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State/Territory Name: Alabama

State Plan Amendment (SPA) #: 23-0012

This file contains the following documents in the order listed:

1) Approval Letter
2) Companion Letter
3) Summary Form (with 179-like data)
4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

August 28, 2023

Stephanie McGee Azar, Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

Re: Alabama State Plan Amendment (SPA) 23-0012

Dear Commissioner Azar:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) AL-23-0012. This amendment proposes to allow audio only services through telemedicine as described in the Medicaid Telemedicine Policy.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR Section 410.78. This letter is to inform you that Alabama Medicaid SPA 23-0012 was approved on August 28, 2023, with an effective date of June 1, 2023.

If you have any questions, please contact Rita E. Nimmons at (404) 562-7415 or via email at Rita.Nimmons@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Stephanie Lindsay

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

August 28, 2023

Stephanie McGee Azar, Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

Re: Alabama State Plan Amendment (SPA) 23-0012

Dear Commissioner Azar:

This letter is sent as a companion to the Centers for Medicare & Medicaid Services' approval of Alabama (AL) State Plan Amendment (SPA) Transmittal Number (TN) 23-0012, which updates the physician services and rehabilitative services benefits to allow for services to be delivered via audio only telehealth. During our review of AL 23-0012, we identified the following same page review concerns on Attachment 3.1-A, Page 2.5 that need to be addressed.

Federally Qualified Health Center and Rural Health Clinic Services

The state indicates on the plan page that physician visits in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are covered under the physician services benefit. Per sections 1905(a)(2)(B) and 1905(l)(1) of the Act, states must cover the core Medicare RHC services, including physician services, under the RHC benefit; and per sections 1905(a)(2)(C) and 1905(l)(2)(A) of the Act, states must cover the core Medicare FQHC services, including physician services, under the FQHC benefit. Thus, physician services in an FQHC or RHC are not coverable under the physician services benefit but rather under the FQHC and RHC benefits. Please delete the reference to FQHCs and RHCs from the plan page and if any amount, duration, or scope limitations described on the plan page are appliable to the FQHC and RHC benefits then please also add those limitations to the appropriate plan page.

Scope of Services

The state indicates on the plan page that group therapy and family therapy services are limited to beneficiaries with a psychiatric diagnosis. Per 42 CFR 440.230(c), a state may not limit the amount, duration, or scope of a mandatory benefit (such as physician services) based solely on the diagnosis, type of illness, or condition of the beneficiary. In addition, the state does not need to describe the discreet services covered under the physician services benefit. Please either delete the psychiatric diagnosis limitations for group therapy and family therapy services; or simply delete the group therapy and family therapy service descriptions from the plan page.

Sufficiency

The state indicates on the plan page that physician visits are limited to:

- No more than 14 visits per calendar year in offices, hospital outpatient settings, or nursing facilities;
- Up to 16 inpatient dates of service per calendar year in inpatient hospitals; and
- One per recipient, per physician, per calendar year for psychiatric evaluations or testing.

It is not clear from the plan page or written correspondence if these limits may be exceeded based upon medical necessity. Per 42 CFR 440.230(b), each service must be sufficient in amount, duration, or scope to achieve its purpose. Please clarify on the plan page if each limit can be exceeded based upon medical necessity. For any limit that cannot be exceeded when medically necessary, the state will need to answer the following questions:

a. What is the reason for the limitation? If the reason for the limitation is duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes has the state tried or considered to address this matter?

b. What is the clinical purpose of the benefit, and will that purpose be achieved even with the limit?

c. Using data within the last 12 months, what percentage of Medicaid beneficiaries utilized the maximum amount of the service? Please provide this information for the following eligibility groups:

    i. Aged, Blind and Disabled
    ii. Non-Dually Eligible Adults (for analyses of services for which Medicare would not be primary payer, otherwise the analysis would include dually eligible individuals)
    iii. Pregnant Women
    iv. Parents/Caretakers /Other Non-Disabled Adults
    v. Adult expansion group

d. If the data requested above are not available or are not relevant to demonstrating the sufficiency of the limited benefit, please indicate support for the scope of services through clinical literature or evidence-based practice guidelines or describe your consultation with your provider community or others that resulted in an assurance that the proposed scope of services has meaningful clinical merit to achieve its intended purpose.

e. Are there any exemptions to the proposed limitations? If so, how was this exemption determined to be appropriate? Does the state have a process for granting other exemptions if similar circumstances warrant? (e.g., if there is an exemption for individuals with one condition because their needs are greater, is there a process for other individuals with conditions that result in greater needs to request an exemption?)

f. Please describe what will or is likely to occur to beneficiaries who will be impacted by this limitation. If the limit cannot be exceeded based on a determination of medical necessity:

   i. How will those affected by the limitation obtain the medical services they need beyond the stated limits?
   ii. Will beneficiaries be billed and expected to pay for any care that may not be covered? Or instead, will the provider or practitioner be expected to absorb the costs of the provided services?
   iii. Will beneficiaries be reassessed to determine need for the service prior to the plan amendment's effective date?

g. How is the limitation tracked? How are providers and beneficiaries informed in advance, so they know they have reached the limit? Please summarize the process.

If you have any questions, please contact Rita E. Nimmons at (404) 562-7415 or via email at Rita.Nimmons@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

cc: Stephanie Lindsay

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 3 — 0 0 1 2

2. STATE: A L

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: June 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
~~Title XIX of the Social Security Act, 42CFR Section 410.78~~
42 CFR 440.50 and 42 CFR 440.130(d)

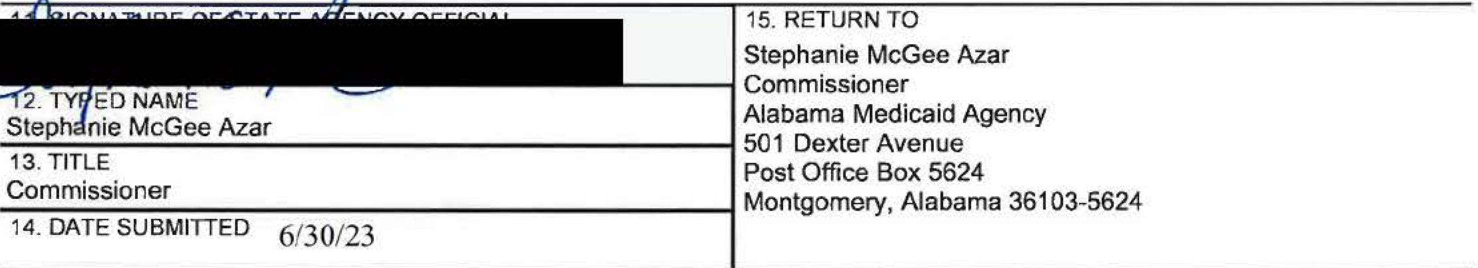
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Page 2.5
Attachment 3.1-A Page 6.13f.5

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Page 2.5 (AL-11-018)
Attachment 3.1-A Page 6.13f.5 (AL-18-0007)

9. SUBJECT OF AMENDMENT
The purpose of these changes is to allow audio only services through telemedicine as described in the Medicaid Telemedicine Policy.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Governor's designee on file via letter with CMS



11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Stephanie McGee Azar

13. TITLE
Commissioner

14. DATE SUBMITTED 6/30/23

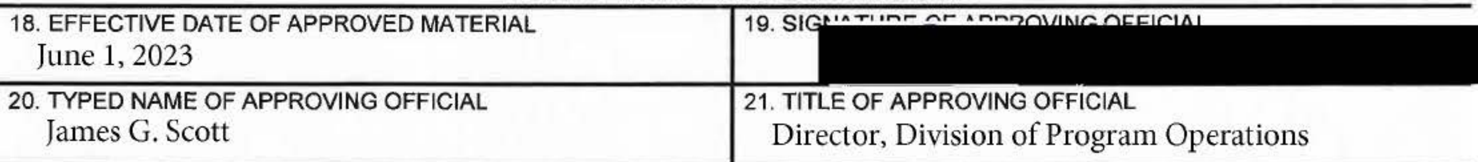
15. RETURN TO
Stephanie McGee Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR CMS USE ONLY

16. DATE RECEIVED
June 30, 2023

17. DATE APPROVED
August 28, 2023

PLAN APPROVED - ONE COPY ATTACHED



18. EFFECTIVE DATE OF APPROVED MATERIAL
June 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

Box #5 - pen & ink change via email 8/8/23
Box #14 - state added submission date via email 8/9/23 which was not on the original Form 179

5a. **Physician's services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.**

Effective Date: 06/01/2023

1. Physician visits in offices, hospital outpatient settings, nursing facilities, Federally Qualified Health Centers, and Rural Health Clinics. Within each calendar year each recipient is limited to no more than a total of 14 physician visits in offices, hospital outpatient settings, nursing facilities, Federally Qualified Health Centers, or Rural Health Clinics. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, psychotherapy (individual, family, or group), and care by ophthalmologists for eye disease. Physician visits provided in a hospital outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year.

Effective Date: 01/01/92

2. Physician visits to hospital inpatients. In addition to the 14 physician visits referred to in paragraph a. above, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider.

Effective Date: 10/01/94

3. Psychiatric evaluations or testing. These are covered services when medically necessary and given by a physician in person. Psychiatric evaluations or tests are limited to one per recipient, per physician, per calendar year. These visits are counted as part of the yearly quota of 14.
4. Psychotherapy visits. These are covered services when medically necessary and given by a physician in person. These visits are counted as part of the yearly quota of 14.
5. Group therapy. This is a covered service when the patient has a psychiatric diagnosis and the therapy is prescribed and performed by a physician in person. These visits are counted as part of the yearly quota of 14.
6. Family therapy. This is a covered service when medically necessary for a recipient with a psychiatric diagnosis. These visits are counted as part of the yearly quota of 14 for the recipient with the psychiatric diagnosis.

13. Other Diagnostic, screening, preventing, and rehabilitative services, i.e., other than those provided elsewhere in the plan. ---(Continued)
13.d. Rehabilitative services ---Continued

Effective Date: 06/01/2023
(27) Nursing Assessment and Care – Nursing Assessment and Care services are (contacts with an individual to monitor, evaluate, assess, establish nursing goals, and/or carry out physicians' orders regarding treatment and rehabilitation of the physical and/or behavioral health conditions of an individual as specified in the individualized recovery plan. It includes providing special nursing assessments to observe, monitor and care for physical, nutritional and psychological issues or crises manifested in the course of the individual's treatment; to assess and monitor individual's response to medication to determine the need to continue medication and/or for a physician referral for a medication review; assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc.); venipuncture required to monitor and assess mental health, substance disorders or directly related conditions, and to monitor side effects of psychotropic medication; consultation with the individual's family and/or significant others for the benefit of the client about medical and nutritional issues; to determine biological, psychological, and social factors which impact the individual's physical health and to subsequently promote wellness and healthy behavior and provide medication education and medication self-administration training to the individual and family.

Eligible Provider Type:
- Licensed Registered Nurse
- Licensed Practical Nurse
- Certified Nursing Assistant
- MAC Worker (operating within their scope of practice)

Billing Unit: 15 minutes
Maximum Units: 2 units per day in a specialized level of care; 732 units per year

(28) Outpatient Detoxification – Face-to-face interactions with a recipient for the purpose of medically managing mild to moderate withdrawal symptoms from alcohol and/or other drugs in an ambulatory setting. Services are provided in regularly scheduled sessions under a defined set of policies, procedures, and medical protocols by authorized medical personnel.

Eligible Provider Type:
- Rehabilitative Services Professional (all types)
- QSAP II
- QSAP III
- Certified Recovery Support Specialist (CRSS)
- QPP, with specialized training
- Licensed Registered Nurse
- Licensed Practical Nurse