Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness

DRAFT FOR PUBLIC COMMENT

Posted January 5, 2021

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I. Executive Summary

Through this waiver application, Alabama Medicaid is seeking authority to reimburse for acute inpatient stays in institutions for mental diseases (IMDs) for Medicaid eligible individuals ages 21-64 with a serious mental illness (SMI). Reimbursement will not be extended for residential stays in an IMD. This request is pursuant to the opportunity announced by the Centers for Medicare and Medicaid Services (CMS) via State Medicaid Director Letter #18-011. Through this Demonstration, Alabama seeks to regain and sustain the benefits achieved under the State's previous participation in the Medicaid Emergency Psychiatric Services Demonstration (MEPD).

The State seeks a waiver of statewideness to target the unique inpatient behavioral health access issues currently present in Mobile, Washington and Baldwin counties. In 2017, the last acute care hospital in the region with an adult psychiatric inpatient unit began serving only geriatric patients. Alabama's state psychiatric hospital, Bryce Hospital, is also located several hours away from the region. By implementing a regional IMD waiver, Alabama will have the opportunity to increase access to critical behavioral health services in the area of the state currently experiencing the most pronounced gaps in the service continuum. A waiver of statewideness will also allow Alabama to target resources to the area of the state with the most need, while evaluating outcomes post-implementation to determine potential options for expansion of the waiver to other regions in the future. While the State proposes to limit reimbursement to IMDs operating in the aforementioned counties, Medicaid enrollees in need of inpatient behavioral health services would be able to access services via the IMDs participating in the Demonstration, regardless of their county of residence.

II. Program Background and Description

Overview of Alabama's Behavioral Health Delivery System

The Alabama Department of Mental Health (ADMH) Division of Mental Health and Substance Abuse Services (DMHSAS) promotes the development of a comprehensive, coordinated system of community-based services for consumers diagnosed with SMI and/or substance use disorders. The division partners with community providers to deliver a comprehensive array of evidence-based prevention, treatment and recovery-based peer support services throughout the state. The public community mental health services system was originally based upon 22 service areas. As of the result of several mergers, there are now 19 public, non-profit regional mental health boards (called 310 Boards based on ACT 310 of the 1967 Regular Session of the Alabama Legislature). There are 24 community mental health centers in the 19 service areas, 19 who also serve as the 310 Board community mental health centers (CMHC) and five who are community mental health centers that operate under a 310 Board CMHC. The Birmingham area has a regional 310 Board and four mental health centers under contract. The Tuscaloosa area has a regional 301 Board with one community mental health center under contract. Outside of the Birmingham area, the mental health centers are organized with a main center in the most populous county or city in their catchment area and satellite offices in outlying counties/areas. The mental health centers provide a continuum of services to all ages with a focus on adults who have a serious mental illness and youth who have a severe emotional disturbance. In some areas, the mental health center also provides services for those who have intellectual disabilities and/or substance use disorders. In addition to the community mental health centers, two of the CMHCs serve as specialty child and adolescent service providers.

Alabama Coordinated Health Networks (ACHN)

The Alabama Medicaid Agency (Agency) received approval in June 2019 of a Section 1915(b) Waiver to implement a consolidated Care Coordination system to address issues with the health status of Medicaid eligible individuals and the level of quality of existing services. Effective in October 2019, the waiver established a managed care system, combining Family Planning Care Coordination services, Patient 1st

(State Plan Amendment (SPA)) Care Coordination services, Health Home (SPA) functions, and Maternity Care (1915(b) Waiver) functions into single, region specific Primary Care Case Management Entities (PCCM-E) throughout the state. PCCM-Es must facilitate care coordination for eligible individuals between primary care providers (PCPs), CMHCs, substance abuse treatment providers, or other behavioral health providers.

PCCM-Es are also tasked with providing discharge planning supports. PCCM-Es are contractually required to establish processes to assist enrollees in transitioning from a psychiatric facility to a community setting. Minimum discharge planning requirements include reviewing daily census at inpatient settings to identify enrollees needing support at discharge and collaborating with hospital or facility discharge planners, care coordinators, and behavioral health staff in preparation for the individual's return to the community. As part of this program, PCCM-E transitional care nurses are required to:

- Complete a face-to-face health risk and psychosocial assessment within ten days of discharge to ensure appropriate home-based support and services are available.
- Develop a care plan to address identified needs.
- Implement medication reconciliation in concert with the physician and transitional pharmacist within ten days of discharge.
- Educate enrollees regarding medical management and provide referrals to resources within ten days of discharge.
- Provide transitional care services until all goals are met.
- Ensure proper transition and coordination with ADMH, Medicaid and CMHCs.

The state will continue to leverage this model for mental health community-based services and supports throughout the demonstration.

Community-Based Services and Supports

Community services are funded through a combination of funding streams, including federal MH Block Grant funds, state funds, Medicaid, Medicare, other third party (insurance), local government, donations, and client fees generated under a sliding fee scale. The level of city and county support for behavioral health providers varies significantly across the state. In addition to contracting with ADMH, providers may also enter local arrangements with the Department of Human Resources, the Department of Youth Services, and local education agencies. In FY 2020, block grant funds were estimated to account for approximately 3% of ADMH contracts for Community Mental Health services while state sources such as the General Fund, Special Mental Health Fund and other state sources accounted for 61% of total resources. Medicaid reimbursements and other federal funding account for an additional 36% of the ADMH Community Mental Health budget. This does not include support that is provided by local sources, the proportion of which varies greatly from center to center.

Assertive Community Treatment (ACT)/ Program for Assertive Community Treatment (PACT)

These teams provide case management, mental health and substance use treatment (provided via the ADMH Substance Abuse Division), basic living skills, vocational rehabilitation, and in some areas of the state peer support services, via multi-disciplinary teams for persons with SMI and co-occurring substance use disorders (SUDs). Eighteen ACT/PACTs are funded via block grant funds from the Substance Abuse and Mental Health Services Administration, and serve persons who are at high risk for admission or readmission to state psychiatric facilities, community-based acute psychiatric hospitals, and jails. The composition of ACT/PACTs may vary by region and provider; however the base model is three full-time team members including a master's-level clinician, a licensed nurse, and a case manager, plus a part-time psychiatrist, and in some areas, a peer support specialist. There are 15 ACT teams across the state and two PACT teams in

the Birmingham area. ACT teams have a one-to-twelve staff-to-persons-served ratio while PACT teams have a one-to-ten staff-to-persons-served ratio. The Jefferson-Blount-St. Clair Mental Health Authority and the University of Alabama at Birmingham's Mental Health Center administer the two PACT teams in the Birmingham area and both teams work with persons they serve to access supportive housing.

Basic Living Skills

These are services provided to individuals or groups in order to improve a person's capacity for independent living. Services include support in the skills necessary for successful transitions to permanent supportive housing (PSH) and for sustaining their own apartment. Basic Living Skills are provided as part of ACT/PACT service, in in-home intensive (IHI) treatment models (see below) for both adults and children with SMI, and as part of outpatient services and day programs.

Certified Peer Specialists (CPS)/ Youth CPSs, Family Peers, Peer Support Specialists, and Peer Bridgers

Peer support providers are individuals uniquely qualified by their own lived experience to support other persons with mental illness and their family members. Peer supports have been in place in Alabama since 1994, starting at Greil Hospital, and have continued to expand to community-based supports via the shifting of funds from hospitals to community services and supports. Peer bridgers support adults transitioning from hospitals in the Birmingham area and at 18 CMHCs and in some residential programs throughout the state.

Current peer supports are funded in some models such as ACT/PACT via block grant funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Recently, ADMH sought more funding for peer supports by working with the Alabama Department of Medicaid to seek federal reimbursement by adding CPS to its latest Medicaid state plan amendment. There are an estimated 50 full- and part-time CPSs, peer support specialists, and peer bridgers across the state. ADMH has pilots underway to expand the use of youth-certified peer specialists and include certified peers on supportive employment teams. JBS Mental Health Authority and Hill Crest Behavioral Health Services in Birmingham have been piloting a youth peer project with adolescent girls in a psychiatric residential treatment facility. ADMH has been working with the Chilton-Shelby Mental Health Center in Calera and AltaPointe Health in Mobile to pilot programs that include certified peer specialists on supportive employment teams.

Day Program Services

Day programs are designed to bridge acute treatment and less intensive services by increasing community living skills via basic living supports, and addressing consumers' clinical needs. Day program services are available across all ADMH CMHC regions and are a longstanding program model in Alabama, funded by Medicaid.

First Episode Psychosis (FEP) Teams

FEP teams are trained to provide support to transition-age youth experiencing the first symptoms of mental illness, who are also often at risk for homelessness. FEP teams are an evidence-based practice that provides timely detection of psychosis/illness, acute care during or following periods of crisis, and recovery-oriented services offered over the first few years following the onset of SMI. Currently, JBS Mental Health Authority is the only provider with a full-fidelity FEP team funded via the SAMHSA Mental Health Block Grant. Jefferson County serves one of the largest populations of transition-age youth experiencing homelessness in the state.

Intensive Day Treatment

This is an active, intermediate-level treatment that specifically addresses a consumer's impairments, deficits, and clinical needs. An initial screening to evaluate the appropriateness of the consumer's participation in the program and to develop an individualized treatment plan is conducted by the CMHC. Various services must be available and provided as indicated by the results of the initial screening including

medication evaluation and management, individual, group, and family therapy, coping skills training, and family and consumer education.

In-Home Intensive (IHI) Treatment (children/youth)/ In-Home Intervention Teams (adults)

These home-based services are provided by a team to youth and adults who need temporary additional support during times of increased symptoms or during transition from a more intense level of service. IHI teams are funded by Alabama Medicaid, and work to defuse crisis situations, stabilize housing, and prevent out-of-home placement for youth. Teams are composed of a rehabilitative services professional (master's level clinician) and a case manager. Services include individual or family counseling, crisis intervention, mental health consultation, basic living skills (as described above), family support, case management, and medication monitoring. There are currently a total of 83 teams, with 32 serving adults and 51 that serve children/youth.

Mobile Crisis Teams and Crisis Response Teams

Mobile response teams focus on defusing crises related to SMI and trauma by working with families and consumers along with law enforcement and hospital emergency departments. These teams provide on-site assessments and de-escalation techniques during crisis situations that help avert unnecessary hospitalizations or involuntary admissions and also educate persons in coping skills and problem-solving to avoid future crises. There are nine mobile crisis teams across the state and six other crisis response teams across Alabama, one of which is a mental health court team. These teams are funded via block grant dollars.

Outpatient Services

Many outpatient services provide intake services for adults with SMI, including psychological evaluations and testing, individual and group counseling services, family therapy services, medical assessments that are integrated with psychiatric assessments, medication monitoring, treatment planning, and crisis intervention supports. Outpatient services are funded by Medicaid.

Projects for Assistance in Transition from Homelessness (PATH)

PATH funds are awarded annually to ADMH by SAMHSA and allocated to five CMHCs in urban areas of the state including Birmingham, Huntsville, Mobile, Montgomery, and Tuscaloosa. Alabama's PATH programs are focused on serving adults and youth with SMI and co-occurring SUDs who are homeless or at risk for homelessness. Services include outreach, screening and diagnostic treatment services, community mental health services, alcohol and drug treatment, case management services, supportive and supervisory services in residential settings, referrals for primary health care services, job training, educational services, and housing search supports. ADMH and CMHC providers of PATH services regularly collaborate with local CoC lead agencies. The Alabama Rural Coalition for the Homeless (ARCH) (also one of the eight CoCs) regularly collaborates with the other seven CoCs and more broadly with the Alabama HUD field office regarding PATH programs across the state.

Supported Employment/Individual Placement and Support (SE/IPS)

SE/IPS services are in the process of being more fully developed by ADMH in Alabama. Currently, ADMH and the Department of Rehabilitation Services collaborate to provide vocational supports and services for employment; however, employment numbers remain relatively low with 13.2% of adults with mental illness employed as of 2016 data. In FY 2014, SAMSHA awarded ADMH a five-year SE grant that supports three IPS pilot programs at AltaPointe Health, the Chilton-Shelby Mental Health Center, and Montgomery Area Mental Health Authority with the aim of increasing the number of persons with SMI working towards competitive employment. IPS is an evidence-based approach that uses employment specialists who explore individualized employment goals, make connections with local employers who offer competitive

employment opportunities, help persons with résumé development and interview training, and provide job coaching to obtain and maintain jobs based on the consumer's preferences.

State Operated Psychiatric Hospitals
There are three state-operated psychiatric inpatient hospitals serving adults in Alabama:

- Bryce Hospital in Tuscaloosa operates an acute unit and an extended care unit.
- Taylor Hardin Secure Medical Facility in Tuscaloosa operates units for Alabama's male forensic psychiatric population.
- Mary Starke Harper Geriatric Psychiatric Center in Tuscaloosa operates units providing specialty geriatric services.

In 2012 an initiative to promote community-based care and reduce reliance on state operated beds resulted in ADMH closures of Greil Memorial Psychiatric Hospital (Montgomery County) on August 31, 2012 and Searcy Hospital (Mobile County) on October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY 2011. Over ninety percent of Greil and Searcy's inpatient capacity has been shifted to local communities. To accomplish this meant building an infrastructure within communities of Region 3 and Region 4 (both in the southern portion of Alabama) which included an array of services to include Designated Mental Health Facilities (DMHF) to provide post-commitment care that would replace this service being provided in a state-run psychiatric hospital.

With ADMH's progress in reducing the institutionalization of individuals with mental illness came an increased number of individuals with SMI being served in community settings and with the potential for a psychiatric emergency. Although Alabama has a number of private hospitals that offer acute psychiatric care and outpatient care, these hospitals often lack capacity and those with greater than 16 beds are unable to receive reimbursement under Medicaid when serving individuals between the ages of 21-64.

Alabama's Participation in MEPD Demonstration
Alabama was one of 11 states selected for the Medicaid Emergency Psychiatric Demonstration. In addition to testing whether Medicaid could support higher quality care at a lower total cost by reimbursing IMDs for certain psychiatric services that previously had been excluded, the shared goal between the state and the CMS was to reduce boarding in hospital emergency departments and provide better continuity of care between acute and community providers, particularly for patients with co-morbidities.[1]

Rationale for Regional Waiver Request
BayPointe Hospital is located in the southwest corner of the state in Mobile, and opened its doors in 2001. The facility currently has an 18-bed capacity to serve adults in psychiatric crisis. EastPointe Hospital, a 66-bed facility in Daphne, opened in January 2012 and offers inpatient psychiatric services to adults in psychiatric crisis. Together these hospitals will serve Mobile, Baldwin and Washington Counties as the primary service area. These are currently the only hospitals in the region with inpatient psychiatric beds serving adults between the ages of 21-64. The counties listed will be the primary service area for patients in the demonstration; however, these facilities often receive patients from all over the state and would receive reimbursement for these individual under the demonstration. Access to these beds should result in a decrease in boarding statewide and improved stabilization of patients in a psychiatric emergency.

[1] https://innovation.cms.gov/innovation-models/medicaid-emergency-psychiatric-demo

Alabama Strategies for Addressing Waiver Milestones

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals

Alabama statute and Alabama Medicaid administrative code currently require licensure of all hospitals operating and/or participating in Medicaid within the state. In addition, psychiatric facilities serving individuals 65 or older and psychiatric facilities serving individuals 21 and younger are currently required to be accredited by the Joint Commission (AL 9.2 Chapter 5, Rule 560 and Chapter 41, Rule 560).

The State will amend Medicaid administrative rule to include requirements for hospitals providing inpatient psychiatric services to individuals aged 21-64 years of age. These rules will include activities associated with ensuring quality of care. Alabama Medicaid has rules in place to ensure that level of care need is met prior to admission as well as in regard to continued stays within inpatient settings for adults. Upon patient admission, an attending physician conducts a thorough mental and physical examination of the patient to determine the admitting diagnosis, any contributing factors and to develop a plan of care that will stabilize the patient and provide for a smooth transition to any post-acute care needed.

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

Alabama administrative code requires that psychiatric hospitals have in effect a written discharge planning process that applies to all patients and includes the following minimum components:

- Identification at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.
- Discharge planning evaluation conducted by registered nurse, social worker, or other appropriately qualified personnel to develop or supervise the development of the evaluation.
- An evaluation of the likelihood a patient will need post-hospital services, the availability of the services and the patient's capacity for self-care or being cared for in the environment from which he or she entered the hospital.
- Completion of the discharge evaluation process on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.
- Development of a discharge plan, with requirement for the hospital to arrange for the initial implementation of the plan.
- Requirement for the hospital to transfer or refer patients, along with necessary medical information, to appropriate licensed facilities, agencies or outpatient services for follow up or ancillary care.

Additionally, the ADMH requires CMHCs to have follow-up appointments within 72 hours for individuals hospitalized under civil or forensic commitment. The state encourages CMHCs to conduct follow-up appointment within 72 hours for all other inpatient psychiatric admissions.

In addition to these standards, ADMH launched the Stepping Up Initiative in 2018. The State expanded the program beyond serving those in jails, to emergency rooms as well. The goal of Alabama's Stepping Up Initiative is to reduce the number of people with SMI in jails and emergency rooms. In June 2018, ADMH released a Request for Proposal (RFP) for CMHCs to apply for an award of $50,000. This award supported intensive case management services to screen, assess, develop a case plan for and link clients to appropriate, necessary mental health (i.e., group/individual mental health counseling, crisis intervention, and court advocacy) and social services (i.e., housing, transportation, food); recruitment for and facilitation of a local planning committee to create supportive local policies, and community outreach to mobilize community support.

Additionally, the IMDs that will participate in the Demonstration provide hospital consultation services for patients who need a psychiatric consult at Mobile area hospitals including Providence, Springhill, USA and

USA Children's and Women's, and Thomas Hospital in Fairhope. Their psychiatrists work with primary care physicians, specialists, nurses and hospital staff to communicate, coordinate and integrate medical and psychiatric care that maximizes the benefit to their mutual patients. If an AltaPointe patient is admitted to any local hospital and needs psychiatric care as well as medical care, the hospital psychiatrist will be a participating-IMD psychiatrist.

Participating IMDs operate crisis response teams (CRTs) that travel to patients in the counties in which the Demonstration will operate (Mobile, Baldwin and Washington). CRT members work with family members, law enforcement and hospital emergency room personnel to diffuse any imminent danger and stabilize the patient. Team members encourage patients in crisis to cooperate with appropriate follow-up treatment so they may avoid unnecessary or involuntary hospitalization.

Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
The ADMH has begun the process to create a full Behavioral Health Crisis Continuum, which will include crisis diversion centers, with three centers created across the state in the next fiscal year. ADMH requested and received $18 million for Fiscal Year 2021, to establish and stand up the first pilot Crisis Diversion Centers in the state. These centers would be a designated place for communities, law enforcement, first responders, and hospitals to take an individual that is in mental health or substance abuse crisis. At the center, the individual could receive stabilization, evaluation, and psychiatric services.

These centers will:

- Reduce the number of hospitalizations and arrests.
- Reduce the frequency of admissions to hospitals.
- Help individuals in crisis achieve stability.
- Achieve sustained recovery and provide linkage to community agencies and organizations, psychiatric and medical services, crisis prevention, and intervention services.

ADMH announced contracts that will result in three crisis diversion centers opening in Montgomery, Mobile, and Huntsville counties. These centers are expected to be operational in the second quarter of 2021.

CMHCs train their local community partners, such as schools, courts, detention facilities, and child-welfare, on services and resources for diversion. Such diversion services include certified peer specialists, intensive care coordinators, in-home teams, ACT teams, court liaisons, school-based mental health collaboration, drop-in centers, supported employment programs, and FEP team. Staff are trained in engagement and outreach, so they can be the front line in actively engaging with the sites of potential hospitalization diversion such as emergency rooms, courts, detention facilities, and private inpatient acute units. All CMHCs have funded Juvenile Court Liaisons (JCL) who work directly with the courts to divert kids that come to the courts' attention to the most appropriate resources. In circumstances when hospitalization is warranted, the JCL serves as a care coordinator and remains involved with the youth consumer and their family and the program in which they are receiving inpatient care to assist with the care coordination back to the community and with the needed resources for a smooth transition. With the closures of three state psychiatric hospitals from 2012-2015, a similar process for adults with SMI was implemented. Since the number of SMI adults served is significantly higher, the efforts for reduction of hospitalization is carried out at a local, regional, and state level. At the local level, each CMHC has a point person for the involved entities. There are also four UR Coordinators, one assigned to each region. Through the DMH Mental Illness Community Programs, staff work with key partners and the DMH Civil Commitment Protocol Process as implemented. Starting in December 2016, ADMH staff, State Hospital Staff, and CMHC staff participate in a monthly care coordination process of an extended treatment planning process in which all committed individuals placed in the three state hospitals are staffed.

Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
An increased focus in Alabama has been on development of a system with more focus on integrated behavioral health and primary care. ADMH works closely with the Alabama Primary Health Care Association (APHCA) and are engaged to expand and enhance the efforts of providers around care coordination. At this time, each behavioral health provider has to ensure the linking of primary health care needs and that has been delegated to the local (310 Board) community planning process. There are a variety of avenues that behavioral health providers have implemented to meet the primary health care needs of the individuals they serve. This ranges from linking behavioral health consumers to needed providers, to co-location of primary care providers in a community provider location or a behavioral health provider in a primary health care location, to some early stages of behavioral health providers hiring their own primary health care providers, to developing a more integrated care system of behavioral health providers and primary health care providers in the same location. At present, ADMH and APHCA are exploring strategies for moving toward a more integrated system that ensures the individuals providers serve are able to receive needed care for both their mental health and primary health care needs.

Alabama's First Episode of Psychosis (FEP) program addresses youth and young adults experiencing symptoms of early psychosis. The NOVA (FEP) programs under ADMH are contracted with JBS Mental Health Authority covering Jefferson County, Wellstone, Inc. covering Madison County, and AltaPointe Health System covering Mobile County. These FEP programs utilize well-researched and evidenced based practices to help youth and young adults recover, stay on track in school, locate and maintain employment, and strengthen their relationships with family and support networks. The targeted parameters for the NOVA programs are individuals aged 15-25 years experiencing their first episode of psychosis and who demonstrate a willingness to participate in the program for a period of two years. The FEP programs provide a coordinated array of recovery-oriented services and supports to the individual and their family. Services include family support through multi-family groups, youth and family peer supports, supported employment and education (using the Individual Placement and Support (IPS) model), case management, cognitive behavioral therapy, and low dose anti-psychotic medications, as needed. The coordinated care approach emphasizes shared decision-making and working with individuals to reach their recovery goals. The NOVA programs collaborate with other state agencies to include the Alabama Department of Rehabilitation Services, as well as the state IPS programs as a means of meeting the client's overall vocational and educational needs.

School-Based Mental Health Collaborative is a program in the Office of Mental Illness Community Programs. The success of the collaborative is now being seen all over the state, with 71 school systems and 19 community mental health authorities participating. The collaborative reaches children and adolescents directly in schools every day to assist with mental health issues. New funds for FY21 will allow the addition of 15 school systems to the collaboration. The aim is to achieve greater integration of mental health services between the mental health centers and the public schools and to increase the utilization of evidence-based practices. The integration of these services will foster continuity of care and ensure sustained gains in academic and developmental domains for children, youth, and their families.

III. Demonstration Goals and Objectives

The State's goals are aligned with those of CMS for this waiver opportunity and build upon the successes achieved through Alabama's participation in the MEPD Demonstration, including:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
- Reduced preventable readmissions to acute care hospitals and residential settings.

- Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

IV. Hypotheses and Evaluation Plan

Alabama proposes the following evaluation plan, which has been developed in alignment with CMS evaluation design guidance for SMI 1115 demonstrations. The State will contract with an independent evaluator to conduct this review.

<table>
<tr><th>Objective/Goal</th><th>Hypothesis</th><th>Evaluation Parameters/Methodology</th></tr>
<tr><td colspan="3">Evaluation Questions:
Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings?
How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics?
How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?</td></tr>
<tr><td>GOAL 1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.</td><td>Hypothesis 1. The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.</td><td>Data Sources:
Claims data
Medical records or administrative records
Interviews or focus groups
Analytic Approach:
Difference-in-differences model
Subgroup analyses
Descriptive quantitative analysis
Qualitative analysis</td></tr>
</table>

<table>
<tr><th>Objective/Goal</th><th>Hypothesis</th><th>Evaluation Parameters/Methodology</th></tr>
<tr><td colspan="3">Evaluation Questions:
Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings?
How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics?
How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings?
Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?</td></tr>
<tr><td>GOAL 2. Reduced preventable readmissions to acute care hospitals and residential settings.</td><td>Hypothesis 2. The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.</td><td>Data Sources:
Claims data
Medical records
Beneficiary survey
Analytic Approach:
Difference-in-difference models
Qualitative analysis
Descriptive quantitative analysis</td></tr>
<tr><td colspan="3">Evaluation Questions:
To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state?
To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization?
To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?</td></tr>
<tr><td>GOAL 3. Improved 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</td><td>Hypothesis 3. The demonstration will result in improved availability of crisis stabilization services throughout the state.</td><td>Data Sources:
Annual assessments of availability of mental health services
AHRF data
NMHSS survey
Administrative data
Provider survey
Analytic Approach:
Descriptive quantitative analysis</td></tr>
</table>

<table>
<tr><th>Objective/Goal</th><th>Hypothesis</th><th>Evaluation Parameters/Methodology</th></tr>
<tr><td colspan="3">Evaluation Questions:
Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health needs?
To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED?
To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services?
How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics?
Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED improve under the demonstration?</td></tr>
<tr><td>GOAL 4. Improved 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</td><td>Hypothesis 4. Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.</td><td>Data Sources:
Claims data
Annual assessments of availability of mental health services
AHRF
NMHSS survey
Administrative data
URS
Medical records
Analytic Approach:
Descriptive quantitative analysis
Chi squared analysis
Difference-in-differences model</td></tr>
<tr><td colspan="3">Evaluation Questions:
Does the demonstration result in improved care coordination for beneficiaries with SMI/SED?
Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?
Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities?
How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?</td></tr>
</table>

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Hypothesis 5.** The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Data Sources:** • Claims data • Medical records • Interviews or focus groups • Facility records **Analytic Approach:** • Difference-in-differences model • Descriptive quantitative analysis • Qualitative analysis

V. Impact on Enrollment, Benefits, Cost Sharing and Delivery System

Demonstration Eligibility

All Alabama Medicaid enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, and between the ages of 21-64, will be eligible for acute inpatient stays in an IMD under the waiver. Only the eligibility groups outlined in the table below will not be eligible for stays in an IMD as they receive limited Medicaid benefits only.

Table 1: Eligibility Groups Excluded from the Demonstration

Eligibility Group Name	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(19)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning – Authorized through Alabama's Plan First §1115 Family Planning Demonstration	1902(a)(10)(A)(ii)(XXI)

Enrollment

This 1115 waiver is not anticipated to impact Alabama Medicaid enrollment over the course of the five-year demonstration, as there are no waiver-specific eligibility criteria included.

Benefits

As described above, Alabama offers a wide range of Medicaid covered behavioral health benefits. Through this waiver application, the State will expand the settings which are eligible for reimbursement for clinically appropriate short term stays for acute psychiatric care. All services will be subject to medical necessity as further described in the attached Implementation Plan. In accordance with CMS requirements, the State will not reimburse for stays of more than 60 consecutive days.

Cost Sharing

All cost-sharing for services provided through this waiver will be consistent with the Medicaid State Plan applicable to an enrollee's specific eligibility category. No modifications are proposed through this waiver application.

Delivery System

The State seeks a waiver of the IMD exclusion for all Medicaid beneficiaries ages 21-64, regardless of delivery system. No modifications to the current Alabama Medicaid fee-for-service or primary care case management entity (PCCM-E) arrangements are proposed through this waiver application. All enrollees will continue to receive services through their current delivery system.

Payment Rates for Services

Payment methodologies will be consistent with those approved in the Medicaid State Plan.

VI. Waiver Implementation

This waiver will be implemented in Mobile, Washington and Baldwin counties, with a requested effective date of October 1, 2021. The State requests a five-year waiver approval for this demonstration.

VII. Requested Waivers and Expenditure Authority

The State requests expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

The State also requests a waiver of §1902(a) of the Social Security Act regarding statewideness to the extent necessary to enable Alabama to reimburse IMDs for short term psychiatric stays in Mobile, Washington and Baldwin counties. Medicaid enrollees will be permitted to access IMD services regardless of their county of residence.

VIII. Financing and Budget Neutrality

Budget Neutrality Overview

This demonstration would permit Alabama to expand coverage of IMD residential and inpatient treatment services for individuals with SMI or SED. In state fiscal year 2019 (October 1, 2018 to September 30, 2019) there were 1,055,720 individuals enrolled in the Medicaid program. This demonstration is not expected to impact, (increase or decrease), the total number of individuals enrolled in Medicaid. The five-year demonstration is proposed to begin October 1, 2021 and end September 30, 2026, each proposed demonstration year (DY) is outlined in Table 2:

Table 2 – Demonstration Years

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Begin and End Dates	10/1/2021 – 9/30/2022	10/1/2022 – 9/30/2023	10/1/2023 – 9/30/2024	10/1/2024 – 9/30/2025	10/1/2025 – 9/30/2026

Historical Data

Alabama was one of 11 states selected for the Medicaid Emergency Psychiatric Demonstration (MEPD). The MEPD was effective for the period between July 2012 and March 2015. Historical enrollment and expenditures for state fiscal year (SFY) 2013 (October 1, 2012 – September 30, 2013) and 2014 (October 1, 2013 – September 30, 2014) from the MEPD are presented in Table 3 below.

Table 3 - Historical Medicaid Emergency Psychiatric Demonstration (MEPD) Caseload and Expenditures

	SFY 2013 (October 1, 2012 to September 30, 2013)	SFY 2014 (October 1, 2013 to September 30, 2014)
MEPD Caseload (Member Months)	533	648
IMD Expenditures	$2,301,000	$2,914,248
State Plan Services Expenditures	$1,234,459	$1,401,499
Total Expenditures	**$3,535,459**	**$4,315,747**
Average IMD Length of Stay (days)	**9.3**	**10.6**

Demonstration Enrollment and Expenditures Projections

Projected Without Waiver and With Waiver caseloads, per capita expenditures, and total expenditures for Medicaid beneficiaries whose health care coverage is impacted by the demonstration for each demonstration year are illustrated in Table 4. Projections were developed based on analysis of historical MEPD information and reflect an average IMD length of stay of 30 days.

The available historical MEPD services included two 12-month state fiscal year periods, SFY 2013 and SFY 2014. SFY 2014 was used as a basis to projected expenditures for the demonstration because following the MEPD expiration there were no Medicaid IMD services and expenditures. The absence of IMD services and expenditures is because Alabama operates their Medicaid program on a fee-for-service basis and federally matched expenditures for IMD services are prohibited without demonstration authority.

Without and With Waiver projections are equal because they are considered hypothetical expenditures associated with services added under the demonstration or those that could be otherwise covered under the State Plan or established waiver authorities.

Table 4 – Without and With Waiver Caseload and Expenditure Projections

Demonstration Year	DY1	DY2	DY3	DY4	DY5	5 Year Total
Caseload (Member Months)	698	704	711	718	724	**3,555**
Per Capita (per member per month)						
IMD	$18,102	$18,817	$19,561	$20,334	$21,137	**$19,604**
State Plan Services	$2,949	$3,065	$3,187	$3,313	$3,443	**$3,194**
Total	**$21,051**	**$21,883**	**$22,747**	**$23,646**	**$24,581**	**$22,798**
Expenditures*						
IMD	$12,632,308	$13,253,691	$13,905,640	$14,589,659	$15,307,324	**$69,688,622**
State Plan Services	$2,057,908	$2,159,137	$2,265,344	$2,376,777	$2,493,690	**$11,352,856**
Total	**$14,690,216**	**$15,412,828**	**$16,170,985**	**$16,966,436**	**$17,801,015**	**$81,041,478**
* Totals may differ due to rounding						

Maintenance of Effort

In accordance with the November 13, 2018, CMS State Medicaid Director Letter, the State understands this waiver request is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of outpatient treatment for these conditions.

The following table details the FY 2020 outpatient community-based behavioral health expenditures.

Table 5: Expenditures on Outpatient Community-Based Behavioral Health Services

Medicaid Program	Total Dollars	Federal Dollars	State Dollars
Regular Title XIX	$159,944,589.30	$119,576,003.35	$40,368,585.95
MCHIP	$9,183,747.66	$8,602,884.01	$580,863.65
Total	**$169,128,336.96**	**$128,178,887.36**	**$40,949,449.60**

Alabama is dedicated to maintaining access to community-based services and intends for services authorized within this waiver to complement but not replace these outpatient services. However, Alabama Medicaid offers the following caveat as considerations for measuring MOE based strictly on total expenditures: unpredictable state budgets, particularly in consideration of the COVID-19 public health emergency, may impact the amount of state funding available for services.

IX. Tribal and Public Notice

The State is conducting public and tribal notice in accordance with 42 CFR §431.408. A summary of comments received and any applicable waiver updates in response to comments will be completed pending completion of the public and tribal notice periods.

Appendix 1: Public Notice

Alabama Medicaid Agency

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

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

KAY IVEY
Governor

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

STEPHANIE MCGEE AZA
Commissioner

PUBLIC NOTICE

SUBJECT: INTENT TO SUBMIT 1115 SERIOUS MENTAL ILLNESS (SMI) INSTITUTIONS FOR MENTAL DISEASES (IMD) WAIVER APPLICATION

Pursuant to 42 CFR §431.408, the Alabama Medicaid Agency (Alabama Medicaid) notifies the public that it intends to submit a Section 1115 Demonstration waiver application to the Centers for Medicare and Medicaid Services (CMS). Through this application, Medicaid is seeking federal authority to reimburse for acute inpatient stays in IMDs for individuals ages 21-64 diagnosed with a serious mental illness.

Reimbursement will be limited to IMDs operating in the Mobile, Washington and Baldwin counties to target the unique inpatient behavioral health access issues in that region. Medicaid enrollees will be able to access services via the IMDs participating in the demonstration, regardless of their county of residence. The proposed effective date of the waiver is October 1, 2021, pending CMS approval.

A copy of the draft Demonstration proposal will be available upon request for public review at each county office of the Department of Human Resources, the State Office of the Alabama Department of Mental Health, and the State Office of the Alabama Medicaid Agency. These documents are also available to be viewed on Alabama Medicaid's website at the following link: https://medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.6_Mental_Health/4.2.6.2_SMI_Waiver.aspx.

Written comments concerning the waiver proposal will be accepted starting January 5, 2021, and are due February 4, 2021. Send comments to the following e-mail address: PublicComment@Medicaid.Alabama.gov or mail hardcopy to: Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624. All written comments will be available for review by the public during normal business hours at the above address.

In order to adhere to the Governor's orders regarding social distancing and based on guidance from CMS, public meetings to provide feedback regarding the proposal will be conducted via teleconference. Information regarding these teleconferences can be found in the "Comments and Public Input Process" section below.

DESCRIPTION, GOALS, AND OBJECTIVES

Medicaid seeks to achieve the following goals through implementation of this waiver:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved availability of crisis stabilization services utilizing multiple service models to meet the unique needs across the state.
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Target Population and Eligibility Criteria

All Medicaid enrollees ages 21-64, eligible for full Medicaid benefits, and with a diagnosed SMI requiring an acute, inpatient level of care would be eligible for short term stays in an IMD under this waiver.

BENEFITS, COST SHARING, AND DELIVERY SYSTEM

No modifications to the current Alabama Medicaid fee-for-service or primary care case management entity (PCCM-E) arrangements are proposed. All enrollees will continue to receive services through their current delivery system. Additionally, this amendment does not propose any changes in the cost sharing requirements for any enrollees.

ANNUAL ENROLLMENT AND ANNUAL EXPENDITURES

This 1115 waiver will have no impact on annual Medicaid enrollment and is expected to be budget neutral as outlined in the tables below.

Historical Data
Alabama was one of 11 states selected for the Medicaid Emergency Psychiatric Demonstration (MEPD). The MEPD was effective for the period between July 2012 and March 2015. Historical enrollment and expenditures for state fiscal year (SFY) 2013 (October 1, 2012 – September 30, 2013) and 2014 (October 1, 2013 – September 30, 2014) from the MEPD are presented in Table 1 below.

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Commissioner

Table 1 – Historical Medicaid Emergency Psychiatric Demonstration (MEPD) Caseload and Expenditures

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Demonstration Enrollment and Expenditures Projections

Projected Without Waiver and With Waiver caseloads, per capita expenditures, and total expenditures for Medicaid beneficiaries whose health care coverage is impacted by the demonstration for each demonstration year are illustrated in Table 2. Without and With Waiver projections are equal because they are considered hypothetical expenditures associated with services added under the demonstration or those that could be otherwise covered under the State Plan or established waiver authorities.

Table 2 – Without and With Waiver Caseload and Expenditure Projections

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Total	**$14,690,216**	**$15,412,828**	**$16,170,985**	**$16,966,436**	**$17,801,015**	**$81,041,478**

HYPOTHESIS AND EVALUATION PARAMETERS

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Alabama proposes the following evaluation plan, which has been developed in alignment with CMS evaluation design guidance for SMI 1115 demonstrations. The State will contract with an independent evaluator to conduct this review.

Objective/Goal	**Hypothesis**	**Evaluation Parameters/Methodology**
Evaluation Questions: • Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings? • How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics? • How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?		
GOAL 1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.	**Hypothesis 1.** The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.	**Data Sources:** • Claims data • Medical records or administrative records • Interviews or focus groups **Analytic Approach:** • Difference-in-differences model • Subgroup analyses • Descriptive quantitative analysis • Qualitative analysis

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Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
Evaluation Questions: • Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings? • How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics? • How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? • Does the demonstration result in increased screening and intervention for comorbid substance use disorders and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?		
GOAL 2. Reduced preventable readmissions to acute care hospitals and residential settings.	**Hypothesis 2.** The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	**Data Sources:** • Claims data • Medical records • Beneficiary survey **Analytic Approach:** • Difference-in-difference models • Qualitative analysis • Descriptive quantitative analysis
Evaluation Questions: • To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state? • To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? • To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?		

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Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 3. Improved 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	**Hypothesis 3.** The demonstration will result in improved availability of crisis stabilization services throughout the state.	**Data Sources:** • Annual assessments of availability of mental health services • AHRF data • NMHSS survey • Administrative data • Provider survey **Analytic Approach:** • Descriptive quantitative analysis

Evaluation Questions:

- Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health needs?
- To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED?
- To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services?
- How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics?
- Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED improve under the demonstration?

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Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 4. Improved 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	**Hypothesis 4.** Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	**Data Sources:** • Claims data • Annual assessments of availability of mental health services • AHRF • NMHSS survey • Administrative data • URS • Medical records **Analytic Approach:** • Descriptive quantitative analysis • Chi squared analysis • Difference-in-differences model

Evaluation Questions:

- Does the demonstration result in improved care coordination for beneficiaries with SMI/SED?
- Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?
- Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities?
- How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?

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Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Hypothesis 5.** The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	**Data Sources:** • Claims data • Medical records • Interviews or focus groups • Facility records **Analytic Approach:** • Difference-in-differences model • Descriptive quantitative analysis • Qualitative analysis

WAIVER AUTHORITY SOUGHT

The State is requesting expenditure authority under Section 1115 for otherwise covered services furnished to otherwise eligible individuals for short term stays for acute care in a psychiatric hospital that qualifies as an IMD.

The State also requests a waiver of §1902(a) of the Social Security Act regarding statewideness to the extent necessary to enable Alabama to reimburse IMDs for short term psychiatric stays in Mobile, Washington and Baldwin counties. Medicaid enrollees will be permitted to access IMD services regardless of their county of residence.

COMMENTS AND PUBLIC INPUT PROCESS

As required by federal regulation, Alabama Medicaid will open a formal comment period January 5, 2021, and interested parties are directed to https://medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.6_Mental_Health/4.2.6.2_SMI_Waiver.aspx. A copy of the draft Demonstration proposal will also be available upon request for public review at each county office of the Department of Human Resources, the State Office of the Alabama Department of Mental Health, and the State Office of the Alabama Medicaid Agency.

Written comments concerning the waiver proposal will be accepted starting January 5, 2021, and are due February 4, 2021. Send comments to the following e-mail address: PublicComment@Medicaid.Alabama.gov or mailed hardcopy to: Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624. All written comments will be available for review by the public during normal business hours at the above address.

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Governor

STEPHANIE MCGEE AZAR
Commissioner

In order to adhere to the Governor's orders regarding social distancing and based on guidance from CMS, public meetings to provide feedback regarding the proposal will be conducted via teleconference. The scheduled opportunities for public comment will be held:

January 12, 2021 10:00 a.m.

Join online: https://algov.webex.com/algov/j.php?MTID=mc6e52d969be07347beab236b5d5b721e
Meeting number (access code): 177 879 4328
Meeting password: Medicaid1

Join by phone:
(415) 655-0001
Meeting number (access code): 177 879 4328#
Attendee number: enter #

January 14, 2021 2:00 p.m.

Join online:
https://algov.webex.com/algov/j.php?MTID=mf777f61c4b11cdea93cb3ab0169d40a9
Meeting number (access code): 177 239 1600#
Meeting password: Medicaid1

Join by phone:
(415) 655-0001
Meeting number (access code): 177 239 1600#
Attendee number: enter #

Stephanie McGee Azar
Commissioner

Appendix 2: Abbreviated Public Notice

Alabama Medicaid Agency

501 Dexter Avenue
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Montgomery, Alabama 36103-5624

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Governor

STEPHANIE MCGEE AZAR
Commissioner

PUBLIC NOTICE

SUBJECT: INTENT TO SUBMIT 1115 SERIOUS MENTAL ILLNESS (SMI) INSTITUTIONS FOR MENTAL DISEASE (IMD) WAIVER APPLICATION

Pursuant to 42 CFR §431.408, the Alabama Medicaid Agency (Alabama Medicaid) notifies the public that it intends to submit a Section 1115 Demonstration waiver application to the Centers for Medicare and Medicaid Services (CMS). Through this application, Medicaid is seeking federal authority to reimburse for acute inpatient stays in IMDs for individuals ages 21-64 diagnosed with a serious mental illness.

Reimbursement will be limited to IMDs operating in the Mobile, Washington and Baldwin counties to target the unique inpatient behavioral health access issues in that region. Medicaid enrollees will be able to access services via the IMDs participating in the demonstration, regardless of their county of residence. The proposed effective date of the waiver is October 1, 2021, pending CMS approval.

As required by federal regulation, Alabama Medicaid will open a formal comment period. Written comments concerning the waiver proposal will be accepted starting January 5, 2021, and are due February 4, 2021. A copy of the draft Demonstration proposal will also be available upon request for public review at each county office of the Department of Human Resources, the State Office of the Alabama Department of Mental Health, and the State Office of the Alabama Medicaid Agency. These documents are also available to be viewed on Alabama Medicaid's website at the following link: https://medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.6_Mental_Health/4.2.6.2_SMI_Waiver.aspx.

Send comments to the following e-mail address: PublicComment@Medicaid.Alabama.gov or mailed hardcopy to: Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624. All written comments will be available for review by the public during normal business hours at the above address.

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Meeting password: Medicaid1

Join by phone:
(415) 655-0001
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Stephanie McGee Azar
Commissioner

Appendix 3: Tribal Notice

Alabama Medicaid Agency

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STEPHANIE MCGEE AZAR
Commissioner

December 17, 2020

Ms. Stephanie A. Bryan
Tribal Chair
Poarch Band Indian Health Department
5811 Jack Springs Road
Atmore, AL 36502

Re: Tribal Consultation Proposed Section 1115 Demonstration Waiver

Dear Ms. Bryan,

As directed by the Tribal Consultation Section 1902(a)(73) of the Social Security Act and 42 CFR § 431.408(b), this notice to the Tribal Government is hereby given to notify the tribe of the Alabama Medicaid Agency's (Alabama Medicaid) intent to submit a §1115 demonstration waiver application to the Centers for Medicare and Medicaid Services (CMS). Through this application, Medicaid is seeking federal authority to reimburse for acute inpatient stays in institutions for mental disease (IMD) for individuals ages 21-64 diagnosed with a serious mental illness.

Reimbursement will be limited to IMDs operating in the Mobile, Washington and Baldwin counties to target the unique inpatient behavioral health access issues in that region. Medicaid enrollees will be able to access services via the IMDs participating in the demonstration, regardless of their county of residence.

As required by federal regulation, Alabama Medicaid has opened a formal comment period. Written comments concerning the waiver proposal will be accepted starting, January 5, 2021, and are due February 4, 2021. A copy of the draft Demonstration proposal will also be available upon request for public review at each county office of the Department of Human Resources, the State Office of the Alabama Department of Mental Health, and the State Office of the Alabama Medicaid Agency. These documents are also available to be viewed on Alabama Medicaid's website at the following link: https://medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.6_Mental_Health/4.2.6.2_SMI_Waiver.aspx.

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Meeting number (access code): 177 879 4328#
Attendee number: enter #

January 14, 2021 2:00 p.m.

Join online:
https://algov.webex.com/algov/j.php?MTID=mf777f61c4b11cdea93cb3ab0169d40a9
Meeting number (access code): 177 239 1600#
Meeting password: Medicaid1

Join by phone:
(415) 655-0001
Meeting number (access code): 177 239 1600#
Attendee number: enter #

If you have any questions, please do not hesitate to ask.

Sincerely,

Solomon Williams, MS, MBA
Associate Director,
Institutional, Labs and Radiology
Alabama Medicaid Agency
334-353-3206

Cc: Edie Jackson (via ejackson@pci-ncn.gov)
Cristi Malone (via cmalone@pci-ncn.gov)