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STEPHANIE MCGEE AZAR
Commissioner

March 1, 2021

The Honorable Norris Cochran, Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Section 1115 Institutions for Mental Disease Waiver

Dear Secretary Cochran,

The Alabama Medicaid Agency is pleased to submit this §1115 waiver application seeking authority to reimburse for acute inpatient stays in institutions for mental disease (IMDs) for Medicaid eligible individuals ages 21-64 with a serious mental illness. Through this Demonstration, Alabama seeks to regain and sustain the benefits achieved under the State's previous participation in the Medicaid Emergency Psychiatric Demonstration.

This waiver will allow the State to target the inpatient behavioral health access issues currently present in Mobile, Washington and Baldwin counties. 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.

Alabama Medicaid looks forward to continuing our partnership with the Centers for Medicare and Medicaid Services to ensure the delivery of behavioral health services to those in need. Thank you for the opportunity to submit this request.

Sincerely,

[redacted]

Stephanie McGee Azar
Commissioner

Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness

March 1, 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>

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<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>

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<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.

Historical MEPD data was aggregated for covered Medicaid populations and aggregated into the following three major eligibility categories; disabled, parents or caretaker relatives (POCR)/Transitional adults and other adults (those enrolled in HCBS waivers). Their composition based on SFY 2014 includes 84.4% disabled, 12.3% POCR and 3.2% other adults. The budget neutrality projection is developed for a single Medicaid Eligibility Group (MEG) to enhance the credibility of the projection under the demonstration.

Caseload (Member Month) Projections
Historical member months from SFY 2014 of the MEPD demonstration were trended to the midpoint of DY1, 96 months. DY1 was used to project DY2 through DY5. The trend factors are described in the Trend section below.

Per Capita Projections
The per capita projections were based on two components:

- State plan services which include inpatient, outpatient, physician, pharmacy, specialist, laboratory, radiology, mental health and substance abuse services, etc.
- IMD stays.

State plan service projections utilized the historical SFY 2014 data from the MEPD program as the base period. The state plan service per capita was trended to the midpoint of DY1 using the average annual trend factor identified in the trend table below. State plan service expenditures and DY1-DY5 projections exclude Alabama Medicaid Hospital Access payments. Hospital Access payments are approved upper payment limit supplemental payments made outside of the claims data for inpatient and outpatient hospital (including emergency department) facilities.

The IMD stay component for DY1 is based on the SFY 2014 data from the MEPD program and adjusted to reflect an average length of stay of 30 days. This average length of stay is the anticipated target length of stay under the demonstration. Additionally, the historical average unit cost was adjusted to reflect $850 per day. This cost per day is consistent with current cost of IMD stays under the demonstration.

Trend Factors

Trend factors utilized to develop the projections include member month and per capita factors. The source of the trend factors utilized in the budget neutrality projections is the 2017 Actuarial Report on the Financial Outlook for Medicaid[2]. This report included enrollment and per capita expenditure growth tables which was used to derive each trend factor.

Trend factors utilized from the 2017 Actuarial Report are based on disabled population and reflect the majority of beneficiaries enrolled in the MEPD program. The trend factors are based on the annualized difference between SFY 2014 (base period) and SFY 2022 (DY1) and outlined in Table 5.

Table 4 – Trend Factors

Trend Factor Description	Annual Factor
Enrollment growth	0.9%
Per capita growth	4.0%

Without and With Waiver projections illustrated in Table 5 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 5 – 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*						

[2] 2017 Actuarial Report on Financial Outlook for Medicaid published by the United States Department of Health & Human Services – Centers for Medicare and Medicaid – Office of the Actuary.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2017.pdf

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 6: 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

Public Comment

In accordance with 42 CFR §431.408, the public had an opportunity to comment on this waiver application through a public notice and comment period that ran from January 5, 2021 through February 4, 2021. The public notice and all waiver documents were posted on the Alabama Medicaid website and made available for 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. An abbreviated notice was also published on December 31, 2020 in the State's administrative record, the Alabama Administrative Monthly. Additionally, Alabama Medicaid sent electronic notice to Medicaid enrolled providers via its provider notice process. Finally, the State held two public hearings on January 12, 2021 and January 14, 2021. Due to the COVID-19 public health emergency, both hearings were held via teleconference; statewide accessibility was assured through telephone and web conference capabilities at both hearings.

Summary of Public Comments

No comments were received at either hearing; a total of four written comments were received. Three of these comments were in support of the waiver application and one opposed. NAMI Mobile and AltaPointe both indicated the waiver will expand access and allow for reduction in emergency room boarding. They further noted the waiver will address the lack of availability of inpatient beds within acute care hospitals in Mobile, Baldwin and Washington counties for Medicaid enrollees ages 21-64.

Additionally, AIDS Alabama indicated the waiver provides a comprehensive plan to expand behavioral health services with wraparound support to adults with SMI and is "very supportive of this plan," believing it will increase wraparound services and create higher standards for providing care to adults with SMI. The commenter also noted a few areas she perceived as gaps in the application. First, the waiver applies to hospitals in three counties which the commenter believes will reduce the ability to reach all adults in need. Second, this commenter indicated while crisis stabilization teams have been established there is not a specific plan to reduce the number of adults with SMI from mental health courts or the community justice

system overall. Third, this commenter indicated the waiver proposal "lacks addressing transition-age youth who are most at risk for presenting SMI," pointing to current programming for first episode psychosis requiring a two-year commitment and the State not proposing to expand these services. The commenter did commend the application for addressing gaps in school-based mental health services. Finally, the commenter indicated there is little mention of services for persons with both SMI and substance use disorder (SUD), and raised concerns the 60 day cut off is insufficient for treating the majority of persons with SUD.

The one commenter that did not support the waiver, Alabama Disabilities Advocacy Program, believes the proposal diverts needed resources from other, more targeted crisis and diversion services. The commenter raised concerns the 60 day maximum length of stay does not meet the definition of an "acute" stay and provides a financial incentive to keep an individual in an IMD longer than necessary and believes the provision should be changed to a 15-day maximum. The commenter urged CMS not to approve the waiver, and if approval is granted urged further research and analysis as to: "1) an appropriate time period that would address the needs of people with mental health issues, and 2) meaningful quality metrics and reporting." The commenter indicated the waiver deters moving toward community-based crisis services and believes nationally the better practice has been to develop smaller facilities that are not IMDs. Finally, the commenter indicated the State should be encouraged to increase paying for home and community based services and self-direction in Medicaid waivers, to expand peer operated crisis respite and stabilization and to incentivize housing and employment outcomes and reductions in incarcerations.

Response to Comments Received

The State appreciates the support received from the majority of commenters and agrees the waiver will expand access to critical behavioral health services and reduce emergency room boarding. The State also appreciates the thoughtful analysis provided by commenters who raised concerns with the proposal. No specific updates to the waiver were made in response to comments for the reasons noted in the summary below.

Regarding the comment the waiver of statewideness will reduce the ability to reach all individuals in need, the State shares the commitment of the commenter to ensure sufficient statewide access. However, our analysis reveals the most pronounced need currently exists in Mobile, Washington and Baldwin counties due to the lack of an acute care or state psychiatric hospital in the region. Similar access issues do not exist elsewhere in the state. We believe this proposal will allow the State to target limited resources to the area with most demonstrated need. Alabama Medicaid will continue to evaluate outcomes post-implementation to determine potential options for expansion of the waiver to other regions in the future.

The State respectfully disagrees with the comment there is not a specific plan to reduce the number of adults with SMI from mental health courts or the community justice system. As noted in the Implementation Plan, Alabama has a series of new or expanded initiatives underway which are intended to reduce criminal justice involvement of individuals with SMI. For example, this includes expanded access to Crisis Diversion Centers, statewide implementation of the Stepping Up program and the collaborative committee established by the ADMH and Alabama Hospital Association with representation of law enforcement to increase continuity of care for transitions between inpatient and outpatient settings.

Regarding the comment that the proposal does not address transition-age youth, the State is continually evaluating access to services for this population. While specific plans have not been identified at this time to expand first episode psychosis programming, current programming is based on evidence-based practices. The current programs are funded by the SAMHSA Mental Health Block Grant; to the extent additional funding were to become available, the State would review opportunities for additional programming.

Additionally, while the application does not explicitly describe services for individuals with co-occurring SMI and SUD, there are a series of state and Medicaid-funded SUD services. For example, withdrawal management, residential treatment, intensive outpatient, outpatient treatment, medication assisted treatment and co-occurring treatment programs are available. The State remains committed to continuing operation of these programs and is continually evaluating expansion of services to address any identified gaps.

Finally, we share the goals of the commenter opposed to the waiver regarding ensuring access to community-based services for individuals with SMI. The intent of this waiver is not to divert funding or resources away from critical community-based and crisis diversion services, but rather to ensure access to a comprehensive continuum of care when an individual in crisis is unable to be safely served in the community and requires a hospital level of care. While the State requests, in alignment with CMS guidance, authority to reimburse for maximum lengths of stay not to exceed 60 days, there are significant safeguards in place to ensure the appropriate length of stay and prevent what the commenter believes is a financial incentive for longer stays. Specifically, as further articulated in the Implementation Plan, Alabama Medicaid has rules in place to ensure that an inpatient level of care is necessary prior to admission and during continued stay reviews. Medical necessity is confirmed by the State's utilization review vendor. Additionally, as illustrated by data from the MEPD demonstration,[3] the State anticipates very few stays will near the upper limit on length of stay. However, Alabama Medicaid believes this outer limit is important in the rare case where a patient requires a longer term stay to achieve stabilization. Specifically, the median length of stay for Alabama under the MEPD demonstration was seven days and the average length of stay was ten days. The State anticipates similar results under this waiver.

Tribal Consultation

In accordance with 42 CFR §431.408, notice of the waiver application was provided to Alabama's federally recognized tribe, the Poarch Band of Creeks, on December 17, 2020. The State received no comment in response.

[3] https://innovation.cms.gov/files/reports/mepd-finalrpt.pdf

Appendix 1: Public Notice

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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.

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

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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 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

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**
Per Capita (per member per month)						
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**

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.

Alabama Medicaid Agency

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

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

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

KAY IVEY
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=mf777f61c4b11cdca93cb3ab0169d40a9
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 #

[redacted]

Stephanie McGee Azar
Commissioner

Appendix 2: Abbreviated 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

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

KAY IVEY
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.

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

Alabama Medicaid Agency

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

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

KAY IVEY
Governor

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

STEPHANIE MCGEE AZAR
Commissioner

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 #

[redacted]

Stephanie McGee Azar
Commissioner

Appendix 3: Tribal 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 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.

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.

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

Alabama Medicaid Agency

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KAY IVEY
Governor

Telecommunication for the Deaf: 1-800-253-0799
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STEPHANIE MCGEE AZAR
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Meeting number (access code): 177 879 4328
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January 14, 2021 2:00 p.m.

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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,

[redacted]

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)

Budget Neutrality Summary

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 1	$ 14,690,216	$ 15,412,828	$ 16,170,985	$ 16,966,436	$ 17,801,015	$ 81,041,478
TOTAL	$ 14,690,216	$ 15,412,828	$ 16,170,985	$ 16,966,436	$ 17,801,015	$ 81,041,478

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 1	$ 14,690,216	$ 15,412,828	$ 16,170,985	$ 16,966,436	$ 17,801,015	$ 81,041,478
TOTAL	$ 14,690,216	$ 15,412,828	$ 16,170,985	$ 16,966,436	$ 17,801,015	$ 81,041,478

HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

Section 1115 SMI/SED Demonstration Implementation Plan
July 23, 2019

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

> **State Response:** The State is in the process of reviewing and updating the current MOU between Alabama Medicaid and the Alabama Department of Mental Health to reflect each agency's respective responsibilities under this waiver. The State anticipates finalizing any required updates by October 1, 2021, the proposed waiver implementation date.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Solomon Williams, MS, MBA, Associate Director - Institutional, Labs and Radiology, Alabama Medicaid Agency
Telephone Number: 334-353-3206
Email Address: Solomon.Williams@medicaid.alabama.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	Alabama
Demonstration name	*1115 SMI/SED Demonstration Implementation Plan*
Approval date	*TBD – Waiver submitted March 1, 2021*
Approval period	*TBD*
Implementation date	*Requested effective date October 1, 2021*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status:* 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).
	Future Status: Alabama Medicaid will amend the administrative code to include rules for hospitals in the demonstration region serving individuals 21-64 and include requirements for licensure in the state as well as accreditation.
	Summary of Actions Needed: Administrative code changes will be completed within the first quarter of post-implementation.
1.b Oversight process (including unannounced visits) to ensure participating hospital and	*Current Status:* As noted on 1.a above, inpatient psychiatric facilities must be accredited by the Joint Commission and have deemed status.

Prompts	Summary
residential settings meet state's licensing or certification and accreditation requirements	*Future Status:* Alabama Medicaid and the Alabama Department of Mental Health (ADMH) will develop an oversight process of the IMDs participating in the Demonstration that will complement the current Joint Commission process.
	Summary of Actions Needed: Oversight process development and any associated administrative code changes will be completed within the first quarter of post-implementation.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status:* 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 65 or older. The state's current vendor for these services is Comagine. **Rule No. 560-X-5-.04. Certification of Need for Service.** (1) Certification of need for services is a determination which is made by a physician regarding the Medicaid recipient's treatment needs for admission to the facility. (2) The physician must certify for each applicant or recipient that inpatient services in a mental hospital are or were needed. (3) The certification must be made at the time of admission. No retroactive certifications will be accepted. (4) For individuals applying for Medicaid while in the hospital, the certification must be made before Medicaid can authorize payment. (5) The physician must complete the PSY-5 form, which is the certification of need for care. This form must be kept in the patient's record. (6) The PSY-6 form, or acceptable equivalent approved by Medicaid, which is the recertification of need for continued inpatient services for each applicant or recipient, must be completed by a physician, a physician assistant, or a nurse practitioner acting under the supervision of a physician. (7) The PSY-6 form, or acceptable equivalent must be completed at least every 60 days after initial certification. This form must be kept in the patient's record. (8) The physician must complete an assessment note in the patient's record within 24 hours of a patient's return from any leave status. **Rule No. 560-X-5-.07. Utilization Review (UR) Plan.** As a condition of participation in the Title XIX Medicaid program, each psychiatric facility shall: (1) Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to him. This written UR Plan must meet the requirements under 42 C.F.R Section 456.201 through Section 456.245; (2) Maintain recipient information required for the UR Plan under 42 C.F.R. Section 456.211, which shall include the certification of need for service and the plan of care; and (3) Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval. **Rule No. 560-X-5-.10. Inpatient Utilization Review**

Prompts	Summary
	(1) The determination of the level of care will be made by a licensed nurse of the hospital staff. (2) Five percent of all admissions and concurrent stay charts will be retrospectively reviewed by the Medicaid Agency or designee on a monthly basis. (3) For an individual who applies for Medicaid while in the facility, a Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made. (4) The following information shall be included on the Psychiatric Admission Form: (a) Recipient information: 1. admitting diagnosis; 2. events leading to hospitalization; 3. history of psychiatric treatment; 4. current medications; 5. physician orders; 6. presenting signs and symptoms. (b) Events leading to present hospitalization (c) History and physical (d) Mental and physical capacity (e) Summary of present medical findings including prognosis (f) Plan of care. (5) Medicaid's Psychiatric Criteria for Age 65 or Over will be utilized in reviewing whether the admission and continued stay were appropriately billed. **Rule No. 560-X-5-.11. Continued Stay Reviews.** (1) The hospital's utilization review personnel will be responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization. (2) The initial continued stay review should be performed on the date assigned by Medicaid. Subsequent reviews should be performed at least every 90 days from the initial CSR date assigned, provided the patient is approved for continued stay. Each continued stay review date assigned should be recorded in the patient's record. (3) If the facility's utilization review personnel determine the patient does not meet the criteria for continued stay, the case should be referred to the facility's psychiatric advisor. If the advisor finds that the continued stay is not needed, the hospital's utilization review procedure for denial of a continued stay should be followed. (4) If a final decision of denial is made, the hospital must notify the recipient and the attending physician within two days of the adverse determination. Medicaid should be notified in writing within 10 days after the denial is made. (5) The facility's utilization review personnel shall be responsible for phoning Medicaid with a report whenever patients are placed on leave status or return from leave. A brief summary describing the outcome of the therapeutic leave should be addressed at this time for patients returning from any leave status.

Prompts	Summary
	As part of the state's Medicaid Emergency Psychiatric Demonstration (MEPD) program, participating IMDs, the state created and successfully implemented similar requirements for enrollees served within an IMD during the demonstration period.
	Future Status: The state plans to reinstate certificate of need forms utilized during the MEPD demonstration. The existing vendor contract for inpatient utilization management (CON confirmation) is scheduled to be (re)procured prior to demonstration implementation and the contract will be updated to reflect the SMI demonstration tasks that will be under contract with the vendor.
	Summary of Actions Needed: Update utilization review vendor contract during upcoming procurement. This procurement is anticipated to be complete prior to implementation of the SMI/SED demonstration.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* In order to receive reimbursement under Medicaid, participating psychiatric hospitals must be enrolled to participate in Alabama Medicaid. Provider enrollment processes fully comply with 42 CFR Part 45 Subparts B&E.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A – milestone requirements already met.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* 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. This information, along with an estimate of the number of days needed for stabilization, is recorded on the Psychiatric Admission Form and signed by the physician. The standardized Psychiatric Admission Form documents, at minimum, the following information: 1. Events leading to present hospitalization 2. Diagnosis 3. History and physical, including any evidence of substance abuse 4. Mental and physical capacity 5. Summary of present medical findings, including prognosis 6. Plan for stabilization to include estimated number of inpatient days needed to stabilize the patient The anticipated discharge plan is also identified upon admission. This includes an assessment of the anticipated aftercare living arrangement/placement and services required upon discharge.
	Future Status: The State will continue to leverage these processes developed for the MEPD demonstration.
	Summary of Actions Needed: N/A – milestone requirements already met.
1.f Other state requirements/policies to	*Current Status:* IMD inpatient providers within the demonstration region currently survey each individual served upon discharge. These surveys are provided to families by the nursing staff, with results tabulated electronically.

Prompts	Summary
ensure good quality of care in inpatient and residential treatment settings.	Results are utilized to identify potential performance improvement projects.
	Future Status: Providers will continue satisfaction survey process.
	Summary of Actions Needed: N/A-milestone requirements already met.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status:* 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 a 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 Alabama Department of Mental Health (ADMH) requires community mental health centers (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. The State also contracts with primary case management entities (PCCM-E), through the Alabama Coordinated Health Network (ACHN), which are tasked with providing discharge planning supports. PCCM-Es are contractually required to establish processes to assist enrollees in transitioning from a facility to community setting. Minimum discharge planning requirements include reviewing daily census at inpatient settings to identify enrollees needing support at

Prompts	Summary
	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. Further, the IMDs that will participate in the Demonstration operate a bridge team that serves as a bridge between hospitalization and outpatient services. A multi-disciplinary team of IMD professionals provides time-limited, intensive follow-up and support services designed to prevent decompensation and re-hospitalization. Finally, the ADMH and Alabama Hospital Association are leading a collaborative committee with broad-based representation from CMHCs, law enforcement, advocacy groups, hospitals and state agencies. This committee and its associated workgroups are exploring strategies to increase continuity of care for transitions between inpatient and outpatient settings. The committee is exploring strategies such as utilization of crisis centers, appropriate and safe housing and workforce development. One of the workgroups of this committee is dedicated to discharge placements. Specifically, this workgroup is charged with addressing all issues from the time patients are assessed for discharge to their placement in the community. Examples of issues being discussed by the committee include minimum standards for community services and availability of information on community resources. This workgroup is developing resources to identify community resources to be made available as part of the discharge planning process.
	Future Status: Continued operation of current requirements, programming, and workgroup activity.
	Summary of Actions Needed: N/A – milestone requirements already met.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* As part of the MEPD Demonstration, the state developed mandated admission forms for use by participating IMDs. As part of this process, the anticipated discharge plan is started upon admission. This includes an assessment of the anticipated aftercare living arrangement/placement and services required upon discharge. Additionally, the State has focused on initiatives to increase the availability of evidence-based housing models for individuals with SMI. For example, from October 2017 through February 2018, ADMH convened local leaders and experts in affordable housing and services from across the state to form the Housing Leadership Group (HLG). An outcome of the HLG was development of the Alabama Permanent Supportive Housing Strategic Plan which is a five-year plan offering strategic objectives and action steps to help maintain, increase, and better utilize permanent supportive housing (PSH) for persons with SMI across the state of Alabama. The goals of the PSH Strategic Plan include: • *Goal 1:* Develop the infrastructure necessary to access PSH. o Create staffing infrastructure for housing coordinators at the state and regional levels to support assessment and referral processes, leverage existing relationships, and build new local partnerships to access housing.

Prompts	Summary
	○ Improve the mental health system's ability to identify, through assessments, persons with SMI who have the greatest housing and service needs and persons who are ready to move on to less restrictive settings. ○ Build a sustainable referral process, including a plan for staffing a mental health system that makes timely, actionable, consumer-driven housing referrals for persons with SMI at the highest need for which they are eligible. • *Goal 2:* Maximize and maintain existing housing resources. ○ Preserve existing set-aside units for persons with SMI. ○ Fully utilize available housing units that are set aside or prioritized for persons with disabilities. ○ Reduce barriers to accessing and maintaining housing through education to stakeholders about accommodations. • *Goal 3:* Develop new PSH housing and rapid re-housing opportunities. ○ Identify capital and rental assistance opportunities. ○ Assess feasibility of strategies to convert existing ADMH residential programs to PSH. • *Goal 4:* Establish priority populations for PSH. ○ Work to adopt the following list as the priority populations for PSH and rapid re-housing (RRH) including persons with SMI who also have forensic histories, ID/DD, co-occurring substance use disorders, persons with high-cost high-need services, and those with medically complex diagnoses. • *Goal 5:* Ensure sufficient capacity in services to successfully support diverse populations in PSH. ○ Expand PSH capacity to move persons from forensic residential programs into PSH and move those from Bryce Hospital who are ready to move into forensic residential programs by increasing services and supports for this population. ○ Transition up to 50 persons with SMI and medically complex conditions from residential group homes and state hospitals by providing HCBS services and supports. ○ Identify the top 100 high cost ADMH Medicaid recipients to better understand their patterns of services utilization, the relationship between service utilization and housing status, and to develop enhanced PSH capacity as a cost-reducing health care intervention. • *Goal 6*: Implement and oversee the PSH Strategic Plan. ○ Build and sustain collaboration between affordable housing and behavioral health system partners at both the state and local levels.
	Future Status: ADMH is working toward implementing the aforementioned five-year strategic plan to implement evidence-based housing models.
	Summary of Actions Needed: Implementation of five-year strategic plan.

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community- based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* The IMDs that will participate in the Demonstration will conduct follow-up calls within 72 hours of a patient's discharge. Data on successful outreach is regularly tracked. As previously mentioned, ADMH also 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. Additionally, PCCM-Es are contractually required to develop a Transitional Care Program to support enrollees identified as needing care coordination services when discharged from an inpatient or residential setting to ensure continued management of care. 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.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - milestone requirements already met.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* 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

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	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. Additionally, 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.
	Future Status: ADMH has a goal of incorporating a Stepping Up program in every Alabama county by the end of Fiscal Year 2022. The state legislature allotted $1.8 million for Fiscal Year 2021, to expand the program by an additional 28 counties.
	Summary of Actions Needed: The Stepping Up program is currently being expanded into multiple additional counties throughout the state by the end of SFY 22.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* Alabama offers multiple Targeted Case Management (TCM) programs, including the following targeted to Medicaid enrollees with behavioral health conditions: • Mentally ill adults: Medicaid-eligible individuals age 18 and over who have been diagnosed with mental illness. • Disabled Children: Medicaid-eligible individuals age 0-21 and who are considered disabled. • Individuals with a Diagnosed Substance Use Disorder: Medicaid-eligible individuals of any age who have been diagnosed with a substance use disorder. • Disabled Children with Autism Spectrum Disorder (ASD) or Serious Emotional Disturbance (SED) and Severely Mentally Ill Adults – High Intensity Care Coordination: Medicaid-eligible individuals age 0-20 or until the individual reaches age 21 who have ASD or SED or an adult with a severe mental illness and requires high intensity care coordination. o Includes youth with multi-system involvement and/or previous institutional level of care. TCM services include: • Needs assessment • Case planning • Service arrangement • Social support • Reassessment and follow-up • Monitoring

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	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - milestone requirements already met.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's	*Current Status:* The Alabama Department of Mental Health's Division of Mental Health and Substance Abuse partners with community providers to deliver a comprehensive array of evidence-based prevention, treatment and recovery-based peer support services throughout the state. ADMH's responsibilities encompass contracting for services, monitoring service contracts, as well as evaluating and certifying service programs according to regulations established in the Alabama Administrative Code. In addition, the division manages ADMH's three mental health facilities: Bryce Hospital, Mary Starke Harper Geriatric Psychiatry Center, and Taylor Hardin Secure Medical Facility. 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 being the 310 Board community mental health centers (CMHC) and 5 being community mental health centers that are operational under a 310 Board CMHC. Expectations for providing minimum continuum of care services for a community mental health provider or a community mental health center is outlined fully in the Alabama Department of Mental Health Mental Illness Community Programs within the Administrative Code – Chapter 580-2-9, Program Standards The following offices under the Division of Mental Health and Substance Abuse share in the roll of ensuring provider network adequacy for behavioral health services in Alabama and will assist in providing data for the initial and ongoing assessment of the availability of mental health services in the demonstration region: The ADMH **Office of MSHA Certification** conducts reviews of mental health and substance abuse community providers to secure compliance with the Program Operations Administrative Code. In addition to conducting onsite reviews, the staff provides technical assistance to providers to enhance compliance with the Administrative Code. The ADMH **Office of Deaf Services** is responsible for developing and implementing programs that meet the linguistic and cultural needs of consumers who are deaf or hard of hearing. Deaf Services work to ensure that communication barriers are eliminated. Services are designed to be affirmative, supportive and culturally competent.

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annual demonstration monitoring reports.	The ADMH **Office of Mental Illness Community Programs** serves as the primary liaison between the department and community mental health providers. This office manages all aspects of mental health treatment by interacting with community providers. Coordination of mental health services includes ensuring quality programs exist for our priority populations of adults with Serious Mental Illness (SMI) and children/adolescents with Serious Emotional Disturbance (SED). This office ensures quality standards are met, the flow of funds and services are efficient, and requirements attached to federal funds are in place. The ADMH **Office of MHSA Peer Programs** is managed by a consumer and provides information, technical support, and assistance to consumers and consumer organizations throughout the state. This office ensures that consumers have a voice in the ADMH planning process, management and service delivery system. Each year more than 800 consumers attend the Alabama Recovery Conference to learn about timely issues, consumer empowerment and self-advocacy. The ADMH MHSA **Office of Pharmacy** provides administrative support and coordination for ADMH's overall pharmaceutical operations including monitoring of expenditures, formulary maintenance and coordinating with community and facility pharmacists. Under SAMHSA, the Pharmacy Office serves as the State Opioid Treatment Authority administrator in conjunction with the Office of Substance Abuse Treatment Services and the Office of Certification. This office also works directly with consumers, families and consumer groups to resolve pharmacy related problems and medication accessibility issues. The ADMH **Office of Substance Abuse Prevention Services** manages all aspects of substance use disorder prevention including services for people of all ages, the Strategic Prevention Framework, the Alabama Epidemiological Outcomes Workgroup, Synar (Tobacco Sales to Minors Program), state incentive grant, regional information clearinghouses and coalition development/support. The ADMH **Office of MHSA Quality Improvement & Risk Management** collects input related to patient care and outcomes from stakeholders, and coordinates activities for performance improvement efforts across the facilities and certified community programs. QIRM measures indicators related to standards of care and consumer satisfaction in facilities and community programs to identify trends, problems or opportunities for improvement. The ADMH **Office of Substance Abuse Treatment Services** manages all aspects of substance use disorder treatment by interacting with community providers. Coordination of services includes ensuring quality programs exist for distinct populations such as adolescents, adults, and persons with co-occurring disorders (mental illnesses and

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	substance use disorders). This office also manages opioid treatment programs and prescribed Medicaid services. For years, ADMH has monitored the utilization of public mental health services through analyzing service data reported to ADMH. This data, in conjunction with periodic survey of the providers, allowed ADMH to identify trends in service utilization by the consumers. Other sources of data utilized by ADMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, ADMH web-based housing inventory (MICRS), ADMH web-based commitment system (Gateway), Child Adolescent Needs and Strengths (CANS) functional assessment tool, ADMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets. Another very valuable measure ADMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children who have multiple needs and who are at risk of placement in a more restrictive setting. ADMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, ADMH worked with the Administrative Office of the Courts to match the ADMH mental health database with mental health court participants. Because Community Mental Health Centers are expected to offer a broad array of services to a demographically and psychiatrically diverse population, the following additional requirements regarding the overall operation of the agency must be met: • Staff capable of providing specialty outpatient services to children, adolescents, adults, and older adults. • Should be able to demonstrate community outreach efforts designed to promote access from all age groups with particular emphasis on those who are seriously mentally ill or severely emotionally disturbed. • The number of recipients both total and by service type and the services provided are acceptable for the time period that the agency has been operational and are roughly proportionate to the number of consumers and types of services provided by agencies similarly certified. • The provider can demonstrate appropriate response to consumers for whom a petition for involuntary

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	commitment has been issued and/or who have been hospitalized at a state psychiatric hospital. • At the end of the first year of operation, the agency must have served at least 100 consumers and the services provided should be proportionate to the average of those agencies that are similarly certified. The community mental health centers work with a variety of public and private resources to obtain services and supports needed by SMI and SED consumers in the community. Case Management services are essential to successful maintenance of persons who have SMI and SED in the community. Adult case managers and supervisors are trained either locally through an approved training curriculum or at training sessions provided by Jefferson-Blount-St. Clair Mental Health/Mental Retardation Authority (JBS). All Child and Adolescent case managers and their supervisors are trained through an ADMH and Medicaid approved training curriculum. ADMH contracts with JBS Mental Health Authority to provide these trainings. These sessions held by JBS, to include C&A In-Home Intervention, occur about every two months. The certification standards require successful completion of this training prior to provision of services. In FY20, 8,332 adults and 3,446 children and adolescents had received case management services. Every community mental health center has case management services for adults and children and adolescents. The following services must be delivered within the Case Management Program: • A systematic determination of the specific human service needs of each consumer. • The development of a systematic consumer coordinated written plan that is developed within 30 days of first face-to-face case management service unless services terminate earlier and that lists the actions necessary to meet the needs of each consumer. • Assisting the consumer through crisis situations and/or arranging for the provision of such assistance by other professional/personal caregivers. • The direct delivery, or the arrangement for, transportation to needed services if the consumer is unable to transport him or herself. • Establishing links between the consumer and service providers or other community resources. • Advocating for and developing access to needed services on the consumer's behalf when the consumer himself is unable to do so alone. • Monitoring of the consumer's access to, linkage with, and usage of necessary community supports as specified in the case plan. • Systematic reevaluation (at 6 months after the original case plan was developed and intervals of 12 months thereafter) of the consumer's human service needs and the consumer's progress toward planned goals so that the established plans can be continued or revised.
	Future Status: Alabama Medicaid, in partnership with ADMH, will continue to monitor provider network capacity on an annual basis.

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	Summary of Actions Needed: Alabama Medicaid will submit an updated Provider Network Template annually and conduct outreach in areas where gaps in services are noted.
3.b Financing plan	*Current Status* Please refer to Financing Plan below.
	Future Status: Please refer to Financing Plan below.
	Summary of Actions Needed: Please refer to Financing Plan below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* The Alabama Incident Management System (AIMS) is a computer software program that allows the Alabama Department of Public Health (ADPH) to monitor hospitals, nursing homes, and ambulance resources. IMDs participating in this demonstration enter bed availability daily. This database is utilized to confirm bed capacity when processing applications for and inpatient certificate of need. AIMS is a secure, encrypted, web-based program that allows and encourages ongoing, real-time communication between healthcare facilities including Hospitals, Nursing Homes, Community Health Centers, Medical Needs Shelters, Healthcare Coalitions members (HCC), and local, area and state Emergency Operations Centers (EOC), representing nearly 500 organizations utilizing AIMS and over 2,000 users. Under normal conditions, healthcare facilities utilize AIMS to share information including status updates of organizational resources (beds, staff, facility operating systems, and fuel) and communicate any resource needs and/or capabilities to provide assistance. When emergency conditions begin to stress the surge capacity and capability of local response systems, coalition partners and EOC staff are able provide support and coordination of resource requests through AIMS. Additional operational features include the use of Reporting Forms to collect surveillance data specific to each of Alabama's nine Healthcare coalitions and/or state-wide. Reporting Forms are customized based on Public Health events such as Heat Related Injuries, Influenza, Hurricanes Florence and Michael, E.D. Psych Reporting, and Surges in Emergency Rooms. AIMS also includes a People Tracking module to track individuals entering and discharging healthcare facilities and Public Health Medical Needs Shelters throughout the state.
	Future Status: Continue operation of AIMS and participation among demonstration providers.
	Summary of Actions Needed: N/A-milestone requirements already met.
3.d State requirement that providers use a widely recognized, publicly	*Current Status:* October 1, 2010, the Child and Adolescent Needs and Strength (CANS) Functional Assessment Tool was implemented state-wide. The CANS is being used statewide for children and adolescents receiving services through the public mental health system. This transformation tool, consistent with system of care values and

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available patient assessment tool to determine appropriate level of care and length of stay	principles, focuses on the needs of the children and families. The CANS-Comprehensive provides a common language, objective criteria to support decisions about intervention plans and intensity of services, monitors progress through outcome measures, and supports quality improvement initiatives. Information from the CANS-Comprehensive will support decisions at multiple levels – direct services, supervision, program management, and system management. For community mental health providers, the CANS for Alabama Comprehensive Multisystem Assessment (5 to Adulthood) or the EC-CANS for Alabama Comprehensive Multisystem Assessment (0 to 4 Years) tools is being utilized. In October 2018, the use of the CANS was expanded to include those providers certified through the ADMH Mental Illness Program Standards. At this time, all providers serving children and adolescents through either a contract or certification through ADMH utilize the CANS for treatment planning purposes. Alabama Administrative Code (580-2-9-.06) establishes minimum requirements for intake documentation. An Intake must include the following information, as appropriate: • Family history • Educational history • Relevant medical background • Employment/vocational history • Psychological/psychiatric treatment history • Military history • Legal history • Alcohol/drug abuse history • Mental status examination • History of trauma • Thoughts and behavior related to suicide • Thoughts and behavior related to aggression In addition, an assignment of a diagnosis (latest DSM version) substantiated by an adequate diagnostic database and, when indicated, a report of a medical examination is required. The diagnosis must be signed by a licensed physician, a licensed psychologist, a licensed professional counselor, a certified registered nurse practitioner, or licensed physician's assistant. A consumer unknown to the provider must be seen face-to-face by a licensed physician, certified registered nurse practitioner, or licensed physician's assistant prior to writing a prescription for psychotropic medication, except in the case of a documented emergency. The intake must also include a description/summarization of the significant problem(s) that the consumer is

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	experiencing, including those that are to be treated and those that impact upon treatment; a description of how linguistic support services will be provided to consumers who are deaf or have limited English proficiency including a signed waiver of free language assistance if the consumer who is deaf or who has limited English Proficiency has refused interpreting or translating services. If a family member is used to interpret, such should be documented in the consumer record. No one under the age of 18 can be used as interpreters; and a written treatment plan that completed by the fifth (5th) face-to-face outpatient service, within ten (10) working days after admission in all day programs and residential programs, or within other Mental Health Chapter 580-2-9 time limits that may be specified under program specific requirements.
	Future Status: ADMH is currently reviewing potential assessments for use with adults and plans to implement a standardized tool in the future.
	Summary of Actions Needed: ADMH is currently reviewing potential assessments for use with adults and plans to implement a standardized tool in the future.
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* The Alabama Department of Mental Health 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 3 crisis diversion centers opening in Montgomery, Mobile, and Huntsville counties. These centers are expected to be operational in the second quarter of 2021. Community Mental Health Centers (CMHCs) train their local community partners, such as, but not limited to, 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,

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	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.
	Future Status: Expanded access to crisis services through the Crisis Diversion Centers.
	Summary of Actions Needed: Award contracts and support Crisis Diversion Center Implementation.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current Status:* 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.
	Future Status: Continued operation of current requirements.

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	Summary of Actions Needed: N/A - milestone requirements already met.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status* 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 is 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 move 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. Additionally, the participating IMD provider in this demonstration also operates an FQHC and integrates physical health and behavioral health care in that setting. The FQHC and outpatient providers in this system of care also utilize telehealth consultation to enhance services in both the FQHC and specialty BH outpatient sites.
	Future Status: Milestone met
	Summary of Actions Needed: N/A-milestone met.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* Alabama provides access to a full continuum of behavioral health services to both youth and adults, including but not limited to: **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).18 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 2 PACT teams in the Birmingham area. ACT teams have a one-to-twelve staff-to-

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	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 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. Statewide Outreach Peers provided recovery support to 612 individuals in the community in FY 2019 and connected 227 individuals to treatment services. **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.

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	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, ADMH has three approved community mental health centers contracted to provide full-fidelity FEP team services: JBS Mental Health covering Jefferson County serves one of the largest populations of transition-age youth experiencing homelessness in the state; Wellstone, Inc. covering Madison County, and AltaPointe Health Systems covering Mobile County. All three of these FEP teams are funded via the SAMHSA Mental Health Block Grant. **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. **Housing Initiatives** **Alabama's Supportive Housing - Evidence Based Practice (EBP) initiative** provides for the development, operation, and supervision of housing units and associated supportive services for adults with SMI who would not otherwise have a viable housing arrangement. Providers operate the housing and supportive services in a manner consistent with the principles of evidence-based permanent supportive housing (PSH) included in ADMH training (Housing First Principles). Key service functions include but are not limited to the provision of case management with low staff-to-participant ratio, apartment set-up costs, and rental assistance. Providers offer this housing in the community, not in a treatment setting. The focus of this EBP housing model is to establish and maintain a place to

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	live rather than to receive treatment. This housing is provided without regard to an individual's agreement to participate in specific treatment services. Currently, there are 324 Supportive Housing - EBP units. **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 all the other seven CoCs and more broadly with the Alabama HUD field office regarding PATH programs across the state.
	Future Status: Fully implemented Crisis Centers.
	Summary of Actions Needed: Award and implementation of Crisis Center contracts.
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* Alabama's **First Episode of Psychosis (FEP)** program addresses youth and young adults experiencing symptoms of early psychosis, which have been named the NOVA programs. In FY20, ADMH contracted with three community health centers to provide FEP team services: JBS Mental Health Authority covering Jefferson County, Wellstone, Inc. covering Madison County, and AltaPointe Health Systems covering Mobile County. This program utilizes 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 program are individuals aged 15-25 years experiencing their first episode of psychosis and who have 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 program as a means of meeting the clients 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

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	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.
	Future Status: Continued operation of FEP (NOVA) and School-Based Mental Health Collaborative programs.
	Summary of Actions Needed: N/A-milestone requirement met.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non- hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status:* **Mobile Crisis Teams, Crisis Response Teams, and Crisis Diversion Centers** 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. The Alabama Department of Mental Health 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 3 crisis diversion centers opening in Montgomery, Mobile, and Huntsville counties. These centers are expected to be operational in the second quarter of 2021. **Consumer-Run Services/Drop-In Centers** These services are supported by ADMH block grant funds although not covered/funded under ADMH CMHC

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	contracts. Consumer-run services and drop-in centers are an important resource for persons for peer interaction and support and can provide the opportunity for persons to attain leadership and advocacy skills. There are four consumer-run drop-in centers around the state, and each serves an average of 94 persons per day. Consumer-run services and drop-in centers provide an alternative, non-residential environment for persons with SMI. The program may offer recreational activities, socialization, individual or group educational activities, mutual support group meetings, information and referrals, or other similar services. In Alabama, the drop-in centers are consumer-led and consumer-driven, with a requirement that at least 50 percent of board requirement be consumers. ADMH contracts directly with the boards of these drop-in centers through the ADMH Office of Peer Programs, using SAMHSA Mental Health Block Grant dollars.
	Future Status: The State will annually monitor access to non-residential crisis stabilization services through processes described in Milestone #3 (3a) and in partnership with an agreed upon methodology.
	Summary of Actions Needed: Annual monitoring.
F.b Increase availability of on- going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status:* As described in previous sections (3a, 4c, Fa) within this template, and as outlined in the attached *Overview of the Assessment of the Availability of Mental Health Services* template, Alabama offers a comprehensive continuum of community-based services.
	Future Status: Continued operation of current programming.
	Summary of Actions Needed: Alabama Medicaid will annually review updated information from the *Assessment of the Availability of Mental Health Services* Template to identify geographic shortage areas and conduct targeted outreach to non-Medicaid enrolled providers in those areas.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	One Health Record® system was created as Alabama's health information exchange (HIE) through a federal grant awarded to the state in 2009. Under the guidance of the Alabama Medicaid Agency and its health care providers and stakeholders, One Health Record® has emerged as an interoperable, bi-directional data exchange system between providers, hospitals and others within Alabama and in other states. Participating providers are able to query the HIE's various clinical document repository via interoperable, data exchange protocols from within their electronic health record system to access patient health data from other providers. Providers without an EHR system can access a secured provider portal for the patient clinical records and for the DIRECT secure messaging (DSM) system. One Health Record® seamlessly and securely connects doctors, hospitals, clinics and other healthcare providers so patient information is available in real time, regardless of location. Participants can query the system from within their electronic health record (EHR) systems to access patient health data from other participants. One Health Record® also offers a provider portal with both a clinical viewer and Direct Messaging for the secure transmission of PHI over the Internet. ADT's (Admission, Discharge, and Transfer) are HL7 messages used by providers connected to the health information exchange to improve the patient's coordination of care. ADT's are triggered when a patient is registered and admitted to a hospital and will follow a patient within the healthcare system until transferred or discharged. When Alabama's One Health Record® receives the ADT message, it generates an alert to the patient's designated provider(s) for follow-up care management. Alabama One Health Record® can accommodate the provider's receipt of the ADT in any one, or combination of, various options available for our core services HIE platform. As of September 1, 2020 Alabama has the following numbers of participating entities:

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	• 484 Connected Facilities • 30 Connected Hospitals • 307 Connected Ambulatory Clinics • 10 Connected ACO's • 7 Connected ACHN Regions • 26 State HIE Connections (Point-to-point, and PCDH network) • 3 State Agencies • 3 Connected Federal Agencies (VA, Dod, & SSA) • 4 VA Hospitals in Alabama (1255 Veterans Administration (VA) Hospitals and Clinics nationwide) Hospitals and facilities in Covington, Dallas, Escambia, Fayette, Geneva, Houston, Jefferson, Lauderdale, Limestone, Marion, Mobile, Tallapoosa, and Tuscaloosa counties are now in the process of connecting to One Health Record®.
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Alabama's State Medicaid Health IT Plan is closely aligned with the Alabama's Department of Mental Health (ADMH) Division of Mental Health and Substance Abuse IT planning efforts. Both Departments work closely together to align efforts in all operational areas including the expansion, promotion, and utilization of health information technology systems and infrastructure by providers.
Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of	Alabama Medicaid implemented a system transformation in 2019 that included the establishment of 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. The applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B do not apply to these PCCM entities.

Prompts	Summary
the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	

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To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."* [4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e- referrals from physician/mental health provider to physician/mental health provider	*Current State:* AltaPointe's two IMD facilities, as well as their outpatient treatment programs, in the proposed demonstration region utilize Netsmart, a certified electronic health record. All community mental health centers in Alabama currently use an EMR, with eight out of 23 using Netsmart. Netsmart provides closed loop referral capabilities as well as secure messaging which is currently being utilized by AltaPointe.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
1.2 Closed loop referrals and e- referrals from institution/hospital/clinic to physician/mental health	*Current State:* AltaPointe's two IMD facilities, as well as their outpatient treatment programs, in the proposed demonstration region utilize Netsmart, a certified electronic health record. Information exchange between inpatient providers is seamless in that both inpatient and outpatient records can be accessed by AltaPointe inpatient and outpatient providers. All community mental health centers in Alabama currently use an EMR, with eight out of 23 using Netsmart. Netsmart provides closed loop referral capabilities as well as secure messaging

Prompts	Summary
provider	which is currently being utilized by AltaPointe.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
1.3 Closed loop referrals and e- referrals from physician/mental health provider to community based supports	*Current State:* Alabama's One Health Record® offers an encrypted, HIPAA compliant messaging service, called Direct Messaging. The service provides providers with an auditable stream of communications that requires no special software or Electronic Health Record (EHR) system. Direct Messaging is compliant with all relevant standards both current and emerging. AltaPointe's two IMD facilities, as well as their outpatient treatment programs, in the proposed demonstration region utilize Netsmart, a certified electronic health record. Netsmart provides closed loop referral capabilities as well as secure messaging which is currently being utilized by AltaPointe.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* The participating IMDs and CMHC serving the demonstration region currently utilize an EHR (Netsmart) that includes the individualized treatment plan and discharge plans within the electronic record.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* The comprehensive inpatient and CMHC provider participating in this demonstration has an EHR and allows access to both inpatient and outpatient clinical notes, including treatment plans, to the care teams serving an individual. The majority of patients served within the IMD who have need for follow-up care, will receive that care from the same provider. Therefore both the outpatient and inpatient teams will have real time access to treatment plans as well as other clinical documentation such as assessments and medication information.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.

Prompts	Summary
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The comprehensive inpatient and CMHC provider participating in this demonstration has an EHR and allows access to both youth and adult inpatient and outpatient clinical notes, including treatment plans, to the care teams serving an individual. Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation such as assessments, therapy notes, and medication information.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* The comprehensive inpatient and CMHC provider participating in this demonstration has an EHR and allows access to both youth and adult inpatient and outpatient clinical notes, including treatment plans, to the care teams serving an individual. Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation such as assessments, therapy notes, and medication information.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* Any licensed provider with Internet access can participate in One Health Record®. To fully benefit from a health information exchange, most doctors, hospitals and other providers link to an HIE via an electronic medical record system. One Health Record® can provide admission, discharge and Transfer (ADT) notification to participating providers. Alabama One Health Record® can provide a provider portal for querying and viewing clinical document documents.
	Future State: Milestone met
	Summary of Actions Needed: N/A - milestone requirements already met.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of	*Current State:* Consents are captured in both the demonstration's provider EHR and the Alabama One Health Record® HIE.
	Future State: Milestone met.

Prompts	Summary
sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Summary of Actions Needed:* N/A - milestone requirements already met.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* All clinical documentation components are included in the participating provider's EHR. One Health Record® has the capability to link with the provider EHR and behavioral health providers are a priority group for linkage with the HIT system.
	Future State: Behavioral health providers, including CMHCs, are linked to Alabama's One Health Record®.
	Summary of Actions Needed: The state will continue to provide technical assistance to providers so that they may link their EHR to the One Health Record® HIE.
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* Behavioral health providers are currently leveraging telehealth to support collaborative care in FQHC settings, providing psychiatric consultation to primary care via telehealth. In addition, the CMHC in the demonstration region currently provides crisis intervention supports to emergency departments in the region via telehealth.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can	*Current State:* The participating behavioral health provider monitor utilization patterns to identify clients at risk. These clients then receive outreach by a clinical team.
	Future State: Milestone met.

Prompts	Summary
notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Summary of Actions Needed:* N/A - milestone requirements already met.
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* Alabama's First Episode of Psychosis (FEP) program addresses youth and young adults experiencing symptoms of early psychosis. The NOVA programs that DMH contracts with are operated by JBS Mental Health Authority covering Jefferson County, Wellstone, Inc. covering Madison County, and AltaPointe Health Systems covering Mobile County. These FEP programs utilizes 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 clients overall Vocational and Educational needs. Providers, including the IMD/CMHC participating in the demonstration utilizes an EHR, with access to clinical health information available to members of the first episode psychosis team.
	Future State: Milestone met.
	Summary of Actions Needed: N/A - milestone requirements already met.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker	*Current State:* Alabama One Health Record® has linkage capabilities; however, the state currently utilizes its eligibility database to identify relatives. At the provider level, surveyed participating demonstration providers have this linkage capability within their EHR.
	Future State: Milestone met.

Prompts	Summary
medical records	*Summary of Actions Needed:* N/A-milestone requirements already met.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* Participating demonstration providers are utilizing EHRs that capture multiple episodes of care and have a process to ensure these episodes are linked to the correct patient.
	Future State: Milestone met
	Summary of Actions Needed: N/A-milestone requirements already met.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.