IMDs for eligible Medicaid beneficiaries. MEPD concluded in 2015. This 1115 demonstration is thus a continuation of the progress achieved through the MEPD program.

This mid-point assessment (MPA) assesses approximately the first two years of the demonstration. The data included in the MPA has a range of measurement periods (for instance, most of the state's monitoring metrics are collected on a calendar year cycle that does not completely align with the demonstration year measurement periods. The following measurement periods are included in the MPA:

Reporting Period	Dates
Baseline: Demonstration Year 1 (DY1)	5/20/2022—5/19/2023
Baseline: Calendar Year 1 (CY1)	01/01/2022—12/31/2022
Mid-Point: Demonstration Year 2 (DY2)	5/20/2023—6/30/2024[3]
Mid-Point: Calendar Year 2 (CY2)	01/01/2023—12/31/2023

FIGURE 1: DEMONSTRATION REPORTING PERIODS

Qualitative data, including the status of implementation plan action items, includes the implementation period from the start of the demonstration 5/20/2022 through end of demonstration year 3, 5/19/2025. Throughout the MPA, the Independent Evaluator (IE) indicates the precise measurement period being evaluated.

A.2. DESCRIPTION OF THE DEMONSTRATION'S POLICY GOALS

This 1115 waiver authorizes federal financial participation (FFP) for acute care services during short term stays in the two psychiatric hospitals qualifying as IMDs in Baldwin and Mobile counties, EastPointe Hospital and BayPointe Hospital. Both EastPointe Hospital and BayPointe Hospital are operated by AltaPointe Health, a health system providing primary and behavioral health care services in the state. EastPointe Hospital has 82 adult inpatient beds. BayPointe Hospital received a certificate of need to

[1] Section 1905(i) of the Social Security Act defines an IMD as a "hospital, nursing facility, or other institution of more than 16 beds, which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."
[2] Medicaid's Institutions for Mental Disease (IMD) Exclusion (congress.gov)
[3] Following the approval of the Demonstration and publication of the STCs, the state and CMS agreed to adjust the Demonstration measurement years with to align more closely with standard state reporting periods.

expand inpatient capacity, and construction began in December 2024 and is expected to be completed by December 2026. While construction is ongoing, BayPointe Hospital is converting 26 existing child and adolescent beds to adult beds, with the goal of the additional converted beds to be ready for occupancy by October 2025. The demonstration covers services provided to Medicaid beneficiaries aged 21-64 diagnosed with SMI who are being treated within these IMDs. Medicaid eligible adults will have access to a full range of SMI treatment services ranging from short-term acute care in inpatient settings for SMI, to perpetual, chronic care for SMI in cost-effective community-based settings. The state is taking a regional approach where the demonstration limits expenditure authority to inpatient services being provided within the two IMDs in Baldwin and Mobile counties, however Alabama residents across the state with SMI are eligible to access these services regardless of their county of residence.

The southwest region includes Baldwin, Clark, Conecuh, Escambia, Mobile, Monroe, and Washington counties. Individuals residing in this area experience the largest gap in the care continuum and do not have reasonable access to inpatient care due to the lack of inpatient psychiatric units in medical hospitals. Beneficiaries residing in other counties have access to non-IMD psychiatric inpatient services through hospitals within their county of residence or are in close proximity to them. In 2017, the last psychiatric hospital providing services to adults in the southwest region began only serving geriatric patients, terminating care accessibility for the 21-64 age group. The closest hospital with an inpatient psychiatric unit and the closest IMD to Medicaid beneficiaries in the southwest region of the state are in Crenshaw County, which is a 3-hour drive away. Bryce Hospital in Tuscaloosa, Alabama's state psychiatric hospital, is also located several hours away from the southwest region, making inpatient psychiatric care virtually inaccessible.

The state is concurrently implementing other initiatives that expand access to community-based mental health care to achieve the demonstration goals on a statewide basis. These initiatives include:

1. Expanding Alabama's "Stepping Up" initiative, which aims to reduce the number of individuals with SMI in jails and the emergency room through providing intensive care management services, to every county in the state.
2. Expanding the School-Based mental health collaborative, which increases access to mental health treatment for children in public schools through integrating mental health centers and public-school systems.
3. Implementing the Alabama Permanent Supportive Housing Strategic Plan, which is a five-year plan with action steps to maintain, increase and more efficiently use permanent supportive housing for individuals with SMI across the state.
4. Establishing crisis diversion centers throughout the state that can provide crisis stabilization services.
5. Establishing Certified Behavioral Health Clinics throughout the state.

As articulated in the demonstration STCs, the goals of the IMD 1115 waiver for SMI are to:

1. Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.
2. Reduce preventable readmissions to acute care hospitals and residential settings.
3. Improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state, participating counties.
4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care; and
5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

The MPA assesses the state's progress on achieving the four milestones identified by CMS and addressed in the state's implementation plan for the IMD 1115 waiver for SMI:

1. Ensuring quality of care in psychiatric hospitals and residential settings.
2. Improving care coordination and transitions to community-based care.
3. Increasing access to continuum of care including crisis stabilization services.
4. Earlier identification and engagement in treatment and increased integration.

A.3. IMPACT OF THE COVID-19 PUBLIC HEALTH EMERGENCY

The end of the COVID-19 Public Health Emergency (PHE) during the second demonstration year of the waiver impacted Medicaid enrollment. After pausing redeterminations of Medicaid eligibility under the continuous enrollment provision of the Families First Coronavirus Response Act (FFCRA), Alabama began its 12-month 'unwinding' period in April 2023, shortly before the start of the second year of the Section 1115 IMD waiver for SMI. As occurred in other states, Alabama's Medicaid unwinding led to a significant decrease in overall Medicaid beneficiaries statewide, and a decrease in Medicaid beneficiaries in Alabama with an SMI diagnosis. This decrease is reflected in the provider availability assessment data presented in Section C.3 of the MPA, "Assessment of state's capacity to provide SUD and/or SMI/SED services".

Additionally, the end of the PHE and the continuous enrollment provision led to an overall reduction in mental health service utilization from DY1 to DY2, likely due to the drop in enrollment. These changes in service utilization are described in further detail in section C of the MPA "Findings." Alabama, like the rest of the country, also experienced challenges with hospital staffing during the pandemic, confirmed by stakeholders at AltaPointe Health, a key implementation stakeholder.

B. METHODOLOGY

B.1. DATA SOURCES

The mid-point assessment utilized the following quantitative and qualitative data sources:

- Monitoring metrics
- State-specific metrics
- Provider availability assessment
- Implementation plan action items
- Stakeholder feedback and contextual information

B.1.1 Monitoring Metrics

The Independent Evaluator (IE) utilized the monitoring reports prepared by the state for quarterly and annual CMS required reporting for the state's Section 1115 IMD waiver for SMI. For the mid-point assessment, the IE utilized monitoring reports that contained annual quality measures that included the data from DY1 (baseline) and DY2 (mid-point).[4] The IE extracted the relevant metrics (critical metrics, service utilization metrics, and any relevant monitoring metrics) from the monitoring reports to conduct a comparison from baseline to mid-point.

[4] The CMS approved and posted monitoring reports for the AL 1115 IMD SMI waiver are limited to claims data from the two IMDs participating in the demonstration, EastPointe Hospital and BayPointe Hospital. Since the mid-point assessment and evaluation are designed to evaluate the impact of the waiver state-wide, the IE asked the state to re-run monitoring metrics state-wide. Please note that these re-run reports are the data utilized in this report and will differ from the CMS-approved monitoring reports.

B.1.2 State-Specific Metrics

The IE utilized several metrics collected by Alabama to augment the CMS-reported monitoring metrics, including statewide crisis center data, facility level data from AltaPointe's behavioral health crisis center, and statewide mobile crisis data. Statewide crisis center and mobile crisis data is collected and made publicly available by the Alabama Department of Mental Health. Aggregate behavioral health crisis center data was collected and shared by AltaPointe with the IE.

B.1.3 Provider Availability Assessment

States with 1115 SUD or SMI/SED demonstrations are required to complete an annual provider availability assessment (PAA), utilizing a data collection template developed by CMS. The PAA captures the ratio of Medicaid beneficiaries with SUD or SMI to the availability of different provider types or facilities that can serve them in the state. This MPA utilizes the two PAAs completed by Alabama and approved by CMS for DY1 and DY2.

B.1.4 Implementation Plan Action Items

Alabama developed an Implementation Plan on April 27, 2022 for the 1115 IMD waiver for SMI. This Implementation Plan was approved by CMS and included in the waiver's approval and STCs. The Implementation Plan documents the state's approach to implementing the demonstration and includes specific action items designated by the state to achieve progress on each demonstration milestone. The IE reviewed and extracted the state's implementation plan action items for the MPA.

B.1.5 Stakeholder Feedback and Contextual Information

The IE meets regularly with stakeholders from Alabama to discuss the Independent Evaluation of the 1115 IMD waiver for SMI. In developing the MPA, the IE reviewed each data source and preliminary findings in detail with Alabama stakeholders, including Alabama Medicaid Agency staff (Mental Health Program leadership and the data analytics team) and demonstration implementing partners representing AltaPointe Health. The IE reviewed all publicly available documentation of the state's efforts to strengthen the mental health continuum of care services in Alabama. Additionally, where relevant, the IE reviewed correspondence between the state and CMS for further clarification on data sources, including the PAA. The IE conducted informal, semi-structured conversations with stakeholders including AltaPointe Health leadership and Alabama Medicaid Agency staff. Finally, AMA staff also engaged stakeholders from AltaPointe Health and the Alabama Department of Mental Health in conducting their review of the MPA and developing their narrative responses to the IE's recommendations.

B.2. ANALYTIC METHODS

The IE assessed the state's overall demonstration progress and performance on monitoring metric targets using a range of analytic methods recommended in CMS's guidance on conducting the mid-point assessment. The application of these analytic methods supported the determination of the state's risk of not meeting demonstration goals and informed recommendations for the state.

The MPA assesses the state's progress in achieving the following four milestones:

1. **Milestone 1:** Ensuring quality of care in psychiatric hospitals and residential settings
2. **Milestone 2:** Improving care coordination and transitions to community-based care
3. **Milestone 3:** Increasing access to continuum of care including crisis stabilization services
4. **Milestone 4:** Earlier identification and engagement in treatment including through increased integration

Per CMS guidance, particular critical metrics are attributed to each milestone and analyzed to measure progress in achieving the milestone. The IE measured change from baseline to mid-point for monitoring metrics (including critical metrics and state-specific metrics) by calculating the Absolute Change and Percent Change:

- *Absolute Change= value of metric at mid-point – value of metric at baseline*
- *Percent Change= (value of metric at mid-point – value of metric at baseline) / value of metric at baseline*

The IE used the same methodology to compare service utilization between baseline and mid-point, though it was not attributed to a particular milestone.

To measure the state's capacity for delivering SMI/SED services, the IE calculated changes (percent change and absolute change) from the baseline year PAA and the mid-point year PAA. The PAA collects information on a range of provider types including:

- General Providers (Psychiatrists and Other Practitioners Authorized to Prescribe, and Other Practitioners Certified or Licensed to Independently Treat Mental Illness)
- Community Mental Health Centers (CMHCs)
- Intensive Outpatient or Partial Hospitalization Providers
- Residential Mental Health Treatment Facilities
- Inpatient
- Institutions for Mental Diseases (IMDs)
- Crisis Stabilization Services
- Federally Qualified Health Centers (FQHCs)

For each provider type, the IE extracted the number of Medicaid-enrolled providers as well as the ratio of Medicaid-enrolled beneficiaries to the number of Medicaid-enrolled providers. The IE excluded any data for providers that are not Medicaid enrolled. Due to limitations in data collection, Alabama Medicaid Agency cannot confirm the methodology or accuracy of provider data outside of Medicaid, limiting the IE's ability to include it in the PAA.

The IE assessed whether service availability was changing in alignment with the state's implementation plan and demonstration goals. In general, an increase in provider availability and a decrease in the ratio of beneficiaries to providers indicates improved provider capacity for mental health services in the state.

B.3. ASSESSMENT OF OVERALL RISK OF NOT MEETING MILESTONES

The IE provided a risk rating for each demonstration milestone, primarily determined by the state's performance on the critical metrics and further informed by progress on their implementation plan action items, sub-sections of the provider availability assessment, certain state-specific metrics, and stakeholder feedback.

In their demonstration monitoring protocol, Alabama indicated both an annual target and a demonstration target for the desired direction of each critical metric (increase, decrease, or remain consistent). The IE calculated the change from baseline to mid-point for each critical metric and then counted the number of critical metrics per milestone that progressed in the target annual direction. Any increase or decrease from baseline to mid-point was considered to constitute a directional change, regardless of the magnitude of the change. Critical metrics with multiple associated measures (for example, a rate of follow-up measure a 7-day and 30-day measurement period) were counted as separate measures.

Per CMS guidance, initial milestone risk ratings were calculated by measuring critical metric performance using the following framework:

- **Low risk:** For >75% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- **Medium risk:** For 25-75% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- **High risk:** For <25% of the critical metrics associated with the milestone, the state is moving in the direction expected according to its annual goals and overall demonstration targets.

The state's progress on implementation plan action items were also considered in determining the risk of not meeting the milestones. The IE reported the percentage of action items that were completed by the mid-point for each milestone. While a contributing factor, the percentage of completed implementation plan action items did not change the IE's risk rating determination based on progress on the critical metrics.

Stakeholder feedback provided important context for understanding the state's performance on critical metrics and implementation plan action items and informed the IE's development of recommendations for improvements and next steps.

While not included in the risk rating determination, PAA data contributed to an overall understanding of the state's capacity to deliver SMI/SED services, as described in Section B.2., Analytic Methods. In particular, PAA data related to the availability of crisis stabilization services in the state is closely aligned with demonstration milestone three: increasing access to the continuum of care.

Data Source	Considerations
Critical metrics	For each metric associated with the milestone, is the state moving in the direction of the state's annual goal?
Implementation plan action items	Has the state completed each action item associated with the milestone as scheduled to date?
State-specific data	Did state-specific data support progress to meeting the milestone?
Stakeholder feedback	Did key stakeholders identify risks related to meeting the milestone?
Provider availability assessment data	Is the state moving in the expected direction as outlined in the demonstration goals and milestones and as described in the state's implementation plan for availability assessment data?

FIGURE 2: MID-POINT ASSESSMENT DATA SOURCES

B.4. LIMITATIONS

1. Methodology for assessing critical metric progression in the expected direction: The IE utilized the standard analytic approaches for conducting mid-point assessments to calculate change from baseline to mid-point and to determine risk ratings for demonstration milestones. While a helpful tool for broadly capturing the state's progress at the mid-point of their demonstration, interpreting any change from baseline to mid-point as potential progress or lack of progress, regardless of magnitude of change or the overall value of the metric, can mask nuances in critical metric findings and overall milestone performance. The IE mitigated this limitation by considering the direction and magnitude of change along with all available data when assigning the final risk assessment.

2. Provider availability assessment data quality: The IE noted a number of data quality issues in the state's provider availability assessment (PAA), including: missing data for either DY1 or DY2 (making a baseline to mid-point comparison impossible), and significant changes in the number of providers from DY1 to DY2 due to changes in methodology, which should be seen as an artifact and not the not a true reflection of a change in provider capacity. The IE was unable to report on changes in Residential Mental

Health Treatment Facilities, Inpatient, and Institutions for Mental Disease (IMDs) as a result. The IE mitigated this limitation by noting where data cannot support reliable findings and making comparisons using the most reliable and complete data available.

C. FINDINGS

C.1. PROGRESS TOWARDS DEMONSTRATION MILESTONES

Progress towards Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

Monitoring Metrics

The state only reports on one critical metric associated with Milestone 1, focused on ensuring quality of care in psychiatric hospitals and residential settings. Metric #23 measures the percentage of patients with serious mental illness and diabetes that have hemoglobin A1c in poor control (>9.0%). From the baseline year to the mid-point, the percentage of patients with SMI and diabetes in poor control decreased by 0.64%, aligning with the state's annual target for this metric.

The values for this measure were exceptionally high in both years (97.3% in CY1 and 96.7% in CY2), indicating that most patients with both diabetes and SMI had poorly controlled diabetes. These results should be interpreted cautiously, however. State stakeholders explained that providers rarely include the CPT code for HbA1c testing on claims and encounters, as the code is not reimbursed by Alabama Medicaid, nor is it included in Alabama's measure slate for incentive payments. Additionally, the measure specifications call for any missing data to be coded as "in poor control," artificially inflating the measure numerator. The data reflected for Metric #23 is not necessarily representative of the state's progress on improving diabetes care for patients with SMI.

The Alabama Coordinated Health Network is working to improve reporting on diabetes care and control. They have added the measure HBD-AD: Hemoglobin A1c Control for Patients with Diabetes to their measure slate for incentive payments, encouraging providers to improve data collection by reporting HbA1c test results on claims.

Metric #	Metric Name	Baseline (CY1)	Mid-Point (CY2)	Absolute Change	Percent Change	State's Annual Target	Directionality at Mid-Point	Progress (Y/N)
23	Diabetes Care for Patients with SMI: HbA1c Poor Control (>9.0%) (HPCMI-AD)	97.3%	96.7%	-0.62	-0.64%	Decrease[5]	Decrease	Y

FIGURE 3: MILESTONE 1 MONITORING METRICS

[5] The state's approved monitoring protocol lists the annual target for Measure 23 as "increase," due to a mistake in the state's interpretation of the measure. The MPA measure target reflects the true annual goal of "decrease."

Implementation Plan Action Items

All of the implementation plan action items that the state identified for Milestone 1 were met or complete at the time the implementation plan was submitted at the start of the demonstration.

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be Completed	Current Status (Open, Complete, Suspended)
1.a	Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.	N/A milestone met	Ongoing	Complete
1.b	Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements.	N/A milestone met	Ongoing	Complete
1.c	Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay.	N/A milestone met	Ongoing	Complete
1.d	Compliance with program integrity requirements and state compliance assurance process.	N/A milestone met	Ongoing	Complete
1.e	State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.	N/A milestone met	Ongoing	Complete
1.f	Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	N/A milestone met	Ongoing	Complete

FIGURE 4: MILESTONE 1 IMPLEMENTATION PLAN ACTION ITEMS

Stakeholder Input

Stakeholders at Alabama's Department of Mental Health (DMH) confirmed that the state has no concerns regarding quality of care provided in psychiatric hospitals or residential settings and that current oversight mechanisms and licensing requirements are effective. They highlighted that the state continues to offer opportunities for training and technical assistance as needed.

Progress towards Milestone 2: Improving Care Coordination and Transitions to Community-Based Care

Milestone 2 focuses on measures for improving care coordination and transitions to community-based care. The critical metrics in this milestone include 30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (Metric 4) and follow-up rates after hospitalization for mental illness and after ED visits (Metrics 8, 9, and 10). Follow-up was measured after 7 days and after 30 days. The state also reported on a non-critical monitoring metric, medication continuation following inpatient psychiatric discharge (Metric 6),

Of the seven critical metrics, three changed in the direction consistent with the state's target: follow-up after emergency department visit for alcohol and other drug abuse or dependence 30-day (Metric 9) and the 7-day and 30-day follow-up measures after ED visit for mental illness (Metric 10).

The change from baseline to mid-point for the remaining three critical metrics in this milestone did not align with the state's annual targets. The state's annual goal was to decrease the readmission rate and increase both 7-day and 30-day follow-up after hospitalization and after ED visits. The 30-day all-cause unplanned readmission rate (Metric 4) increased by 17.76%, the largest change away from the state's goal for Milestone 2. Medication continuation (Metric 6) decreased slightly rather than staying consistent. 7-day follow-up after ED visit for alcohol and other drug abuse or dependence (Metric 9) decreased instead of increasing, and both 7-day and 30-day follow-up after hospitalization for mental illness decreased slightly instead of increasing. The 7-day follow-up after ED visit for alcohol and other drug abuse or dependence also decreased greatly, with a 14.68% decline in follow-up. The follow-up rates after ED visits for alcohol and other drug abuse or dependence (Metric 9) are particularly low at less than 6% follow-up at both the 7-day and 30-day windows.

Monitoring Metrics

Metric #	Metric Name	Baseline (CY1)	Mid-Point (CY2)	Absolute Change	Percent Change	State's Annual Target	Directionality at Mid-Point	Progress (Y/N)
4	30-Day-All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	4%	4.71%	.71	17.76%	Decrease	Increase	N
6[6]	*Medication Continuation Following Inpatient Psychiatric Discharge*	*68.90%*	*67.74%*	*-1.16*	*-1.68%*	*Consistent*[7]	*Decrease*	*N*

[6] Metric 6 is not considered a critical measure. It is included as a monitoring metric for additional context, but not included in the milestone risk rating calculation, which is limited to performance on critical metrics.
[7] The IE used the overall demonstration target to determine an annual directionality target, as the state did not provide an annual target in their monitoring protocol.

8	Follow-up After Hospitalization for Mental Illness (30 Day)	48.5%	48.18%	-0.32	-0.65%	Increase	Decrease	N
8	Follow-up After Hospitalization for Menal Illness (7-Day)	31%	30.57%	-0.43	-1.38%	Increase	Decrease	N
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30-Day)	5.5%	5.6%	0.10	1.73%	Consistent[8]	Increase	Y
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7-Day)	3%	2.6%	-0.44	-14.68%	Consistent[9]	Decrease	N
10	Follow-up After Emergency Department Visit for Mental Illness (30-Day)	57.6%	59.8%	2.19	3.80%	Increase	Increase	Y
10	Follow-up After Emergency Department Visit for	38.4%	40.4%	1.96	5.10%	Increase	Increase	Y

[8] The IE used the overall demonstration target to determine an annual directionality target, as the state did not provide an annual target in their monitoring protocol.
[9] The IE used the overall demonstration target to determine an annual directionality target, as the state did not provide an annual target in their monitoring protocol.

	Mental Illness (7-Day)							

FIGURE 5: MILESTONE 2 MONITORING METRICS

Implementation Plan Action Items

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be Completed	Current Status (Open, Complete, Suspended)
2.a	Actions to ensure psychiatric hospitals and residential settings care out intensive pre-discharge planning and include community-based providers in care transitions	N/A milestone met	N/A	Complete
2.b	Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available	Implementation of five-year strategic plan for permanent supportive housing	Undetermined	Open
2.c	State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through the most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	N/A milestone met	N/A	Complete
2.d	Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	Expand Stepping Up program in every Alabama county	End of FY 2022	Open
2.e	Other State requirements/policies to improve care coordination and connection to community-based care	N/A milestone met	January 2026	Complete

FIGURE 6: MILESTONE 2 IMPLEMENTATION PLAN ACTION ITEMS

Stepping Up is a national program with the goal of reducing the rate of incarceration of people with mental illness. Stepping Up is sponsored by the National Association of Counties, the American Psychiatric Foundation, and the Council of State Goernments Justice Center, in partnership with the U.S. Departmetn of Justice's Bureau of Justice Assistance. In a report commissioned by the Alabama Department of Mental Health (ADMH) to evaluate year 4 of the state's implementation of the Stepping Up initaitve, as of September 2022, 27 of the 67 counties in Alabama passed Stepping Up resolutions, and 17 counties received grant funding from ADMH to implement the program. While the state has not yet achieved their implementation plan action item goal of expanding Stepping Up to every county in the state by the end of FY 2022, they have made significant progress in expanding the program.

Stakeholder Input

Stakeholders at DMH and AltaPointe Health provided additional information on Implementation Plan Action Item 2.b, explaining that in residential settings, providers assess beneficiaries' housing status and

circumstances at the point of admission, to inform the best options at discharge. DMH stakeholders shared that housing resources include different levels of care, such as housing at a beneficiary's own home or with family or housing with appropriately determined mental health supports such as case management, peer services, or medication. EastePointe Hospital assesses each beneficiary's housing status and circumstances and coordinates referrals. The Bio-Psycho-Social Assessment that EastePointe Hospital completes with all beneficiaries assesses financial stressors, including housing instability. Within the same assessment, the assigned clinician completes a section that identifies specific community resources to address any housing-related issues.

Progress towards Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

Milestone 3 focuses on measures to increase access to continuum of care, including crisis stabilization services. The only critical metric for this milestone was Metric #19, which measures average length of stay (ALOS) in IMDs. The metric is split into two measurements: one for all IMDs (#19a), and one for IMDs receiving FFP only (#19b). The values for Metrics 19a and 19b are the same, since all of the state's IMDs receive FFP from CMS. From the baseline year to the mid-point, ALOS in IMDs increased by 10.3% from 26 days to 29 days. The state's annual ALOS target is less than 30 days; baseline ALOS and mid-point ALOS both meet this target.

Monitoring Metrics

Metric #	Metric Name	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	State's Annual Target	Mid-Point Status	Progress (Y/N)
19a	Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs)	26	29	3	10.3%	No more than 30 days	Less than 30 days	Y
19b	Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs) receiving FFP only	26	29	3	10.3%	No more than 30 days	Less than 30 days	Y

FIGURE 7 MILESTONE 3: MONITORING METRICS

State-Specific Data: Crisis Stabilization Services

Alabama has made significant progress in expanding access to a range of crisis stabilization services across the state. Since 2021, six crisis centers have opened. The most recent crisis center, operated by SpectraCare, began services in February 2025. Crisis centers are open at all times to individuals experiencing a mental health or substance use crisis. Individuals can walk-in or be brought by first

responders or law enforcement to receive stabilization, evaluation, or psychiatric services. They also provide referrals to community-based resources.

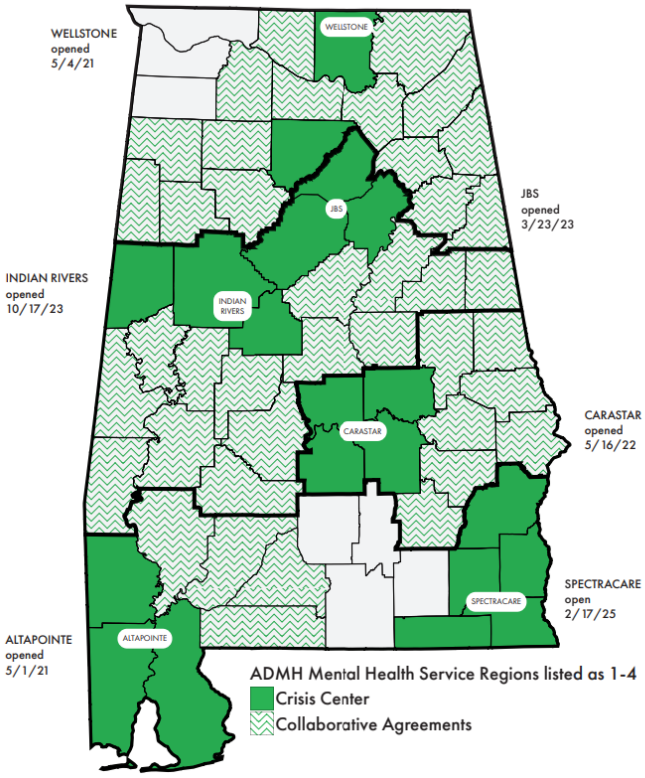


FIGURE 8 CRISIS CENTERS OPERATING IN ALABAMA IN 2025

AltaPointe Health, the same health system operating the state's two IMDs, opened a Behavioral Health Crisis Center in May 2021 to serve Baldwin, Clark, Conecuh, Escambia, Monroe, and Washington counties. AltaPointe tracks a range of measures to capture the services they provide and their impact on reducing adverse outcomes, such as unnecessary acute-care utilization and incarceration. If an individual was transported by law enforcement or the crisis response team after being contacted by law enforcement, their alternative treatment at the crisis center is considered to be a jail diversion. If an individual would have chosen an emergency department but instead accessed care at the crisis center, they are considered to be an ED diversion.

Measure Title	CY 21	CY 22	CY 23	CY 24
Total Crisis Evaluations	408	1109	1582	1894
Community Linkage	8	5	39	38
Admissions	328	961	1283	--
Individuals who avoided ED admission	--	812	1328	1590
Individuals who avoided jail admission	--	166	539	941

FIGURE 9 ALTAPOINTE HEALTH BEHAVIORAL HEALTH CRISIS CENTER UTILIZATION AND IMPACT DATA

In addition to establishing crisis centers, the state began funding its first mobile crisis teams in 2021. Mobile crisis teams offer a range of services to individuals in crisis wherever they are: home, work, or in the community. Response teams are trained to provide triage, assessment, de-escalation, peer support, coordination with medical services, supportive counseling, crisis planning, and follow-up. In Alabama, 55 of the state's 67 counties are considered rural, and access to crisis stabilization services can be challenging. Mobile crisis teams extend the reach of the crisis system of care for individuals who may not have access to a crisis center, community mental health center, or other care option. Between October 2022 and November 2024, ADMH reports serving over 8,000 adults and over 1,000 children and adolescents across all mobile crisis teams.

Mobile crisis teams operate out of seven Community Mental Health Centers (CMHCs):

- Cahaba Center for Mental Health
- Northwest Alabama Mental Health Center
- Southwest Alabama Behavioral Health Care Systems
- WellStone
- West Alabama Mental Health Center
- South Central Mental Health Center
- SpectraCare Health

An additional three crisis centers received funding for six teams:

- AltaPointe Health
- Carastar Health
- WellStone

Three CMHCs received funding for five child and adolescent mobile crisis teams:

- AltaPointe Health
- Jefferson, Blount, St. Clair Mental Authority
- WellStone

Implementation Plan Action Items

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be Completed	Current Status *(Open, Complete, Suspended)*
3.a	The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of	Alabama Medicaid will submit an updated Provider Network Template annually and conduct outreach in areas where gaps in service are noted.	Ongoing	Complete

	mental health services submitted with the demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.			
3.b	Financing plan	N/A	N/A	N/A
3.c	Strategies to improve state tracking of availability of inpatient and crisis stabilization beds.	N/A milestone requirements already met (continue operation of AIMS and MICRS)	Ongoing	Complete
3.d	State requirements that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay.	ADMH is currently reviewing potential assessments for use with adults and plans to implement a standardized tool in the future.	2028 (A decision on a statewide standardized tool for adults will be made after the conclusion of the CCBHC demonstration period, ending 6/30/2028).	Open
3.e	Other state requirements/policies to improve access to a full continuum of care including crisis stabilization.	Award contracts and support Crisis Center Implementation.	2026 (Six crisis centers have opened since 2021. The final one is anticipated to open in 2026).	Open

FIGURE 10 MILESTONE 3 IMPLEMENTATION PLAN ACTION ITEMS

Stakeholder Input

Stakeholders shared that the significant increase in the availability of crisis stabilization services for individuals with a range of mental health needs in the state has been effective in diverting less-acute patietns from inpatient stays in psychaitric hospitals or residential treatment setting, like IMDs. Mobile crisis and crisis center interventiosn have been successful in supporting individuals' ability to remain in the community. This success, however, may be reflected in the increasing ALOS in IMDs, seen in Metric 19. On average, individuals who would have had a shorter length of stay and reduced the ALOS in IMDs are staying out of IMDs all together. Stakeholders shared that in their view, an increasing ALOS demonstrates overall progress on Milestone 3: increasing access to continuum of care including crisis stabilization services.

Progress towards Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration

Milestone 4 focuses on measures for earlier identification and engagement in treatment, including through increased integration. The critical measures for this milestone include access to preventive/ambulatory services (Metric 26), and follow-up care for those who are newly prescribed an antipsychotic medication (Metric 30). Although by a small amount (<0.5%), Metrics 26 and 30 both increased in value, progressing in the expected direction consistent with the state's annual target. Metric 24, screening for depression and follow-up plan, is not designated as a critical metric, but rather a monitoring metric the state reports on regularly. The values for Metric 24 are very small in both years (<1%), indicating a very low rate of screening for depression. This screen and follow-up planning data should be interpreted cautiously. State stakeholders shared that most providers do not bill for depression screening, as it is not reimbursed by Alabama Medicaid. The data that is available is primarily from denied claims. Metric 24 is likely not an accurate representation of the rates of screening for depression and follow-up planning, but may indicate an area for process improvements for the state.

Monitoring Metrics

Metric #	Metric Name	Baseline (CY1)	Mid-Point (CY2)	Absolute Change	Percent Change	State's Annual Target	Directionality at Mid-Point	Progress (Y/N)
24	Screening for Depression and Follow-up Plan	0.2%	0.1%	-0.1	-26.4%	Increase	Decrease	N
26	Access to Preventative/Ambulatory Health Services for Medicaid Beneficiaries with SMI	92.10%	92.4%	.29	.31%	Increase	Increase	Y
30	Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	85.60%	86.01%	.41	.48%	Increase	Increase	Y

FIGURE 11 MILESTONE 4: MONITORING METRICS

Implementation Plan Action Items

Action Item #	Action Item Description	Summary of Actions Needed (in IP)	Date to be Completed	Current Status (Open, Complete, Suspended)
4.a.	Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported	ADMH is currently providing fidelity assessments of the SE/IPS service sites and will analyze provider's adherence to elements of the evidence-based practice. DMH and the	N/A	Complete

	employment and supported programs.	Alabama Department of Rehabilitative Services (ADRS) will analyze other sites and funding streams for considered expansion to new sites. The state anticipates completing this review by FY2024. Expanded number of SE/IPS service sites with fidelity.		
4.b.	Plan for increasing integration of behavioral health care in non-specialtysettings to improve early identification of SED/SMI and linkages to treatment.	Incorporate federal requirements into CCBHCs: 1) CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. 2) CCBHC ensures children receive age-appropriate screening and preventative interventions including, where appropriate, assessment of learning disabilities, and other adults receive age-appropriate screening and preventive interventions.	6/30/2028	Open
4.c.	Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	N/A milestone met	N/A	Complete

Certified Community Behavioral Health Clinic Model

In September 2023, Alabama received a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to plan for a transformation of the state's behavioral health care services to align with the Certified Community Behavioral Health Clinic (CCBHC) model. Prior to receiving the grant, the state conducted a needs assessment in early 2022 to develop a comprehensive understanding of the behavioral health need gaps in the state.

CCBHCs are a nationally recognized model that prioritizes integration of behavioral health and physical health or primary care. The model seeks to ensure high-quality care for underserved populations,

promote integration of services, reduce silos, and support a well-trained behavioral health workforce. Establishing crisis centers and mobile crisis teams was a key part of the state's overall shift towards the CCBHC model.

Alabama's participation in the SAMHSA CCBHC Demonstration program began in July 2024. The state's long-term goal is to certify all 19 CMHCs in the state as CCBHCs. CCBHC certification requires sites to offer a standard set of services across crisis services, screening, diagnosis and risk assessment, psychiatric rehabilitation services, outpatient primary care screening and monitoring, targeted case management, peer, family support and counselor services, community-based mental health care for veterans, person and family centered treatment planning, and outpatient mental health and substance use services. At the time of the mid-point assessment, there are two certified CCBHC providers in the state: AltaPointe Health and Wellstone, with three and two locations respectively.

Alabama Medicaid Agency stakeholders shared that they view the CCBHC model as a "game changer" in expanding access to mental health services in the state, particularly for Medicaid beneficiaries as well as individuals who are uninsured or underinsured. CCBHCs serve patients of all ages, filling gaps in services for individuals aged 21-64 and over 65. AMA stakeholders noted the benefits of CCBHCs acting as "one stop shops," allowing individuals to receive all their services, inclusive of pharmacy needs, at once. AMA stakeholders noted that they are aware of the potential challenge of duplicated services in the CCBHC setting and private facilities, and are working to identify appropriate solutions.

Service Utilization Metrics

While not attributed to a particular demonstration milestone, the service utilization data provides broad context into mental health services utilization trends from the baseline year to the mid-point year. Utilization of inpatient services decreased by 9.73%. This decline could be due to the state's focus on strengthening the continuum of care, which may have shifted utilization to non-hospital settings such as intensive outpatient centers. This effect is reflected in the 18.37% increase in utilization for intensive outpatient and partial hospitalization services. Regular outpatient utilization, however, decreased by 7.62%.

While the state is working to reduce ED utilization for mental health services, ED utilization increased at the mid-point year by 16.69%.

Utilization of telehealth mental health services decreased significantly by 75% from baseline to mid-point. The COVID-19 PHE ended at the start of the mid-point year, and Medicaid redetermination occurred throughout the mid-point of the demonstration. This trend is consistent with a return to more in-person services at the end of the pandemic.

Utilization for any mental health services declined by 9.42% overall. This decrease can likely be attributed to the overall reduction in Medicaid beneficiaries and Medicaid beneficiaries with an SMI diagnosis, as a result of Medicaid redetermination.

Metric #	Metric Name	Baseline (DY1)[10]	Mid-Point (DY2)[11]	Absolute Change	Percent Change	Directionality at Mid-point
13	Mental Health Services Utilization—Inpatient	10,245	9,248	-997	-9.73%	Decrease

[10] Mental Health Services Utilization data for DY1 covers 6/1/2022—5/31/2023.
[11] Mental Health Service Utilization data for DY2 covers 6/1/2023—5/31/2024.

14	Mental Health Services Utilization—Intensive Outpatient and Partial Hospitalization	54,544	64,563	10,019	18.37%	Increase
15	Mental Health Service Utilization—Outpatient	118,016	109,029	-8,987	-7.62%	Decrease
16	Mental Health Services Utilization—ED	50,724	59,191	8,467	16.69%	Increase
17	Mental Health Services Utilization—Telehealth	20,762	5,124	-15,638	-75.32%	Decrease
18	Mental Health Services Utilization—Any Services	146,912	133,069	-13,843	-9.42%	Decrease

FIGURE 12: MENTAL HEALTH SERVICE UTILIZATION DATA

Provider Availability Assessment

The state completed an initial and annual provider availability assessment (PAA), utilizing CMS-developed PAA data reporting templates. An overall picture of provider availability in relation to the demonstration population (adult Medicaid beneficiaries with SMI) is helpful to understand overall capacity in the state to deliver SMI services to Medicaid beneficiaries.

To analyze the state's capacity to provide services, the IE conducted a comparative analysis between the baseline year PAA and the mid-point year PAA.[12] The PAA categorizes providers by type, and for each provider type, the IE noted the directionality of change at the mid-point (increase, decrease, or consistent). For certain provider types, challenges in data availability or concerns with data quality limited the ability to make determinations of capacity changes. In some instances, PAA data is not consistent with other demonstration-related data or findings. The IE notes these reporting inconsistencies in the PAA data. Additionally, the IE limited the PAA data utilized in the MPA to Medicaid providers, as data on other providers was unavailable.

[12] Provider Availability Assessment data for DY1 covers 5/1/2022—4/30/2023 and 5/1/2023—4/30/2024 for DY2.

SMI/SED Service Capacity Overview

Provider Type	Capacity Directionality (Increase, Decrease, Stable or Unable to Report)
Providers	Increase
Community Mental Health Centers (CMHCs)	Increase
Intensive Outpatient or Partial Hospitalization Providers	Increase
Residential Mental Health Treatment Facilities	*Unable to Report*
Inpatient	*Unable to Report*
Institutions for Mental Disease (IMDs)	*Unable to Report*
Crisis Stabilization Services	Increase
Federally Qualified Health Centers (FQHCs)	Increase

FIGURE 13 OVERVIEW OF CHANGES IN SMI/SED PROVIDER CAPACITY FROM BASELINE TO MID-POINT

Beneficiaries

Between the baseline and mid-point years, the number of Medicaid beneficiaries with SMI decreased by 15.13%. This decline can be attributed to the unwinding of the continuous enrollment provision associated with the PHE. Since capacity was assessed as a ratio of beneficiaries to providers throughout the PAA, it is important to note that decreases in ratios may not reflect greater provider availability, but rather a smaller number of beneficiaries.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change
Number of Adult Medicaid Beneficiaries (21+)	526,635	439,904	-86,731	-16.47%
Number of Adult Medicaid Beneficiaries with SMI (21+)	34,183	29,010	-5,173	-15.13%
Percent of total Adult Medicaid Beneficiaries with SMI (21+)	6.49%	6.59%	0.10%	1.54%

FIGURE 14 PROVIDER AVAILABILITY ASSESSMENT: MEDICAID BENEFICIARIES

Providers

Practitioners able to prescribe and practitioners licensed to independently treat mental illness both increased from baseline to mid-point. Ratios of beneficiaries with SMI/SED to both provider types decreased from baseline to mid-point, indicating an improvement in capacity.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe[13]	21,359	21,584	225	1.05%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	5.29	4.38	-0.91	-17.21%	Decrease
Number of Medicaid-Enrolled Other Practitioners Certified or	1,661	1,861	200	12.04%	Increase

[13] This metric is inclusive of all providers in the state who are authorized to prescribe.

Licensed to Independently Treat Mental Illness					
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	68.03	50.80	-17.23	-25.33%	Decrease

FIGURE 15 PROVIDER AVAILABILITY ASSESSMENT: PROVIDERS

Community Mental Health Centers (CMHCs)

The number of CMHCs increased from 57 to 67, a 17.54% increase between the years. The beneficiary to provider ratio decreased, reflecting an increase in capacity. The increase in the number of CMHCs is due to the opening of new locations for existing CMHCs.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of Medicaid-Enrolled CMHCs	57	67	10	17.54%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs	1982.54	1411.04	-571.50	-28.83%	Decrease

FIGURE 16 PROVIDER AVAILABILITY ASSESSMENT: COMMUNITY MENTAL HEALTH CENTERS

Intensive Outpatient or Partial Hospitalization Providers

The decreasing beneficiary to provider ratio for intensive outpatient/partial hospitalization providers was primarily due to the declining number of beneficiaries, as the number of providers only increased by 1, or 4.0%. While this ultimately represents an increase in capacity, the change was minimal.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	25	26	1	4.0%	Increase

Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	4520.20	3636.15	-884.05	-19.56%	Decrease

FIGURE 17 PROVIDER AVAILABILITY ASSESSMENT: INTENSIVE OUTPATIENT OR PARTIAL HOSPITALIZATION PROVIDERS

Residential Mental Health Treatment Facilities

The number of residential mental health treatment facilities and treatment beds were reported as zero in DY2. The IE cannot report on a change from baseline to mid-point due to data quality concerns.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult)	14	0	Unable to report		
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult)	2558.93	-			
Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)	145	0			
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	247.07	-			

FIGURE 18 PROVIDER AVAILABILITY ASSESSMENT RESIDENTIAL MENTAL HEALTH TREATMENT FACILITIES

Inpatient

The total number of psychiatric hospitals appears to have decreased significantly from DY1 to DY2. This may be due to a difference in how the measure was defined and reported in the baseline and midpoint years, and not reflect a true decrease in psychiatric hospitals in the state. The IE is unable to report a change in capacity for psychiatric hospital capacity.

Additional inpatient measures related to psychiatric units and hospital beds showed a reduction in units within acute care hospitals. There were no psychiatric units recorded in critical access hospitals in either year.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	39	36	-3	-7.69%	Decrease
Number of Medicaid-Enrolled Psychiatric Units in Critical Access Hospitals (CAHs)	0	0	0	N/A	N/A
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	2897.56	2626.11	-271.45	-9.37%	Decrease
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	-	-	N/A	N/A	N/A
Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	1792	1858	66	3.68%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	63.06	50.88	-12.18	-19.31%	Decrease
Number of Public and Private Psychiatric Hospitals	-	10	Unable to Report		
Ratio of Medicaid Beneficiaries with SMI/SED to Public and Private Psychiatric Hospitals	-	11817.50	Unable to Report		

Available to Medicaid Patients			
Number of Psychiatric Hospitals	50	-	Unable to Report
Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals Available to Medicaid Patients	14125.63	-	Unable to Report

FIGURE 19 PROVIDER AVAILABILITY ASSESSMENT: INPATIENT

Institutions for Mental Diseases (IMDs)

The IE observed reporting inconsistencies for Institutions for Mental Disease (IMDs) as well, with certain measures available only in the baseline year and others only reported in the mid-point year. Consequently, the IE was unable to determine capacity trends for IMDs. There are two Medicaid-enrolled IMDs taking part in the 1115 IMD Waiver for SMI, however the IE was unable to verify the number of Medicaid-Enrolled IMDs statewide.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of Psychiatric Hospitals that Qualify as IMDs	8	3	-5	-62.5%	Decrease
Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	14125.63	31513.33	17387.71	123.09%	Increase
Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	38	0	Unable to report		
Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential	942.76	-	Unable to report		

Mental Health Treatment Facilities that Qualify as IMDs			
Number of Medicaid-Enrolled Qualified Residential Treatment Programs (QRTPs) that Qualify as IMDs	-	3	Unable to report
Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Qualified Residential Treatment Programs (QRTPs) that Qualify as IMDs	-	31513.33	Unable to report

FIGURE 20 PROVIDER AVAILABILITY ASSESSMENT: INSTITUTIONS FOR MENTAL DISEASE

Crisis Stabilization Services

Crisis stabilization service providers remained consistent from DY1 to DY2, though the beneficiary to provider ratio decreased due to the decreased number of beneficiaries.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of Crisis Call Centers	6	6	0	0.0%	Consistent
Number of Mobile Crisis Units	6	6	0	0.0%	Consistent
Number of Crisis Observation/Assessment Centers	6	6	0	0.0%	Consistent
Number of Crisis Stabilization Units	6	6	0	0.0%	Consistent
Number of Coordinated Community Crisis Response Teams	11	11	0	0.0%	Consistent
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	18834.17	15756.67	-3077.50	-16.34%	Decrease

Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	18834.17	15756.67	-3077.50	-16.34%	Decrease
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	18834.17	15756.67	-3077.50	-16.34%	Decrease
Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	18834.17	15756.67	-3077.50	-16.34%	Decrease
Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams	10273.18	8594.55	-1678.64	-16.34%	Decrease

FIGURE 21 PROVIDER AVAILABILITY ASSESSMENT: CRISIS STABILIZATION SERVICES

Federally Qualified Health Centers (FQHCs)

Changes in measures for Federally Qualified Health Centers (FQHCs) indicate an increase in capacity, with a 34.89% decrease in the ratio of beneficiaries to providers.

Measure Title	Baseline (DY1)	Mid-Point (DY2)	Absolute Change	Percent Change	Directionality at Mid-Point
Number of FQHCs that Offer Behavioral Health Services	158	203	45	28.48%	Increase
Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	715.22	465.71	-249.51	-34.89%	Decrease

FIGURE 22 PROVIDER AVAILABILITY ASSESSMENT: FEDERALLY QUALIFIED HEALTH CENTERS

C.2. ASSESSMENT OF OVERALL RISK OF NOT MEETING MILESTONES

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

The IE determined that Alabama is at low risk for not achieving demonstration milestones 1. 100% of critical metric goals were met and 100% of implementation plan action items were completed.

Due to the reporting issues associated with Metric #23, assessing diabetes control for individuals with diabetes and SMI, the IE recommends that the state work with CMS to add a state-specific monitoring metric (HBD-AD, for instance) that more accurately captures the state's progress on achieving milestone 1. The State should consider selecting a measure that is included in the state's measure slate for incentive payments to increase the likelihood that providers claim the CPT code. In addition, the state could explore options for increasing the likelihood that providers claim the CPT code such as provider training on the importance of data collection for quality improvement and reimbursing for this code.

Alabama Medicaid Agency Response:

Both Diabetes measures are calculated the same way in that missing A1C test values are counted in the poor control group along with those whose levels are more than 9.0. The agency has attached performance incentives to one of the diabetes measures (HBD-AD) that calculates control and poor control. The providers are working towards documenting in their claims compliant and non-compliant results. Rates are already increasing because providers are documenting the results now and will continue going forward. Since both HPCMI-AD and HBD-AD specify handling of missing values the same, there is no need to change the measure. We will continue using the HPCMI-AD measure that is in the Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics Version 4.0.

Milestone 2: Improving Care Coordination and Transitions to Community-Based Care

The IE determined that Alabama is at medium risk for not achieving demonstration milestone 2. 43% of critical metric goals were met and 60% of implementation action items were completed.

Follow-up measures after hospitalization and ED visits for both mental illness and alcohol use or other drug dependence were low across several critical metrics at both the 7-day and 30-day measurement periods. In particular, follow-up after and ED visit for alcohol and other drug abuse or dependence was minimal. The IE recommends that the state work with providers to understand the primary barriers or challenges to completing timely follow-up with patients and develop process improvements or workflow changes to improve performance.

Alabama Medicaid Agency Response:

Providers have been challenged by staff-shortages, but are working to improve rates of follow-up. The state will coordinate with the Alabama Coordinated Health Network (ACHN) to reach out to recipients within a 7–10-day time period following an inpatient stay to ensure that follow up appointments were scheduled at discharge by the psychiatric hospital. The state will also encourage psych hospitals representatives to reach out for follow up connections for all inpatient recipients within 30 days of discharge. Additionally, the state will work with EastPointe and BayPointe Hospitals as well as AltaPointe, the provider organization. AltaPointe has indicated that they are taking steps to improve the consistency of follow-up contact, and are exploring the use of an automated call system in addition to the individual calls placed by facility staff.

Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

The IE determined that Alabama is at low risk for not achieving demonstration milestone 3. 100% of critical metric goals were met and 50% of implementation plan action items were completed.

Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration

The IE determined that Alabama is at low risk for not achieving demonstration milestone 4. 100% of critical metric goals were met and 66% of implementation plan action items were completed.

Milestone	Percentage of fully completed action items	Percentage of critical metric goals met	Risk level	IA's recommended modifications (for medium or high risk)
Milestone 1	100%	100%	Low	Use a different measure to assess quality of care that more accurately captures the state's progress.
Milestone 2	60%	43%	Medium	Work with providers to establish process improvements for follow-up rates after hospitalizations and ED visits
Milestone 3	50%	100%	Low	N/A
Milestone 4	66%	100%	Low	N/A

FIGURE 23 OVERVIEW OF MILESTONE RISK RATINGS

C.3. ASSESSMENT OF STATES CAPACITY TO PROVIDE SMI/SED SERVICES

Changes in provider capacity from the baseline to mid-point years of the demonstration as reflected in the provider availability assessment indicate that overall, capacity to provide SMI/SED services is increasing in Alabama. As described in the progress towards milestone 3, the state has significantly expanded the availability of crisis stabilization services in the state, through the establishment of six new crisis centers since 2021 and the rollout of over 10 mobile crisis teams. Additionally, the construction of new beds for adult inpatient stays at BayPointe Psychiatric Hospital will help meet the needs for inpatient SMI services in a previously underserved part of the state.

Interpreting service capacity data from the first two years of the demonstration is complicated by the end of the COVID-19 PHE and its impact on enrollment and service utilization. Medicaid redetermination began at the start of DY2, resulting in a 16% drop in adult Medicaid beneficiaries from DY1 to DY2 and a 15% reduction in adult Medicaid beneficiaries with an SMI diagnosis. This sudden drop in beneficiaries makes analyzing trends in capacity (particularly ratios of beneficiaries to providers) more challenging.

Additionally, AltaPointe Health, a key implementation stakeholder, shared that EastPointe Hospital experienced challenges with workforce acquisition and retention during the COVID-19 pandemic. Bed availability was sometimes impacted by limited staffing as a result of positive COVID-19 cases within the facility's workforce. Construction to expand inpatient adult capacity at BayPointe Hospital was also delayed due to effects of the pandemic, including workforce shortages and the widespread elevated costs of construction and materials shortages.

Finally, challenges with data quality in the PAA create gaps in the IE's assessment. To develop a more comprehensive understanding of the statewide provider capacity landscape, the IE recommends the state strengthen their approach to PAA reporting, prioritizing clearly documenting methodologic approaches, measure definitions, and data collection frameworks so that outside factors such as agency staff turnover do not limit the state's reporting capabilities.

Provider Type	Capacity Directionality (Increase, Decrease, Stable or Unable to report)
Providers	Increase
Community Mental Health Centers (CMHCs)	Increase
Intensive Outpatient or Partial Hospitalization Providers	Increase
Residential Mental Health Treatment Facilities	*Unable to Report*
Inpatient	*Unable to Report*
Institutions for Mental Disease (IMDs)	*Unable to Report*

Crisis Stabilization Services	Increase
Federally Qualified Health Centers (FQHCs)	Increase

C.4. NEXT STEPS

IE Recommendation	Alabama's Proposed Next Steps and Planned Performance Improvement Activities
Milestone 1: 1) Improve accuracy of measurement of diabetes control for the adult SMI population.	As the two relevant diabetes measures (HPCMI-AD and HBD-AD) have the same challenges with missing data that is coded as "poor control," the state does not plan to change the reporting measure at this time. The state is working with providers to improve documentation and reduce the number of missing results.
Milestone 2: 1) Conduct an assessment of the contributing factors or barriers to low follow-up rates for post-hospitalization or ED visits for mental illness or alcohol and other drug use. 2) Based on the assessment findings, work with providers to make process improvements to follow-up protocols	The state will coordinate with the Alabama Coordinated Health Network (ACHN) to reach out to recipients within a 7–10-day time period following an inpatient stay to ensure that follow up appointments were scheduled at discharge by the psychiatric hospital. The state will also encourage psychiatric hospital representatives to reach out for follow-up connections for all inpatient recipients within 30 days of discharge.
Provider Availability Assessment Improve documentation and strengthen methodology to remedy data quality issues in the annual PAA.	The state will work to improve reporting by: • Engaging with data analytics staff and other stakeholders to identify challenges, review data sources and methodologies • Document decisions and develop a feasible timeline for compliance and reporting

D. ATTACHMENTS

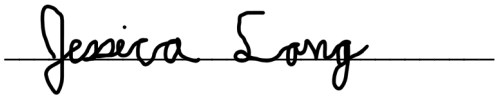
1. INDEPENDENT ASSESSOR DESCRIPTION

Public Consulting Group (PCG) serves as the Independent Evaluator for Alabama's Section 1115 IMD Waiver for SMI. The Mid-Point Assessment deliverable is included in PCG's scope as IE.

The PCG Evaluation Team worked with the Alabama Medicaid Agency to develop and conduct the Mid-Point Assessment. The IE and state ensured that the MPA was fair, impartial, and accurate by taking the following steps:

- The IE reviewed the goals, process, CMS-guidance, and format of the MPA with the state in advance of initiating data collection and drafting
- The IE, state Medicaid agency program leadership and data analytics staff, and implementing provider partners (when appropriate) met to discuss any data quality issues or reporting inconsistencies related to the MPA data sources
- The IE analyzed data, drafted the report, made risk rating determinations, and developed recommendations independently of the state
- The IE provided the state ample time to review and respond to the MPA draft, as outlined in the STCs. The IE appreciates the state's thoughtful review and feedback, but notes that it did not influence the independent determination of the milestone risk rating determinations.

As the Lead Evaluator of this Independent Evaluation, I attest that there are no conflicts of interest between the PCG Evaluation Team members who conducted the Mid-Point Assessment and the Alabama Medicaid Agency.

 (signature)

Jessica Lang, Director of Evaluation (name, title)

7/11/25 (date)

APPENDIX A: SMI/SED CRITICAL MONITORING METRICS

Metric #	SMI/SED Monitoring Metric Name	Inclusion in AL 1115 SMI MPA	Independent Assessor Notes
Milestone 1: Ensuring quality of care in psychiatric hospitals and residential settings			
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	N/A	Demonstration population does not include children or adolescents.
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	N/A	State did not report on this measure in CMS-approved monitoring reports.
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Included	
Milestone 2: Improving care coordination and transitions to community-based care			
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care (PMH-20)	N/A	State did not report on this measure in CMS-approved monitoring reports.
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	Included	
7	Follow-up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	N/A	Demonstration population does not include children.
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Included	
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	Included	
10	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)	Included	
Milestone 3: Increasing access to continuum of care including crisis stabilization services			
19	Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs)	Included	
Milestone 4: Earlier identification and engagement in treatment including through increased integration			
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SMI	Included	
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	N/A	Demonstration population does not include children or adolescents.
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Included	

APPENDIX B: STAKEHOLDER CONVERSATION GUIDE

AL Section 1115 IMD Waiver for SMI
Mid-Point Assessment
Stakeholder Conversation Guide

Topics for Discussion:

Implementing the Demonstration and Concurrent Initiatives

1. The end of the COVID-19 Public Health Emergency coincided with the second year of the Demonstration. Did the pandemic and the PHE impact the implementation of the demonstration? If so, how?
    - For example, use of telehealth for SMI services
2. Alabama is in the process of implementing a Certified Community Behavioral Health Clinic (CCBHC) model in the state. How is implementation of that model progressing?
    - Challenges, facilitators of success
    - Early successes

Impact of the Demonstration

3. How has the IMD waiver and its provision to cover acute care services during short term stays in IMDs for Medicaid beneficiaries with SMI impacted the state's capacity to provide services for individuals with SMI?

4. Alabama has made significant investments in provider capacity for SMI services since 2022. From your perspective, what impact have these investments had on patients, families, providers, or the state systems they interact with?
    - Mobile crisis teams
    - Crisis centers

Other

5. Is there anything else you'd like to share about the demonstration and related activities?