ALABAMA MEDICAID AGENCY

Medical Care Advisory Committee

MINUTES

March 16, 2015

Attendees

Lawrence Gardella, Louise Jones, Katrina Magdon, Jim Reddoch, Faye Nelson representing Nancy Buckner, Greg Carlson representing Jim Carnes

Medicaid Attendees

Dr. Don Williamson, Acting Commissioner Stephanie Azar, Dr. Robert Moon, Kathy Hall, Flake Oakley, Marty Redden, Theresa Richburg, Annie Smith, Cynthia Dobyne, Robert Kelly, Gary Parker, Karen Wainwright, Paul McWhorter, James Whitehead, Robin Rawls, Audrey Hopkins, Drew Nelson

Call to Order

The Medical Care Advisory Committee Meeting was called to order by Acting Commissioner Stephanie Azar at 2:14 p.m. Commissioner Azar welcomed everyone to the meeting. She directed the meeting toward Dr. Don Williamson to give the updates on Regional Care Organizations (RCO), Legislative Session, and the Medicaid budget status.

RCO, Legislature, Budget Update

Dr. Don Williamson informed the Committee that the Medicaid Agency is moving forward with the implementation of RCOs. For the RCOs to work well, legislature must appropriate sufficient funds into the budget for the amount equivalent to the operational expense. Another big issue is the 1115 Waiver. He stated that there has been meaningful discussions with CMS during the last 3 months about the 1115 Waiver along with several visits to Washington to discuss this issue. Another meeting has been scheduled with CMS in April for further decisions.

Communications: RCO Outreach Update

Robin Rawls stated that during the past several months, the Agency has been performing outreach activities designed to inform providers of the changes ahead due to RCOs. RCOs are locally-led managed care systems that will ultimately provide healthcare services to most Medicaid enrollees at an established cost under the supervision and approval of the Medicaid Agency. RCOs are nonprofit entities, incorporated in Alabama. Implementation of the full-risk RCOs is scheduled to begin no later than October 1, 2016. Approximately two-thirds of Alabama Medicaid's eligible population will receive their care via an RCO. One of the most important responsibilities of the state is to ensure that RCOs are able to meet all requirements required by law and comply with regulations developed to implementation of the law. (Appendix I)

RCO Implementation and Delivery Reform Incentive Payment Overview (DSRIP)

Dr. Moon stated that it is not known yet how the 1115 Waiver will transpire. One possible option is to add additional federal funding through the Delivery System Reform Incentive Payment (DSRIP) Program. He directed the meeting toward Drew Nelson to give the power point presentation on RCO implementation and the DSRIP Program.

Drew Nelson informed the Committee that the Agency has accomplished key milestones to further the design and implementation of RCOs. The process began in the year 2012. In 2013, Senate Bill 340 and the RCO Regions were established. In 2014, Senate Bill 459 was established, Section 1115 application was submitted to CMS, RCO draft contract was developed, and the probationary RCO were approved. RCOs are designed to give providers financial incentives to work together to improve people's health and reduce costs. RCOs were also designed to use local leaders and providers to achieve state wide goals. (See Appendix II)

DSRIP is a program funded by the federal government in a partnership with states to achieve transformation in the healthcare system. The Agency is developing a DSRIP program to help Alabama reach the objectives of the RCO program. In the coming months, the Agency will collaborate with stakeholders to refine DSRIP program design activities. (See Appendix II)

Eligibility Update

Paul McWhorter gave a brief update of the Eligibility and Enrollment System. A new development team has assumed responsibility for continued development and enhancement of the Eligibility and Enrollment system. The E&E system has been named the Centralized Alabama Recipient Eligibility System (CARES). Since implementation of Express Lane Eligibility (ELE), the data has successfully matched over 25,000 pending applicants. (Appendix III)

ADJOURNMENT

There being no further business to come before the Committee, the Medical Care Advisory Committee was adjourned by Acting Commissioner Stephanie Azar at 2:58 p.m.

Stephanie McGee Azar,
Acting Commissioner

Audrey Hopkins,
Recorder

MEDICAL CARE ADVISORY COMMITTEE MEETING

Monday, March 16, 2015
Medicaid Boardroom
2:00 P.M.

AGENDA

1. Opening Remarks
   Stephanie M. Azar, Acting Commissioner

2. Regional Care Organizations (RCO) Ongoing Developments
   Donald E. Williamson, MD, Chairman, Medicaid Transition Task Force

   a. Legislative Session
   b. Budget Status

3. Communications: RCO Outreach Activities
   Robin Rawls

4. Delivery Reform Incentive Payment Overview
   Robert Moon, MD, Deputy Commissioner Health Systems/Chief Medical Officer and Drew Nelson, MPH

5. Eligibility Update
   Gretel Felton

6. Open Forum

7. Closing Remarks/Adjourn
   Stephanie M. Azar, Acting Commissioner

Alabama Medicaid's Regional Care Organizations

What are RCOs?

Regional Care Organizations (RCOs) are locally-led managed care systems that will ultimately provide healthcare services to most Medicaid enrollees at an established cost under the supervision and approval of the Alabama Medicaid Agency.

State legislation passed in 2013 and updated in 2014 created the new managed care structure to enable Medicaid to move away from a volume-based, fee-for-service environment to a payment system that incentivizes the delivery of quality health care and improved health outcomes.

Under the new structure, Alabama Medicaid will enter into contracts with RCOs to provide certain covered services for Medicaid patients at an established cost. The new system of care is based on a recommendation from the Alabama Medicaid Advisory Commission, created by Governor Robert Bentley in October 2012 to address ways to improve Medicaid's financial stability while also providing high-quality patient care.

How is an RCO different from commercial managed care?

RCOs are uniquely Alabama entities. By law, they are non-profit entities, incorporated in Alabama. They are governed by a board which includes both risk-bearing (12) and non-risk bearing (8) members.

Risk bearers contribute cash, capital or other assets to the RCO. Non-risk bearing members include statutorily-required appointments of five medical professionals who provide care to Medicaid recipients in the region in which the RCO operates. Three must be primary care physicians, including one from a federally qualified health center (FQHC), one optometrist and one pharmacist. The board must also include a business executive who works in the region and is nominated by a chamber of commerce in the region. The Citizens' Advisory Committee chair also serves on the governing board as does a CAC member who represents either Alabama Arise or a group that is part of the Disabilities Leadership Coalition of Alabama.

State law also requires each RCO to have a Citizens' Advisory Committee to advise on ways the RCO may be more efficient in providing quality care to Medicaid recipients. The CAC is to be inclusive and reflect the demographics and diversity of the state.

When will this system start and how will it work?

Implementation of full-risk Regional Care Organizations is slated to begin no later than October 1, 2016. At that time, Alabama Medicaid will pay a set monthly amount to each RCO which in turn will be responsible for paying for all RCO-covered services.

Why are there five RCO regions and how were they chosen?

As required by state law, the state established regions that would ensure that there were a sufficient number of Medicaid recipients (as determined by an actuary) in each region. In developing the regions, state officials also sought to honor existing referral patterns, to keep health systems together when possible and to allow for more than one RCO in a region.

Will RCOs save money for the state?

There are four major factors that impact Medicaid costs: Enrollment, inflation, benefit package and federally-determined match rate (FMAP), most of which Alabama Medicaid has little control over. Federal eligibility mandates the state has no control over have increased Alabama's overall enrollment by almost 300,000 since 2007. The federal matching rate is based on economic factors over three years. Even so, Alabama Medicaid has one of the lowest costs per eligible in the nation.

Reforming the payment and finance system will not change the match rate and the people enrolled, but it potentially changes the incentives within the system. The incentive for providers will be to switch to value-based purchasing that will result in more appropriate utilization. For Medicaid's recipients, case management will ensure continuity of care and shift care to less expensive settings. The goal in moving to managed care is to shift the focus from visits and volume to outcomes and quality and give Medicaid the opportunity to "bend the cost curve" to provide a more predictable budgeting environment for the state legislature and better outcomes for Medicaid recipients.

What will Medicaid do to make sure that the quality of care that is provided to Medicaid recipients is not diminished under RCOs?

State law required the formation of a Quality Assurance Committee comprised of practicing healthcare professionals, 60 percent of which must be physicians. This group approved 42 quality measures that will be used for monitoring RCOs' performance, 10 of which will be incentivized under the new managed care system.

All but one of the 42 measures are nationally recognized and validated which will allow Alabama to compare its performance to other states and national benchmarks. The measures not only include metrics related to diabetes, asthma and well-child care, but mental and behavioral health, care coordination and if care is provided in the most appropriate location.

Update on Regional Care Organization (RCO) Implementation and Preliminary Framework for Delivery System Reform Incentive Payment (DSRIP) Program

March 16, 2015

Disclaimer

- The Alabama Medicaid Agency has not received approval for the 1115 Demonstration Application submitted in mid-2014
- Information provided in this presentation is tentative based on ultimate CMS approval

Agenda

I. **Update on Regional Care Organization (RCO) Implementation**
- RCO Development to Date
- Provider-Led Managed Care
- RCO Eligible Populations
- RCO Covered Services
- Seeking Authority to Implement RCOs
- RCO Regions and Probationary RCOs
- Probationary Certification Overview

II. **Preliminary Framework for Delivery System Reform Incentive Payment (DSRIP) Program**
- DSRIP Overview
- Alabama DSRIP Design
- Alabama's Healthcare Landscape to Inform DSRIP
- RCO Program Objectives and DSRIP Targeted Areas
- Identification of Preliminary DSRIP Projects
- Preliminary DSRIP Projects
- Overview of RCO Program Effectiveness, RCO Quality, and DSRIP Measures

III. **Opportunities for Input**
- Next Steps
- Preliminary DSRIP Projects and Objectives

Update on Regional Care Organization (RCO) Implementation

Section 1

Update on RCO Implementation: RCO Development to Date

- In recent years the Agency has accomplished key milestones to further the design and implementation of RCOs

Recent Accomplishments

- Governor Bentley Convened Medicaid Advisory Commission (MAC)
- MAC Submits Reform Plan Recommendations
- Senate Bill 340 Established
- RCO Regions Established
- Senate Bill 459 Established
- Section 1115 Demonstration Application Submitted to CMS
- RCO Draft Contract Developed
- Probationary RCOs Approved

Update on RCO Implementation: Provider-Led Managed Care

- RCOs are designed to help deliver the Agency's transformation goals

Provider-Led Organizations

RCOs are designed to **give providers financial incentives** to work together to **improve people's health** and reduce costs

- Clinicians included in governance structure
- Beneficiary engagement through required RCO Citizens' Advisory Committees
- Accountability through at-risk capitation payments
- Accountability through quality reporting
- Close relationships with provider community
- Investment in local delivery systems

Regionally-Based Organizations

RCOs are designed to **use local leaders and providers** to **achieve statewide goals**

- Use the strengths of the current Patient Care Networks of Alabama and Maternity Care Program in the RCO program design
- Provide local and broad representation of providers and beneficiaries
- Target local needs

Update on RCO Implementation: RCO Eligible Populations

- As RCOs achieve success, the future program could be enhanced to include initially excluded populations

RCO Enrollment	Populations
Mandatory	• Recipients of Medicaid for Low Income Families (MLIF) • SOBRA children and adults • Aged, blind & disabled individuals
Voluntary	• Adopted children • Native Americans • Aged, blind, or disabled individuals receiving only optional State supplements • Women who have been screened for breast and cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program
Excluded	• Children in foster care • Children in the custody of the Department of Youth Services • Program of All-Inclusive Care for the Elderly (PACE) participants • Dually eligible beneficiaries • Individuals residing in long-term care facilities • Individuals utilizing home- and community-based waiver Individuals utilizing hospice services • Individuals receiving Refugee Medical Assistance

Note: This is not an exhaustive list of Medicaid populations.

Update on RCO Implementation: RCO Covered Services

RCO Coverage	Services
Included in RCO Benefit Package	Most services within the following categories: • Primary care • Acute care • Behavioral health care • Maternal care services • Post-acute services
Excluded from RCO Benefit Package Until October 2018	• Targeted Case Management • Mental health rehab option services provided by DHR and DYS • Rehabilitative substance abuse services • Children's Specialty Clinic Services • Hearing aid services for children
Excluded from RCO Benefit Package Pending Further Evaluation	• Long term supports and services • Hospice • Institutional and home- and community-based services • Dental services

Note: This is not an exhaustive list of Medicaid services.

Update on RCO Implementation: Seeking Authority to Implement RCOs

- **Federal Authority:** Currently in negotiations for 1115 Demonstration approval
  - Bi-weekly calls with CMS
  - In-person meetings with CMS as needed
- **State Authority:**
  - Code of Alabama, 1975 Section 22-6-150 *et seq*
  - Numerous rules have been developed to govern the administration of the RCO program
  - Draft RCO contract shared with Probationary RCOs and other stakeholders in December 2014

Federal Law
Title XIX of Social Security Act

State Law
Code of Alabama, 1975 Section 22-6-150 *et seq*

Rules
Open for public comment

Contract
- Can expand or extend provisions of rule
- Must include provisions of the rule as minimum requirement
- Restricted to negotiation between AMA and contracted entity

Policy Manuals

Reporting Manual

Other Guidelines

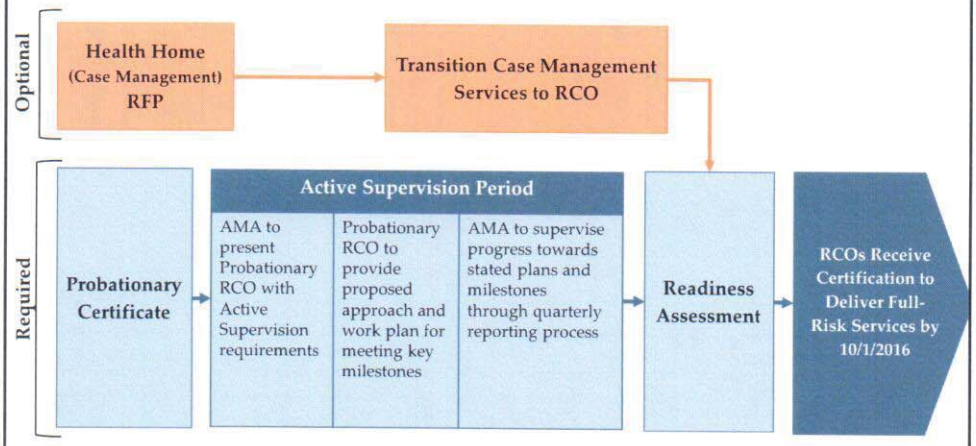
Update on RCO Implementation: RCO Regions and Probationary RCOs

- Alabama is divided into regions for community-led, risk-bearing networks that will coordinate the healthcare services of beneficiaries
- The Agency has certified 11 organizations as Probationary RCOs

Region	Probationary RCOs
A	• Alabama Community Care – Region A • Alabama Healthcare Advantage North • My Care Alabama
B	• Alabama Care Plan • Alabama Healthcare Advantage East
C	• Alabama Community Care – Region C • Alabama Healthcare Advantage West
D	• Alabama Healthcare Advantage • Care Network of Alabama
E	• Alabama Healthcare Advantage South • Gulf Coast Regional Care Organization

Update on RCO Implementation:
Probationary Certification Overview

- Probationary Certification gives an applicant the ability to pursue operations as a Health Home in a region and continue onto Active Supervision
  - Probationary RCOs must demonstrate the ability to take on full-risk in the Readiness Assessment Process



Preliminary Framework for Delivery System Reform Incentive Payment (DSRIP) Program

Section 2

Preliminary Framework for DSRIP Program: DSRIP Overview

- DSRIP is a program funded by the federal government in a partnership with states to achieve transformation in the healthcare system

National DSRIP Programs

Framework Has Evolved Over Time

State	DSRIP Status	DSRIP Dollars (total dollars for all years)	Participating Providers
AL	**Proposed**	**$626 million**	**RCOs: 11**
KS	Protocols	$60 million	Hospitals: 2
NY	Applications	$6.92 billion	Performing Provider Systems: 25
NJ	Implemented	$583.1 million	Hospitals: 64
TX	Implemented	$11.4 billion	Regional Healthcare Partnerships: 20
CA	Implemented	$3.3 billion	Public Hospital Systems: 21

Preliminary Framework for DSRIP Program: Alabama DSRIP Design

- The Agency is developing a DSRIP program to help Alabama reach the objectives of the RCO Program

Overarching DSRIP Principles

- Encourages providers to make measurable improvements in healthcare delivery
- Increase the number of physicians willing to take Medicaid patients
- Incentivizes RCOs to work with providers and other groups to carry out Agency-approved projects

Project Components

- Transform the way care is provided to a broader population than just Medicaid
- Be evidence-based
- Create impetus for changing the fundamental way the delivery system provides care

Exclusions Typically CMS does not allow DSRIP to fund projects that:

- Receive federal funding (i.e., no duplicate funding)
- Are not new or significantly enhanced
- Do not require the achievement of measurable milestones and outcomes

Preliminary Framework for DSRIP Program: Alabama's Healthcare Landscape to Inform DSRIP

- The Agency used access and quality data to identify DSRIP targeted areas and projects

Quality Data: Condition (Kaiser Measure)	Alabama Claims[1]	National Rank[2]
Heart (Heart Disease Deaths per 100,000)	$1,303,975,099	47
Mental Health (Percent of Adults with Poor Mental Health)	$1,263,451,448	49
Diabetes (Percent of Adults with Diabetes)	$607,061,914	46
Chronic Obstructive Pulmonary Disease (COPD)	$385,714,212	n/a
Severe Mental Illness	$361,767,183	n/a
BMI	$240,973,641	
(Percent of Adults who are Overweight or Obese)		44
(Overweight or Obese Children)		42
Asthma	$179,592,038	n/a
Cancer (Cancer Deaths per 100,000)	$126,103,620	43
Maternity	n/a	
(Teen Birth Rate)		37
(Number of Infant Deaths)		36
(Number of Preterm Births)		32
(Number of Low Birth Weight)		31
Access Data	**Alabama[3]**	**National[3]**
Hospital Admissions per 1,000 Population	135	110
Hospital Emergency Room Visits per 1,000 Population	488	424
Hospital Outpatient Visits per 1,000 Population	1,424	2,040

[1] Source: Alabama Claims (2013)
[2] Source: Kaiser Family Foundation State Health Facts Data (2009 – 2012)
[3] Source: Kaiser Family Foundation State Health Facts Data (2012)

Preliminary Framework for DSRIP Program: RCO Program Objectives and DSRIP Targeted Areas

- The DSRIP targeted areas and their associated sample DSRIP measures are designed to support Alabama's RCO program objectives

RCO Program Objectives

- **Care Coordination:** *Improve care coordination and reduce fragmentation in the State's delivery system*
- **Outcomes:** *Create aligned incentives to improve beneficiary clinical outcomes*
- **Access:** *Improve access to healthcare providers*
- **Cost:** *Reduce the rate of growth of Medicaid expenditures*

DSRIP Targeted Areas

Improved Prevention and Management of Chronic Disease	Improved Access to and Care Coordination of Mental Health Services	Improved Birth Outcomes	Improved Financial Stability

Sample DSRIP Measures

- _ percent reduction in unnecessary emergency department visits for targeted conditions
- _ percent reduction in preventable admissions and readmissions in targeted conditions
- >85% screening for mental health / substance abuse in primary care
- Individualized care plans developed for >85% of at risk patients
- _ percent reduction in preventable readmissions in mental health
- _ percent reduction in low-birth weight babies
- _ percent reduction in the Medicaid expenditure growth rate

Preliminary Framework for DSRIP Program: Identification of Preliminary DSRIP Projects

- Pre-approved DSRIP projects were reviewed against requirement criteria to determine a preliminary DSRIP project menu for Alabama

DSRIP Project Requirements

A project should:

1. Address Alabama's:
   - Primary cost drivers (identified through 2013 claims experience analysis)
   - Poor ranking against peers in chronic conditions and access/utilization (captured from Kaiser Family Foundation State Health Facts)
2. Align with the 42 RCO Quality Measures
3. Contribute to achievement of the RCO Program Objectives

Based on these criteria, the Agency identified 11 project categories for reaching improved outcomes in Alabama

Preliminary Framework for DSRIP Program: Preliminary DSRIP Projects

- The Agency will provide requirements for each DSRIP project and will define DSRIP measures (including process and outcome measures) for each project
  - To encourage innovation, RCOs will propose specific evidence-based strategies to meet the measures, subject to approval of the Agency

DSRIP Targeted Area	Preliminary DSRIP Project Categories	Project Components
Chronic Disease	• Evidence-Based Strategies for Disease Management (focus on heart disease, diabetes, and co-morbidities) • Emergency Department (ED) Care Triage for At-Risk Populations with Chronic Conditions • Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions • Medical Village Development Using Existing Hospital Infrastructure	Core requirements in all projects (as appropriate): • Health Homes • Post-acute care management • Care transition management
Mental Health	• Integration of Primary Care and Behavioral Health Services • Community Crisis Stabilization • ED Care Triage for At-Risk Populations with Mental Health Conditions • Care Transitions Intervention Model to Reduce 30-Day Readmissions for Mental Health Conditions	
Birth Outcomes	• Innovative Models of Prenatal Care (e.g., types of home visitation models such as Family Nurse Partnerships) • Care/Referral Community Network • Strategies to Reduce Low Birth Weight Deliveries	

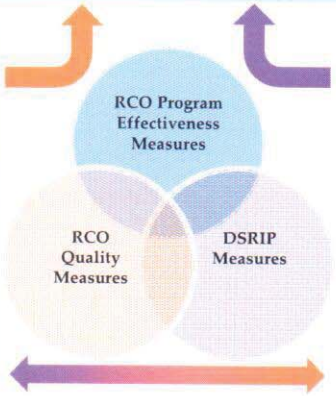
Preliminary Framework for DSRIP Program: Alignment of DSRIP Measures with RCO Program Effectiveness and RCO Quality Measures

RCO Program Effectiveness Measures*

- *Target:* RCO program
- *Purpose:* Assess effectiveness and success of the overall RCO program
- *Measure Categories:* Clinical (Maternity, Utilization and Prevention, Mental Health) and Administrative
- *Measures:* 14 measures

RCO Quality Measures

- *Target:* RCOs
- *Purpose:* Monitor and assess individual RCO performance
- *Measure Categories:* 12 clinical quality domains
- *Measures:* 42 measures (including 10 Quality Withhold Program Incentive Measures)



DSRIP Measures*

- *Target:* DSRIP projects
- *Purpose:* Monitor and assess DSRIP project progress
- *Measure Categories:* administrative, process, and outcomes measures for DSRIP Targeted Areas (Chronic Disease, Mental Health, Birth Outcomes and Financial Stability)
- *Measures:* TBD

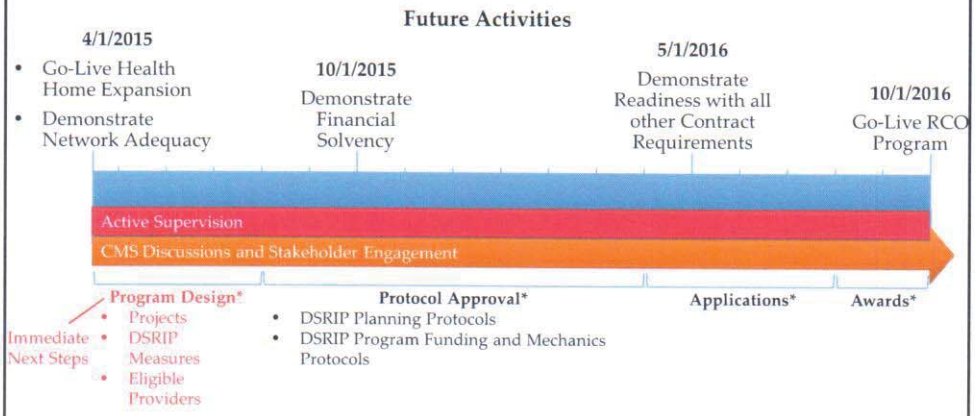
*Under development

Opportunities for Input

Section 3

Opportunities for Input:
Next Steps

- In the coming months, the Agency will collaborate with stakeholders to refine DSRIP program design activities



*Target dates only; actual timeframes will vary based on actual CMS approval

Opportunities for Input:
Preliminary DSRIP Projects/Objectives: Chronic Disease

- DSRIP projects are supported by RCO contract care coordination (including care coordination for the Health Home program and pregnant enrollees) requirements

Projects	Objectives
Evidence-Based Strategies for Disease Management (focus on heart disease, diabetes and co-morbidities)	• Ensure clinical practices in the community and ambulatory care setting use evidence-based disease management strategies • Increase patient self-efficacy and confidence in self-management
Emergency Department (ED) Care Triage for At-Risk Populations with Chronic Conditions	• Develop an evidence-based care coordination and transitional care program to link patients with a primary medical provider (PMP) • Support patient understanding and self-management of health conditions through increased education and expanded PMP relationships • Increase provider to provider communications
Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions	• Provide a 30-day supported transition period after a hospitalization • Ensure discharge directions are understood and implemented by patients
Medical Village Development Using Existing Hospital Infrastructure	• Integrate outpatient service centers providing primary and behavioral health services • Repurpose unneeded inpatient hospital infrastructure into "medical villages" • Provide access to the range of outpatient services needed within that community

Opportunities for Input:
Preliminary DSRIP Projects/Objectives: Mental Health

- DSRIP projects are supported by RCO contract care coordination (including care coordination for the Health Home program and pregnant enrollees) requirements

Projects	Objectives
Integration of Primary Care and Behavioral Health Services	• Integrate mental health and substance abuse with primary care services to ensure coordination of care • Identify behavioral health diagnoses early for rapid treatment • Ensure treatments for medical and behavioral health conditions are compatible • De-stigmatize treatment for behavioral health diagnoses
Community Crisis Stabilization	• Provide readily accessible behavioral health crisis services • Allow access to appropriate level of service and providers
ED Care Triage for At-Risk Populations with Mental Health Conditions	• Develop an evidence-based care coordination and transitional care program to link patients with a primary medical provider (PMP) • Support patient understanding and self-management of health conditions through increased education and expanded PMP relationships • Increase provider to provider communications
Care Transitions Intervention Model to Reduce 30-Day Readmissions for Mental Health Conditions	• Provide a 30-day supported transition period after a hospitalization • Ensure discharge directions are understood and implemented by patients

Opportunities for Input:
Preliminary DSRIP Projects/Objectives: Birth Outcomes

- DSRIP projects are supported by RCO contract care coordination (including care coordination for the Health Home program and pregnant enrollees) requirements

Projects	Objectives
Innovative Models of Prenatal Care (e.g., types of home visitation models such as Family Nurse Partnerships)	• Reduce avoidable poor pregnancy outcomes and subsequent hospitalization • Improve maternal and child health through the first two years of the child's life
Care/Referral Community Network	• Establish a care/referral community network for high risk pregnancies and infants
Strategies to Reduce Low Birth Weight Deliveries	• Reduce low fetal birth weight births and preterm births

Alabama Medicaid Eligibility Update – March 2015

Eligibility and Enrollment System Update:

Progress continues to be made with the development of the E&E System. A new development team has assumed responsibility for continued development and enhancements. The E&E system has been named the Centralized Alabama Recipient Eligibility System (CARES). The CARES team has completed their staffing and finalized the transition from the previous development team. The CARES project continues to be a team effort of a large group of staff from Medicaid, ALLKids, Alabama Department of Public Health (ADPH), Department of Human Resources (DHR), Alabama Department of Senior Services (ADSS), Alabama Department of Mental Health (ADMH) and the Governor's office.

Express Lane Eligibility (ELE) Update:

Using data from Alabama DHR's (Department of Human Resources) Food Assistance and Family Assistance programs, Alabama Medicaid has successfully completed our twenty-fourth run of the automated ELE renewal match and administrative renewals. The numbers for the previous month of automated renewals has a **73.82%** match rate on individuals with Supplemental Assistance Nutrition Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) database with **50.10%** of the cases being automatically renewed due to the ELE match. Alabama Medicaid began a daily ELE match in June, 2013 for pending Medicaid applications. Since implementation the ELE data has successfully matched over **25,000** pending applicants.

Medicaid Income Limits for 2015

To qualify for Medicaid through SSI the income limit for an aged, blind or disabled individual cannot exceed $753 per month or $1,120 for a couple. In addition, resource limits apply. For an individual the resources cannot exceed $2,000 per month or $3,000 per month for a couple. Some examples of resources are: cash, money in checking and savings accounts, loans, promissory notes, stocks, bonds, time deposits (certificates of deposit, annuities, etc), mutual funds, mineral and timber rights, real estate, etc. Individuals must apply with the Social Security Administration for the SSI (Supplemental Security Income) Program.

Nursing Home (Institutionalized) Medicaid:
The Medicaid income limit for individuals eligible for the Nursing Home (institutional) program is $2,199 per month. The resource limit is $2,000 as of the first day of the month. Please see the "Medicaid for the Elderly and Disabled" handout for detailed information.

Home and Community Based Waivers:
The income limits for these waivers are as follows:

Elderly and Disabled Waiver is $2,199 per month.
Independent Living Waiver is $2,199 per month.
Persons With Intellectual Disabilities Waiver is $2,199 per month.
HIV/AIDS Waiver is $2,199 per month.
Technology Assisted Waiver for Adults is $2,199 per month.

The resource limit for these waivers is $2,000 per month.

Medicare Savings Programs:

QMB or Qualified Medicare Beneficiary (effective 02/2015):

Income cannot exceed $1001 per month for an individual.
Income cannot exceed $1,348 per month for a couple.

SLMB or Specified Low Income Medicare Beneficiary (effective 02/2015):

Income cannot exceed $1,197 per month for an individual.
Income cannot exceed $1,613 per month for a couple.

QI-1 or Qualified Individual (effective 02/2015):

Income cannot exceed $1,345 per month for an individual.
Income cannot exceed $1,813 per month for a couple.

NOTE: The resource limits do not apply for these Medicare savings programs. If both spouses are on Medicare, their combined income cannot exceed the couple income limit. If only one spouse has Medicare, then the Medicare spouse who is applying can have income of no more that the individual limit and the income of both spouses combined can be no more than the couple limit.

Modified Adjusted Gross Income (MAGI) (effective 2/2015)

Plan First/Pregnant Women/Children (Ages 0-18):

Income after deductions cannot exceed $1,433 per month for a family of 1
Income after deductions cannot exceed $1,939 per month for a family of 2
Income after deductions cannot exceed $2,445 per month for a family of 3
Income after deductions cannot exceed $2,951 per month for a family of 4

Parent and Caretaker Relatives:

Income after deductions cannot exceed $177 per month for a family of 1
Income after deductions cannot exceed $239 per month for a family of 2
Income after deductions cannot exceed $302 per month for a family of 3
Income after deductions cannot exceed $364 per month for a family of 4

(Please see the eligibility requirements for Pregnant Women, Plan First, Children and Parents and Other Caretaker Relatives programs (formerly SOBRA and MLIF) Pregnant Women/Children/Parents and Caretaker Relatives) handout for family sizes over 4.)

***NOTE: The amount above is based on the 146% Federal Poverty Level (The amount includes the 5% FPL disregard)**

(Revised 02/15)

Monthly Gross Income Guidelines for SOBRA Medicaid and ALL Kids
Valid Beginning February 1, 2015

ALL Kids
Children's Health Insurance Program

If your child is under age 19 and uninsured, APPLY TODAY.

Eligibility is determined by family size and income.

To determine the program for which your child MAY qualify:

- **Find your family size (include legal parent(s), children (natural and adopted) and unborn children.**
- **Find your income. Include all household members' income.**
- **Look at the top of the column for the program name.**

Family Size	Children under 19 Years			
	Monthly		Annual	
	Medicaid	ALL Kids	Medicaid	ALL Kids
1	0-$1,433	$1,434-$3,110	0-$17,185	$17,186-$37,311
2	0-$1,939	$1,940-$4,209	0-$23,258	$23,259-$50,499
3	0-$2,445	$2,446-$5,308	0-$29,332	$29,333-$63,686
4	0-$2,951	$2,952-$6,407	0-$35,405	$35,406-$76,873
5	0-$3,457	$3,458-$7,505	0-$41,479	$41,480-$90,060

THESE ARE THE GUIDELINES
Deductions may be take off your gross (before taxes) monthly income for:

- **Alimony paid**
- **Student loan interest**

NOTE: If self-employed, send in your entire current personal tax return, signed, including both pages of the schedule "C" or "F".

APPLY Online: **adph.org**

For more information or to have an application mailed to you,
call toll-free: 1-888-373-5437 (se habla español)
ALL KIDS IS ADMINISTERED BY THE ALABAMA DEPARTMENT OF PUBLIC HEALTH