DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

April 8, 2024

Stephanie Azar
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36103

Dear Commissioner Azar:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to Alabama's section 1115(a) demonstration (Project Number 11-W-00371/4), entitled "Institutions for Mental Disease Waiver for Serious Mental Illness." The technical corrections ensure that the state is able to accurately comply with the special terms and conditions (STCs).

At the state's request, STC 58 has been updated to align the demonstration years with the CMS 64 reporting so the state is able to submit aligned budget neutrality reports. STC 67 was updated to reflect the PMPM change due to shifting demonstration years and a CMS miscalculation. A copy of the updated STCs, implementation plan and expenditure authorities are enclosed.

Your CMS project officer, Ms. Shelby Higgins, is available to address any questions you may have related to this correspondence. Ms. Higgins can be reached at (443) 926-6513 or Shelby.Higgins@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosures

cc: Kia Carter-Anderson, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00371/4
TITLE: Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness
AWARDEE: Alabama Medicaid Agency

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Alabama for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from May 20, 2022 through May 19, 2027, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Alabama to operate the above-identified section 1115(a) demonstration.

1. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a SMI who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD) in Baldwin and Mobile counties as specified in the STCs.

The Following Title XIX Requirements Do Not Apply to These Expenditure Authorities

1. **Statewide Operation** **Section 1902(a)(1)**
To the extent necessary to enable the state to provide Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD) on less than a statewide basis.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00371/4

TITLE: Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness 1115(a) Demonstration

AWARDEE: Alabama Medicaid Agency

I. PREFACE

The following are the Special Terms and Conditions (STC) for the "Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Alabama Medicaid Agency (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

STCs related to the programs for those state plan populations affected by the demonstration are effective from May 20, 2022 through May 19, 2027, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. SMI Program and Benefits
VI. Cost Sharing
VII. Delivery System
VIII. General Reporting Requirements
IX. Evaluation of the Demonstration
X. General Financial Requirements Under Title XIX
XI. Monitoring Budget Neutrality for the Demonstration
XII. Schedule of Deliverables for the Demonstration Extension Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: SMI Implementation Plan and Financing Plan
- Attachment D: SMI Monitoring Protocol
- Attachment E: SMI Evaluation Design

II. PROGRAM DESCRIPTION AND OBJECTIVES

In this demonstration, the state will maintain and enhance access to mental health services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SMI. This demonstration will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD in Baldwin and Mobile counties. Although reimbursement is limited to this region, Medicaid enrollees in need of inpatient behavioral health services will be able to access services via the IMDs participating in the demonstration, regardless of their county of residence. It will also support state efforts to enhance provider capacity and improve access to a continuum of treatments for SMI.

During the demonstration period, the state seeks to achieve the following goals which align with the SMI SMDL #18-011. CMS expects the state to achieve the goals on a statewide basis despite authorizing expenditure authority on less than a statewide basis since the state will concurrently implement initiatives that improve community-based mental health care. These actions are listed in detail in the state's implementation plan and are a condition of receiving FFP for IMDs:

SMI Demonstration Goals:

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination

Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval

at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

    b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

    c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    d. An up-to-date CHIP allotment worksheet, if necessary;

    e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR § 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility and the standards and methodologies for eligibility remain set forth under the state plan. 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 demonstration. Only the eligibility groups outlined in Table 1 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)1905p
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)	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)

V. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

17. **SMI Program Benefits.** Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to

ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. While reimbursement will be limited to IMDs in Baldwin and Mobile counties, Medicaid enrollees in need of inpatient behavioral health services will be able to access services via the IMDs participating in the demonstration, regardless of their county of residence. The state must achieve an average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving treatment at IMDs in this demonstration, to be monitored pursuant to the SMI Monitoring Protocol as outlined in STCs 28-30 below.

18. SMI Implementation Plan.

a. The state must submit the SMI Implementation Plan within ninety (90) calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under the expenditure authority until CMS has approved the SMI Implementation Plan and the SMI financing plan described in STC 18. After approval of the required Implementation Plan and Financing Plan, FFP will be available prospectively, but not retrospectively.

b. Once approved, the SMI Implementation Plan will be incorporated into the STCs as Attachment C, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 25.

c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. **Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.**

1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals in Baldwin and Mobile counties must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being

in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. **Improving Care Coordination and Transitions to Community-Based Care.**

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);

2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available;

3. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;

4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. **Increasing Access to Continuum of Care Including Crisis Stabilization Services.**

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;

2. Commitment to implementation of the SMI/SED financing plan described in STC 18(e);

3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;

4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. **Earlier Identification and Engagement in Treatment and Increased Integration**

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;

3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

d. **SMI Health Information Technology (Health IT) Plan.** The Health IT Plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it 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 the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 18(b) and 18(d)), to develop the infrastructure/capabilities of the state's health IT infrastructure.

The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment C), and must be

aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

The state will include in its Monitoring Protocol (see STC 28(a)) an approach to monitoring its SMI Health IT Plan which will include performance metrics to be approved in advance by CMS.

The state will monitor progress, each DY, on the implementation of its SMI Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Monitoring Report (see STC 29).

As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SMI Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

Components of the Health IT Plan include:

i. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

iii. In developing the Health IT Plan, states should use the following resources:

1. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration".

2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

e. **SMI Financing Plan.** As part of the SMI Implementation Plan referred to in STC 18, the state must submit, within 90 calendar days after approval of the demonstration, a Financing Plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the Implementation Plan in Attachment C and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

   i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

   ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;

19. Maintenance of Effort (MOE). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of this demonstration that is no less than the amount of funding provided at the beginning of the demonstration. The annual MOE will be reported and monitored as part of the annual monitoring report described in STC 29.

20. Availability of FFP for the SMI Services Under Expenditure Authority #1. Federal Financial Participation is only available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for services furnished to

beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days as relevant.

21. **Unallowable Expenditures Under the SMI Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

    a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

    b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

    c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

    d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

VI. COST SHARING

22. **Cost Sharing**. Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

23. **Delivery System.** No modifications to any current Alabama Medicaid fee-for-service or primary care case management entity (PCCM-E) arrangements are included in this demonstration. All enrollees will continue to receive services through their current delivery system.

VIII. GENERAL REPORTING REQUIREMENTS

24. **Deferral for Failure to Submit Timely Demonstration Deliverables**. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral

shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days (30) after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

25. Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred

in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

26. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

27. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

    c. Submit deliverables to the appropriate system as directed by CMS.

28. **SMI Monitoring Protocol.** The state must submit a Monitoring Protocol for the SMI program authorized by this demonstration within 150 calendar days after the effective date of the demonstration. The Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit the revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment D. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol must include:

    a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 18(c), information relevant to the state's SMI financing plan described in Attachment C, and information relevant to the state's Health IT plans described in STC 18(d);

    b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII (General Reporting Requirements) of the demonstration; and

    c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

29. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The state

must submit a revised Monitoring Report within sixty (60) calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; updates on the state's financing plan and maintenance of effort described in STCs 18(e) and 19; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones and/or goals and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of

evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SMI Health IT. The state will include a summary of progress made in regards to SMI Health IT requirements outlined in STC 18(d).

30. SMI Mid-Point Assessment. The state will contract with an independent entity to conduct a Mid-Point Assessment of the demonstration by May 20, 2025. This timeline will allow for the Mid-Point Assessment to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care organizations (MCOs), SMI treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after May 20, 2025. The state must brief CMS on the report, if requested. The state must submit a revised Mid-Point Assessment within sixty (60) calendar days after receipt of CMS's comments, if any.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SMI Implementation Plan, the SMI Financing Plan, and the SMI Monitoring Protocol for ameliorating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and Monitoring Protocol are subject to CMS approval.

Elements of the Mid-Point Assessment must include, at a minimum:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI Implementation Plan, the SMI Financing Plan, and toward meeting the targets for performance measures as approved in the SMI Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI Implementation Plan and/or SMI Financing Plan or to other pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

31. **Corrective Action.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10.

32. **Close-Out Report**. Within 120 calendar days after the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

    a. The Draft Close-Out Report must comply with the most current guidance from CMS.

    b. The state will present to and participate in a discussion with CMS on the Close-Out Report.

    c. The state must take into consideration CMS's comments for incorporation into the Final Close-Out Report.

    d. The Final Close-Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.

    e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 24.

33. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

    a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

    b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

    c. The state and CMS will jointly develop the agenda for the calls.

34. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

IX. EVALUATION OF THE DEMONSTRATION

35. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 24.

36. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

37. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline no later than 180 calendar days after approval of the demonstration.

The draft Evaluation Design must be developed in accordance with:

a. Attachment A (Developing the Evaluation Design) of these STCs;

b. CMS's evaluation design guidance for SMI demonstrations, including guidance for approaches to analyzing associated costs; and

c. All applicable CMS guidance on applying robust evaluation approaches, including establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 41 and 42.

38. Evaluation Budget. A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by

CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

39. **Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft Evaluation Designs within sixty (60) calendar days after receipt of CMS's comments. Upon CMS approval of the Evaluation Design, the documents will be included as an Attachment E to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

40. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the Evaluation Design must include a discussion of the evaluation questions and hypotheses that the state intends to test. The evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals. Each demonstration component should have at least one evaluation question and hypothesis. The state must also conduct a demonstration cost assessment. Additionally, the state should accommodate data collection and analyses stratified by key subpopulations of interest to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration's policies might support bridging any such inequities.

    The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

    The findings from each evaluation component must be integrated to help inform whether the state met the overall demonstration goals, with recommendations for future efforts regarding all components.

41. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting a renewal for the demonstration, the Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Interim Evaluation Report.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

42. **Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.

b. Once approved by CMS, the final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

c. The Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs.

43. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and

sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

44. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

45. **Public Access.** The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, the approved Evaluation Design, Interim Evaluation Reports, and Summative Evaluation Reports) on the state's website within thirty (30) calendar days of approval by CMS.

46. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

47. **Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[1]

48. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just

[1] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

49. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

50. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share funding of demonstration expenditures have been met:

a. Units of state or local government, including health care providers that are units of state or local government, certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching

funds received cannot be used as the non-federal share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local revenues and are transferred by units of government within the state. Any transfers from units of government must be made in an amount not to exceed the non-federal share of title XIX payments and any payment derived from a proper IGT is not contingent upon receipt of the IGT.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

f. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

51. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.

52. Requirements for health care related taxes and provider donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All health care-related taxes as defined by Section 1903(w)(3)(A) of the Social Security Act and 42 CFR §433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Social Security Act and 42 CFR §433.68(c).

b. All health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Social Security Act and 42 CFR §433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Social Security Act and 42 CFR §433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Social Security Act and 42 CFR §433.68(f).

e. All provider related-donations as defined by 42 CFR §433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR §433.66, and 42 CFR §433.54.

53. State Monitoring of Non-federal Share. No later than 60 days after demonstration approval, the state must provide a report to CMS regarding payments under the demonstration specifying that payments under the demonstration are funded all or in part by a locality tax, if applicable. This report must include:

a. Any agreement written or otherwise regarding the arrangement among the providers with counties, the state or other entities for each locality tax;

b. Number of hospitals in each locality of the taxing entities for each locality tax;

c. Whether or not all hospitals will be paying the assessment for each locality tax;

d. The assessment rate that the hospitals will be paying for each locality tax;

e. Whether any hospitals that pay the assessment will not be receiving payments funded by the assessment;

f. Number of hospitals that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax comply with section 1903(w)(4) of the Social Security Act and 42 CFR §433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.

This deliverable is subject to the deferral as described in STC 24.

54. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XI:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration

extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

55. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

56. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
IMD Services SP	Hypo 1	X		X	Medicaid beneficiaries diagnosed with a SMI in fee-for-service

57. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00371/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

    a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section VIII, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
IMD Services MEG #1	Medicaid beneficiaries diagnosed with an SMI in fee-for-service	See STC 21	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	5/20/ 2022	5/19/ 2027

58. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 4: Demonstration Years		
Demonstration Year 1	May 20, 2022 to May 19, 2023	12 months
Demonstration Year 2	May 20, 2023 to June 30, 2024	13 months
Demonstration Year 3	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 4	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 5	July 1, 2026 to May 19, 2027	11 months

59. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XI. CMS will provide technical assistance, upon request.[2]

60. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the

[2] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

61. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

62. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

63. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

64. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

65. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

66. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state

agrees (as a condition of CMS approval) to offset that excess spending by refunding the FFP to CMS.

67. **Hypothetical Budget Neutrality Test 1:** SMI Initiative for Expenditure Authority 1, residential and inpatient treatment for individuals with SMI. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5: Hypothetical Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR *2019*	TREND	DY 1	DY 2	DY 3	DY 4	DY 5
IMD Services MEG #1	**PC**	Both	$12,076.31	6.3%	$15,077.63	$16,084.74	$17,159.13	$18,239.22	$19,319.32

68. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

69. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from May 20, 2022 to May 19, 2027. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

70. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure

limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 6: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit	0.0 percent

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 7: Schedule of Deliverables for the Demonstration Period		
Date	**Deliverable**	**STC**
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after demonstration approval	SMI Implementation Plan (including Health IT Plan)	STC 18(a)
60 calendar days after receipt of CMS comments	Revised SMI Implementation Plan (including Health IT Plan)	STC 18(a)
150 calendar days after demonstration approval	Monitoring Protocol	STC 28
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 28
180 calendar days after demonstration approval	Draft Evaluation Design	STC 37
60 days after receipt of CMS comments	Revised Evaluation Design	STC 39
No later than 60 calendar days after May 17, 2025	Mid-Point Assessment	STC 30
60 calendar days after receipt of CMS comments	Revised Mid-Point Assessment	STC 30
May 17, 2026, or with renewal application	Draft Interim Evaluation Report	STC 41(c)
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 41(d)
Within 18 months of May 17, 2027	Draft Summative Evaluation Report	STC 42
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 42(a)
Monthly Deliverables	Monitoring Calls	STC 33
Quarterly Monitoring Reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 29
	Quarterly Expenditure Reports	STC 29(c)
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 29

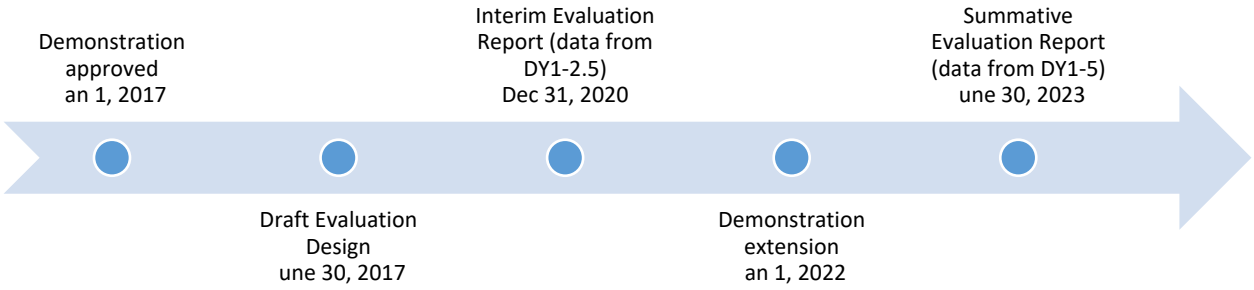
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable

evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the

relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes;
b. No or minimal appeals and grievances;
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

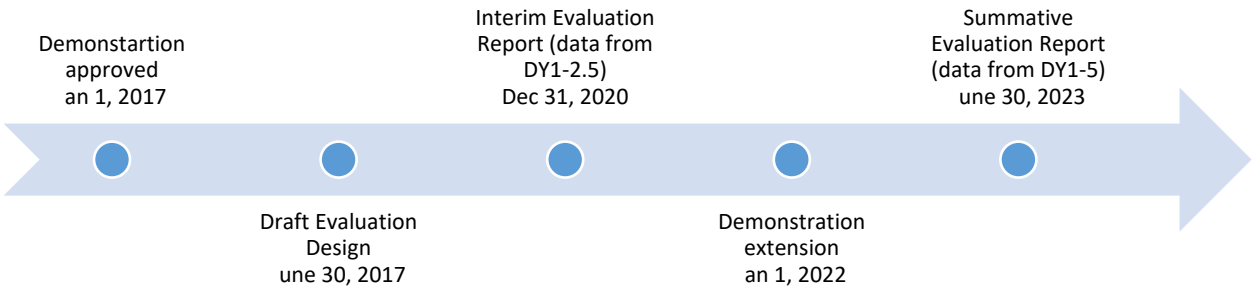
Attachment B:
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?

3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C

Section 1115 SMI/SED Demonstration Implementation Plan

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: Elizabeth Huckabee, BS, MS, Director, Medical Services Division, Alabama Medicaid Agency
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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	*Alabama Section 1115 Institutions for Mental Disease Waiver for Serious Mental Illness*
Approval date	*May 20, 2022*
Approval period	*May 20, 2022 – May 19, 2027*
Implementation date	*TBD – Approved* *May 20, 2022*

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). Both IMDs participating in the Demonstration are licensed and meet federal conditions of participation.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A – milestone met.
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. IMDs participating in the Demonstration meet conditions of participation and the State conducts periodic reviews to confirm ongoing compliance.

Prompts	Summary
residential settings meet state's licensing or certification and accreditation requirements	*Future Status:* Continued operation of current requirements. *Summary of Actions Needed:* N/A – milestone met
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 Kepro. **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: All admissions under the demonstration will be subject to prior authorization under the Rules provided in the Current Status section, including use of the existing Certificate of Need forms utilized for other populations receiving acute psychiatric inpatient stabilization services.
	Summary of Actions Needed: Milestone met.
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, including screening for suicidal ideation, 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 bythe 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, which begins upon admission, 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 Medicaid Agency also contracts with primary case management entities (PCCM-E), through the Alabama Coordinated HealthNetwork (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. **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 nototherwise 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 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.
	Future Status: ADMH is working toward implementing the aforementioned five-year strategic plan to implement evidence-based housing models. Additionally, the state will require use of the psychiatric admission form. The psychiatric admission form includes, as part of the anticipated discharge plan, a section for after discharge aftercare living/placement plan. This section includes setting identification as well as services and supports that are needed.
	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 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

Prompts	Summary
	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 Mobile and Baldwin counties. 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. See milestone 3.e for information on the behavioral health crisis system, including mobile crisis and crisis centers.
	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

Prompts	Summary
	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.

Prompts	Summary
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

Prompts	Summary
	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

Prompts	Summary
	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.

Prompts	Summary
	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. All hospitals, including those participating in the demo enter bed availability daily. This database is utilized to confirm bed capacity when processing applications for and inpatient certificate of need. Additionally, the ADMH Mental Illness Community Residential System (MICRS) tracks all crisis residential and diversion center beds. All CMHCs can view this information on bed availability and can leverage the information to identify potential providers to refer the patient to. 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 MICRS.
	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

Prompts	Summary
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

Prompts	Summary
	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. Additionally, all participating IMDs currently apply InterQual criteria as part of the admission assessment and DSM-V scaled tools.
	Future Status: ADMH is currently reviewing potential assessments for use with adults and plans to implement a standardized tool in the future. The review by ADMH is being conducted as a part of multiple transformation initiatives, including expansion of crisis services such as 988 implementation, and expansion of CCBHCs in all regions of the state over three to five years. ADMH has a CMHC who currently has been awarded a SAMHSA CCBHC grant. Also, ADMH has contracted with consultants to analyze the steps necessary for transforming CMHCs into a CCBHC. This will require working closely with AMA to identify and utilize the most appropriate funding stream(s). The state will identify a standardized tool(s) for outpatient level of care decision making when the new continuum or service array is established. This will ensure the right tool is chosen that can be leveraged across the crisis continuum as well as outpatient levels of care.
	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 centers, with three centers created across the state in FY 2021and a fourth one being implemented by end of FY22. ADMH requested and received $18 million for Fiscal Year 2021, to establish and stand up the first pilot Crisis Center in the state. ADMH was awarded another $6 million for Fiscal Year 2022 to establish and stand up the fourth Crisis Center. These centers are 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 will 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 centers opening in Montgomery, Mobile, and Huntsville counties. 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,

Prompts	Summary
	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. There are twelve mobile crisis teams across the state and six other crisis response teams across Alabama. These teams are funded through blended funding streams to include SAMHSA MI Block Grant funds and state funds that allows for Medicaid federals funds to be secured for appropriate Medicaid billing. Finally, Alabama received a CMS Mobile Crisis Planning Grant, to enhance access to robust and timely crisis behavioral health services using evidence-based best practices identified within SAMHSA's "National Guidelines for Behavioral Health Crisis Care."
	Future Status: Expanded access to crisis services through the Crisis Centers established in SFY22 as well as mobile crisis services
	Summary of Actions Needed: Award contracts and support Crisis 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 analyzed to determine if they can be more fully developed by ADMH and ADRS 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 FY2014 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 ofincreasing 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. 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 andsupport 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. *Future Status:* ADMH is currently providing fidelity assessments of the SE/IPS service sites and will analyze provider's adherence to elements of the evidence-based practice. DMH and the Alabama Department of Rehabilitative Services (ADRS) will analyze other sites and funding streams for considered expansion to new sites. The state anticipates completing this review by FY2024.

Prompts	Summary
	Summary of Actions Needed: Expanded number of SE/IPS service sites with fidelity.
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 a move toward a more integrated system that ensures the individual providers serve are able to receive needed care for both their mental health and primary health care needs. ADMH and APHCA have explored grant opportunities for increased integration and collaboration between their provider networks to develop community coordination that is non-competitive. Also, ADMH partnered with the CMHC connected to this demonstration to apply for a SAMHSA Promoting Integration of Primary and Behavioral Health Care (PIPBHC) demonstration grant and was awarded. The demonstration grant began on April 1, 2020 and is a 5-year grant that will targets SMI adults and SED youth with a goal to promote full integration ad collaboration in clinical practice between primary and behavioral healthcare. Additionally, the participating IMD providers in this demonstration also operates an FQHC and integrates physical hand 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. SBIRT is built into maternity psychosocial assessments performed by PCCM-E care coordinators with a substance use screening if indicated which touches about one million recipients. Depression screenings are a part of maternity screenings.
	Future Status: In the transformation to CCBHCs by DMH, CCBHCs will be required to include the following federal requirements: 1. The CCBHC will be responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC will be responsible for ensuring these services are received in a timely fashion. 2. The CCBHC will ensure children receive age-appropriate screening and preventive interventions including, where

	appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions. Prevention will be a key component of primary care services provided by the CCBHC. Nothing in these criteria prevent a CCBHC from providing other primary care services.
	Summary of Actions Needed: As the transformation to CCBHCs occurs, incorporate federal requirements as mentioned above.
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-

Prompts	Summary
	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. ADMH requires the use of peers in its crisis mobile teams, crisis centers, first episode psychosis and supported employment programs. The State has also increased the rate for peer supports to incentivize expansion. **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.

Prompts	Summary
	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

Prompts	Summary
	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. **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. Funds for FY21 allowed 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 Continue operations with current programming.
	Summary of Actions Needed: N/A – Milestone met.

4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* N/A

Prompts	Summary
	Future Status: N/A
	Summary of Actions Needed: N/A

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 Centers** Since 2019, the state has significantly increased investments in the ADMH Crisis System of Care, with the Alabama Legislature's annual appropriation of funds to support crisis intervention and stabilization facilities, known as Crisis Centers ($18 million in FY21, $24 million in FY22, and $36 million in FY23); mobile crisis services ($5 million annually); and the Stepping Up Initiative ($1.8 million annually). The state is currently implementing four new Crisis Centers, each including components of mobile crisis services into their regional framework based on community needs and will add two new Crisis Centers in the upcoming year. 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 12 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 state dollars, Medicaid dollars, and block grant dollars. 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.

	Consumer-Run Services/Drop-In Centers These services are supported by ADMH block grant funds although not covered/funded under ADMH CMHC

Prompts	Summary
	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 Alabama Department of Mental Health has begun the process to create a full Behavioral Health Crisis Continuum, which will include crisis centers, with three centers created across the state in FY 21. ADMH requested and received $18 million for Fiscal Year 2021, to establish and stand up the first pilot CrisisCenters 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 for in 3 crisis centers opening in Montgomery, Mobile, andHuntsville counties. The Huntsville and Mobile crisis centers were operational in the second quarter of 2021. The Montgomery crisis center is projected to open with delay. Additionally, the state will align efforts with its CMS Mobile Crisis State Planning Grant, coordinating enhanced access to robust and timely crisis behavioral health services using evidence-based best practices identified within SAMHSA's "National Guidelines for Behavioral Health Crisis Care." The combined goals of the grant and waiver are to divert individuals from the criminal justice system as well as avoidable use of emergency departments. Combined with broadened community-based supports under the waiver period, the state also hopes to decrease the rate of referral to restrictive institutional settings, including psychiatric hospitals with extended lengths of stay.

	Also, ADMH has a goal of incorporating a Stepping Up program (described above in 2d) 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: Open a new crisis center in Montgomery county – FY22 Expand the Stepping Up program to an additional 28 counties – FY22 Enhance Behavioral Health Crisis System – Over the course of the demonstration
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: In addition to continued operation of current programming, the aforementioned **Permanent Supportive Housing** Strategic Plan includes transitioning up to 50 persons with SMI and medically complex conditions from residential group homes and state hospitals by providing HCBS services and supports. The five-year strategic plan implementation begins in FY 2023. **As noted in milestone 4.a, Supported Employment/Individual Placement and Support** (SE/IPS) SE/IPS services are also in the process of being more fully developed by ADMH in Alabama. Efforts to expand **peer support services** include ADMH pilots underway that 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. Specific to school-based mental health services, 15 new school systems were added to the School-Based Mental Health Collaborative. 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. ADMH is currently conducting multiple transformation initiatives, including expansion of crisis services such as 988 implementations, and expansion of CCBHCs in all regions of the state over three to five years. ADMH has a CMHC

who currently has been awarded a SAMHSA CCBHC grant. ADMH is allocating $5 million from the state's American Rescue Plan Act supplemental appropriations to the SAMHSA Mental Health Block Grant to support phased-in CCBHC implementation over the next five years. Also, ADMH will be contracting with consultants to analyze the steps necessary for transforming CMHCs into CCBHCs. This will require working closely with AMA to identify and utilize the most appropriate funding stream(s).

The following action steps are anticipated for Statewide CCBHC Implementation:
1. **Establish CCBHC leadership, goals, and project management processes** within government and in the community to ensure staff are supported with a shared vision and strategic partners are included in planning. Proposed completion date is May 2022.
2. **Conduct a community needs assessment and environmental scan** to support the establishment of program goals and customization of the CCBHC model to Alabama. Proposed completion date is May 2022.
3. **Craft CCBHC certification criteria** to meet Alabama's goals for strengthening its care delivery system. Proposed completion time is the end of SFY 2023.
4. **Establish a CCBHC prospective payment methodology** that covers the anticipated costs of delivery of mental health and substance use services and identify a mechanism for quality bonus payments for high-performing clinics. Proposed completion time is the end of SFY 2024.
5. **Develop data collection and reporting capacity at the clinic and state levels** that are supported through strengthened health information technologies between and within different community-based and statewide systems for CCBHC, including observations of qualitative and quantitative information that depict historical trends and comments on demand (e.g., Medicaid enrollments), pricing (e.g., budget outlooks, behavioral health budgets), service trends, and other regulatory matters that affect what the future rate environment may look like in Alabama. Proposed completion time is the end of SFY 2025.
6. **Secure a state plan amendment or Medicaid waiver** and address budgetary considerations such as needed state appropriations to support the CCBHC effort. Proposed completion time is the end of SFY 2026.

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:

Prompts	Summary
	• 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)) CareCoordination 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 standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B are applicable to the PCCM entities, and will be implemented in accordance with the demonstrated EHR capability of AltaPointe's EHR vendor, Netsmart. The expectation is to have the HIE connectivity completed by October 1, 2021. Please refer to the additional details in the answers to the questions in Section 4 below. However, there are no PCCM entity contracts which require updating.

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.	

Prompts	Summary
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, which will include assistance in establishing and utilizing interoperable HIE services, connectivity with the CMHC facilities for data exchange, and content validation on document standards and data frequency based on C-CDA sections /HL7 segments. ALOHR will serve as a data collector/aggregator as a source for various data elements required by the Agency. The expected timeline for implementation of the Health IT plane is October 1, 2021. These activities are overseen by the Agency's Chief Data Office and ALOHR Director.
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.

ATTACHMENT D

What follows are the Planned Metrics, Definitions, Planned Subpopulations and Reporting Schedule tabs from the SMI monitoring protocol workbook (part A). The full workbook is available in spreadsheet format on Medicaid.gov

Medicaid Section 1115 SMI/SED Demonstration Monitoring Protocol (Part A) - Planned metrics (Version 2.0)

State: Alabama

Demonstration Name: "Institutions for Mental Disease Waiver for Serious Mental Illness" (Project Number 11-W-00371/4)

Table: Serious Mental Illness and Serious Emotional Disturbance Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phase-in metrics reporting		
#	Metric name	Metric description	Milestone or incentive tools	Metric type	Reporter category	Data source	Measurement period	Reporter frequency	Reporter intensity	State will report (Y/N)	Baseline period (MM/DD/YYYY)- MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data source, definition, codes, layout, annualization, etc.)**	State plans to phase in reporting (Y/N)	SMI/SED monitoring report in which metric will be phased in (Format: DY[Q#] e.g. DY1Q3)	Explanation of any plans to phase in over time
EXAMPLE: 28 (Do not delete or edit this row)	*EXAMPLE: Beneficiaries With SMI/SED Treated as an IMD for Mental Health*	*EXAMPLE: Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year.*	*EXAMPLE: Milestone 3*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other annual metrics*	*EXAMPLE: Claims*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020-12/31/2020*	*EXAMPLE: Increase*	*EXAMPLE: Consistent*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: N*	*EXAMPLE: DY1Q3*	*EXAMPLE: The demonstration site will be updating its EMR during the start of the demonstration. We plan to phase in reporting after the system update has been completed by mid to late 2021 (DY2).*
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings	Two rates will be reported for this measure: 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay 2. SUB-2a: Patients who screened positive for unhealthy alcohol use during the hospital stay	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	Y	01/01/2022-12/31/2022	Increase	Increase	Y		N		
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	N				Y		Waiver approved for adults ages 21-64	N		
3	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	The rate of implanted, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022-12/31/2022	Decrease	Decrease	Y		N		
4	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/1/2021 - 12/31/2022		Consistent			Waiver is approved for adults ages 21-64 for SMI treatment	N		
5	Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported. • Percentage of discharges for which the child received follow-up within 30 days after discharge • Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	N						Waiver is approved for adults ages 21-64	N		
6	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported. • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022-12/31/2022	Increase	Increase	Y		N		
7	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported. • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022-12/31/2022		Consistent	Y		Waiver approved for SMI treatment services	N		
10	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022-12/31/2022	Increase	Increase	Y		N		
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	Y	05/01/2022-04/30/2023	Decrease	Decrease	Y				
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	Y	05/01/2022-04/30/2023	Decrease	Decrease	Y				
13	MentalHealth Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	05/01/2022-04/30/2023	Increase	Constant	Y				
14	MentalHealth Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	05/01/2022-04/30/2023	Increase	Increase	Y				
15	MentalHealth Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	05/01/2022-04/30/2023	Increase	Increase	Y				
16	MentalHealth Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	05/01/2022-04/30/2023	Decrease	Decrease	Y				
17	MentalHealth Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	05/01/2022-04/30/2023	Increase	Increase	Y				
18	MentalHealth Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	05/01/2022-04/30/2023	Increase	Increase	Y				
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (more than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	05/01/2022-04/30/2023	No More Than 30 Days	No More Than 30 Days	Y				
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (more than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	05/01/2022-04/30/2023	No More Than 30 Days	NO More Than 30 Days	Y				
20	Beneficiaries With SMI/SED Treated as an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	5/1/2022-4/19/2023	Increase	Constant	Y				
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	05/01/2022-04/30/2023	Increase	Increase	Y				
22	Count of Beneficiaries With SMI/SED (annual)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Increase	Y				
23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SMC-HA-A2A)	Percentage of beneficiaries age 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) as poor control (>9.0%)	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2022-12/31/2022	Increase	Consistent	Y				
24	Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screening	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	Y	01/01/2022-12/31/2022	Increase	Increase	Y				
25	Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screening	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N	5/1/2022-4/19/2023			Y		Waiver is approved for adults ages 21-64	N		
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries: Ages 20 to 44	The percentage of Medicaid beneficiaries age 20 years or older with SMI who had an ambulatory or preventive care visit during the measurement period	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022-12/31/2022	Increase	Increase	Y				
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: •Percentage of children and adolescents on antipsychotics who received blood glucose testing •Percentage of children and adolescents on antipsychotics who received cholesterol testing •Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022-12/31/2022		Consistent	Y		Waiver is approved for adults ages 21-64	N		
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who meet the following criteria •age 18 years and older, and •completed a follow-up visit with a provider with prescribing authority within four weeks (28	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2022-12/31/2022	Increase	Increase	Y				
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Constant	Y		"The spending reported for Metrics 32, 33 and 39 are based on Alabama Medicaid fee-for-service (FFS) reimbursement. Please note, spending for inpatient, outpatient and emergency department expenditures represent the base FFS fee schedule and exclude Hospital Access payments. Alabama Hospital Access payments are CMS-approved upper payment limit supplemental payments made outside of the claims data for inpatient and outpatient hospital (including emergency department) facilities. The costs reported for pharmacy are gross of pharmacy rebates consistent with budget neutrality reporting articulated in STC 91.x of the approved demonstration."	N		
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	05/01/2022-04/30/2023	Constant	Decrease	Y		"The spending reported for Metrics 32, 33 and 39 are based on Alabama Medicaid fee-for-service (FFS) reimbursement. Please note, spending for inpatient, outpatient and emergency department expenditures represent the base FFS fee schedule and exclude Hospital Access payments. Alabama Hospital Access payments are CMS-approved upper payment limit supplemental payments made outside of the claims data for inpatient and outpatient hospital (including emergency department) facilities. The costs reported for pharmacy are gross of pharmacy rebates consistent with budget neutrality reporting articulated in STC 91.x of the approved demonstration."	N		
34	Per Capita Costs Associated With MentalHealth Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Increase	Y			N		
35	Per Capita Costs Associated With MentalHealth Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	05/01/2022-04/30/2023	Constant	Decrease	Y			N		
36	Number of Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	05/01/2022-04/30/2023	Constant	Decrease	Y			N		
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	05/01/2022-04/30/2023	Constant	Decrease	Y			N		
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	05/01/2022-04/30/2023	Decrease	Decrease	Y			N		
39	Total Costs Associated With Treatment for Mental Health as an IMD Among Beneficiaries With SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Constant	Y		"The spending reported for Metrics 32, 33 and 39 are based on Alabama Medicaid fee-for-service (FFS) reimbursement. Please note, spending for inpatient, outpatient and emergency department expenditures represent the base FFS fee schedule and exclude Hospital Access payments. Alabama Hospital Access payments are CMS-approved upper payment limit supplemental payments made outside of the claims data for inpatient and outpatient hospital (including emergency department) facilities. The costs reported for pharmacy are gross of pharmacy rebates consistent with budget neutrality reporting articulated in STC 91.x of the approved demonstration."	N		
40	Per Capita Costs Associated With Treatment for Mental Health as an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health as an IMD during the reporting year	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Constant	Y			N		
Q1	*Connecting behavioral and med mental health providers health information exchange (HIE)*	Percent of total inpatient psychiatric facilities connected to HIE	HealthIT	State-specific	Other annual metrics	HIE data	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Increase				N		
Q2	*eReferral/eConsult - closed loop referral services for consultation and/or follow up services*	Percent of referral and/or consultations that resulted in completed services	HealthIT	State-specific	Other annual metrics	HIE data	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Increase				N		
Q3	*Care management/recovery*	Percent of hospitals that sent electronic alerts of beneficiary inpatient or emergency department visits to care providers est of hospitals that have electronic alert capability in their locale (# of alerts)	HealthIT	State-specific	Other annual metrics	HIE data	Year	Annually	Required	Y	05/01/2022-04/30/2023	Increase	Increase				N		
State-specific metrics:																		
[Insert rows for any additional state-specific metrics by right-clicking on row 38 and selecting "Insert"]																		

If the data is not somehow a reasoned metric (i.e., column K = "N"), enter explanation in recommendation text in column P.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - SMI/SED definitions (Version 3.0)

State: Alabama

Demonstration Name: "Institutions for Mental Disease Waiver for Serious Mental Illness" (Project Number 11-W-00371/4)

Table: Serious Mental Illness and Serious Emotional Disturbance Definitions

Narrative description of the SMI/SED demonstration population		
Alabama Medicaid enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, between the ages of 21-64, will be eligible for acute inpatient stays in an IMD under the demonstration		
	Serious Mental Illness (SMI)	
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*At least one acute inpatient claim from a participating facility for a recipient with a recognized SMI diagnosis.*	*See SMI example for format and required information*
Codes used to identify population[b] *States may use ICD-10 diagnosis codes or state-specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD-10 codes with state-specific codes.*	*The state will be utilizing the revenue code 124 for inpatient claims associated with this waiver. Revenue code 124 was created solely for the purpose of the SMI Waiver Demonstration. Quality measures will be examined retrospectively utilizing the revenue code that was assigned to this project, which will identify all SMI participants..*	*See SMI example for format and required information*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements[b] *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state-specific codes) used to identify/define service requirements.*	*Revenue code 124*	*See SMI example for format and required information*

[a]The examples are based on a definition of SMI from the National Committee for Quality Assurance (NCQA). The examples provided are intended to be illustrative only. The example codes provided are not comprehensive.

[b]States may choose to include codes as separate tabs in this workbook.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (Version 3.0)

State: Alabama

Demonstration Name: "Institutions for Mental Disease Waiver for Serious Mental Illness" (Project Number 11-W-00371/4)

Table: Serious Mental Illness and Serious Emotional Disturbance Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format: comma separated)[a,b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: Age group (Do not delete or edit this row)	*EXAMPLE: Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)*	*EXAMPLE: Required*	*EXAMPLE: Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22*	*EXAMPLE: CMS-provided*	*EXAMPLE: Y*	*EXAMPLE: N*	*EXAMPLE: Children/Young adults (ages 12-20), Adults (ages 21-65)*	*EXAMPLE: N*	*EXAMPLE: 11, 12, 13, 14*
Standardized definition of SMI[d]	Individuals who meet the standardized definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y	Adults (ages 21-64)	Y	
State-specific definition of SMI	Enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage, between the	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	State-specific	Y	Y	Adults (ages 21-64)	Y	
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required	Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y	Adults (ages 21-64)	Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y	Adults (ages 21-64)	Y	
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N		The state is reporting on metrics approved by CMS for the purpose of the SMI demonstration.		
Criminal justice status	Criminally involved, Not criminally involved	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N		The state is reporting on metrics approved by CMS for the purpose of the SMI demonstration.		
Co-occurring SUD	Individuals with co-occurring SUD	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N		The state is reporting on metrics approved by CMS for the purpose of the SMI demonstration.		
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N		The state is reporting on metrics approved by CMS for the purpose of the SMI demonstration.		
State-specific subpopulations									
[Insert row(s) for any state-specific subpopulation(s)][e]									

[a] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[b] If the state is reporting on the Dual-eligible status subpopulation category, the state should use column H to outline its subpopulation identification approach as explained in Version 4.0 of the Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations Monitoring Protocol Instructions.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should (1) select N in column G and (2) provide an explanation and the report (SMI/SED DY and Q) in which it will begin reporting the subpopulation category in column H.

[d] "Standardized definition of SMI" and "State-specific definition of SMI" are included within the list of subpopulation categories because the state should report on these populations separately from the "Demonstration reporting" calculation for certain metrics. The state should reference Version 4.0 of the Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics for detailed descriptions on calculating metrics according to the standardized and state-specific definitions of SMI.

[e] Any state that claims federal financial participation (FFP) for services provided in Qualified Residential Treatment Programs (QRTPs) that are IMDs should add QRTPs that are IMDs as a state-specific subpopulation in row 19. Specifically, the state should note "QRTPs that are IMDs" in column A, "Individuals treated within QRTPs that are IMDs" in column B, and "Metrics #19a and 19b" in column D.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Reporting schedule (Version 3.0)

State: Alabama

Demonstration Name: "Institutions for Mental Disease Waiver for Serious Mental Illness" (Project Number 11-W-00371/4)

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SMI/SED demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SMI/SED demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column F, select Y or N in column H, "Deviations from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e. column H= "Y"), the state should describe these deviations in column I, "Explanation for deviations (if column H="Y")" and use column J, "Proposed deviation in measurement period from standard reporting schedule in column G," to indicate the SMI/SED measurement periods with which it wishes to overwrite the standard schedule (column G). All other columns are locked for editing and should not be altered by the state.

Table 1. Serious Mental Illness and Serious Emotional Disturbance Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SMI/SED demonstration year:	
Start date	05/20/2022
End date	05/19/2023
Dates of first quarter of the baseline period for CMS-constructed metrics:	
(SMI/SED DY and Q) (Format DY#Q#; e.g., DY1Q1)	DY1Q1
Start date	06/01/2022
End date	08/31/2022
Broader section 1115 demonstration reporting period corresponding with the first SMI/SED reporting quarter, if applicable. If there is no broader demonstration, fill in the first SMI/SED reporting period. (Format DY#Q#; e.g., DY3Q1)	DY1Q1
First SMI/SED monitoring report due date (per STCs) (MM/DD/YYYY)	10/31/2022
First SMI/SED monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs):	
EQMs (Format CY#; e.g.,	CY2022
SMI/SED DY and Q associated with monitoring report (Format DY#Q#; e.g., DY1Q1)	DY2Q1
SMI/SED DY and Q start date	06/01/2023
SMI/SED DY and Q end date	08/31/2023
Dates of last SMI/SED reporting quarter:	
Start date	03/01/2027
End date	05/31/2027

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[9] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
06/01/2022	08/31/2022	10/31/2022	DY1Q1	DY1Q1	Narrative information	DY1Q1	N	N	
					Grievances and appeals	DY1Q1	N	N	
					Other monthly and quarterly metrics		N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
09/01/2022	11/30/2022	01/29/2023	DY1Q2	DY1Q2	Narrative information	DY1Q2	N	N	
					Grievances and appeals	DY1Q2	N	N	
					Other monthly and quarterly metrics	DY1Q1	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
12/01/2022	02/28/2023	04/29/2023	DY1Q3	DY1Q3	Narrative information	DY1Q3	N	N	
					Grievances and appeals	DY1Q3	N	N	
					Other monthly and quarterly metrics	DY1Q2	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
03/01/2023	05/31/2023	08/29/2023	DY1Q4	DY1Q4	Narrative information	DY1Q4	N	N	
					Grievances and appeals	DY1Q4	N	N	
					Other monthly and quarterly metrics	DY1Q3	N	N	
					Annual availability assessment	AA1	N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
06/01/2023	08/31/2023	10/30/2023	DY2Q1	DY2Q1	Narrative information	DY2Q1	N	N	
					Grievances and appeals	DY2Q1	N	N	
					Other monthly and quarterly metrics	DY1Q4	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures	CY2022	N	N	
					Other annual metrics	DY1	N	N	
09/01/2023	11/30/2023	01/29/2024	DY2Q2	DY2Q2	Narrative information	DY2Q2	N	N	
					Grievances and appeals	DY2Q2	N	N	
					Other monthly and quarterly metrics	DY2Q1	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Other annual metrics		N	N	
12/01/2023	02/29/2024	04/29/2024	DY2Q3	DY2Q3	Narrative information	DY2Q3	N	N	
					Grievances and appeals	DY2Q3	N	N	
					Other monthly and quarterly metrics	DY2Q2	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
03/01/2024	05/31/2024	08/29/2024	DY2Q4	DY2Q4	Narrative information	DY2Q4	N	N	
					Grievances and appeals	DY2Q4	N	N	
					Other monthly and quarterly metrics	DY2Q3	N	N	
					Annual availability assessment	AA2	N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
06/01/2024	08/31/2024	10/30/2024	DY3Q1	DY3Q1	Narrative information	DY3Q1	N	N	
					Grievances and appeals	DY3Q1	N	N	
					Other monthly and quarterly metrics	DY2Q4	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures	CY2023	N	N	
					Other annual metrics	DY2	N	N	
09/01/2024	11/30/2024	01/29/2025	DY3Q2	DY3Q2	Narrative information	DY3Q2	N	N	
					Grievances and appeals	DY3Q2	N	N	
					Other monthly and quarterly metrics	DY3Q1	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics			N	
12/01/2024	02/28/2025	04/29/2025	DY3Q3	DY3Q3	Narrative information	DY3Q3	N	N	
					Grievances and appeals	DY3Q3	N	N	
					Other monthly and quarterly metrics	DY3Q2	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
03/01/2025	05/31/2025	08/29/2025	DY3Q4	DY3Q4	Narrative information	DY3Q4	N	N	
					Grievances and appeals	DY3Q4	N	N	
					Other monthly and quarterly metrics	DY3Q3	N	N	
					Annual availability assessment	AA3	N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
06/01/2025	08/31/2025	10/30/2025	DY4Q1	DY4Q1	Narrative information	DY4Q1	N	N	
					Grievances and appeals	DY4Q1	N	N	
					Other monthly and quarterly metrics	DY3Q4	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures	CY2024	N	N	
					Other annual metrics	DY3	N	N	
09/01/2025	11/30/2025	01/29/2026	DY4Q2	DY4Q2	Narrative information	DY4Q2	N	N	
					Grievances and appeals	DY4Q2	N	N	
					Other monthly and quarterly metrics	DY4Q1	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
12/01/2025	02/28/2026	04/29/2026	DY4Q3	DY4Q3	Narrative information	DY4Q3	N	N	
					Grievances and appeals	DY4Q3	N	N	
					Other monthly and quarterly metrics	DY4Q2	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
03/01/2026	05/31/2026	08/29/2026	DY4Q4	DY4Q4	Narrative information	DY4Q4	N	N	
					Grievances and appeals	DY4Q4	N	N	
					Other monthly and quarterly metrics	DY4Q3	N	N	
					Annual availability assessment	AA4	N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
06/01/2026	08/31/2026	10/30/2026	DY5Q1	DY5Q1	Narrative information	DY5Q1	N	N	
					Grievances and appeals	DY5Q1	N	N	
					Other monthly and quarterly metrics	DY4Q4	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures	CY2025	N	N	
					Other annual metrics	DY4	N	N	
09/01/2026	11/30/2026	01/29/2027	DY5Q2	DY5Q2	Narrative information	DY5Q2	N	N	
					Grievances and appeals	DY5Q2	N	N	
					Other monthly and quarterly metrics	DY5Q1	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
12/01/2026	02/28/2027	04/29/2027	DY5Q3	DY5Q3	Narrative information	DY5Q3	N	N	
					Grievances and appeals	DY5Q3	N	N	
					Other monthly and quarterly metrics	DY5Q2	N	N	
					Annual availability assessment		N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
03/01/2027	05/31/2027	08/29/2027	DY5Q4	DY5Q4	Narrative information	DY5Q4	N	N	
					Grievances and appeals	DY5Q4	N	N	
					Other monthly and quarterly metrics	DY5Q3	N	N	
					Annual availability assessment	AA5	N	N	
					Annual metrics that are established quality measures		N	N	
					Other annual metrics		N	N	
[Add rows for all additional demonstration reporting quarters]									

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)

[a] **SMI/SED demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the effective date listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "SMI/SED reporting schedule" tab should align with the first day of a month. If a state's SMI/SED demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "SMI-SED reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each SMI/SED demonstration year and quarter. However, the state is not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

AA# refers to the Annual Assessment of the Availability of Mental Health Services ("Annual Availability Assessment") and the SMI/SED DY in which the Annual Availability Assessment will be submitted (for example, "AA1" refers to the Annual Availability Assessment that will be submitted with the state's annual monitoring report for SMI/SED DY1). Data in each Annual Availability Assessment should be reported as of the month and day indicated in the state's approved monitoring protocol. If the state cannot submit its Annual Availability Assessment when it submits its annual monitoring report, it should propose and describe a reporting deviation in Columns G and H.

Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Protocol Template

Per the PRA disclosure statement requirement, the estimated time to complete this document was 2 hours.

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

The state should complete this title page as part of its SMI/SED monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are provided below the table.

State	*Alabama*
Demonstration name	*Institutions for Mental Disease Waiver for Serious Mental Illness" (Project Number 11-W-00371/4)*
Approval period for section 1115 demonstration	*05/20/2022-05/19/2027*
SMI/SED demonstration start date[a]	*05/20/2022*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	*05/20/2022*
SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration goals and objectives	1. Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings; 2. Reduce preventable readmissions to acute care hospitals and residential settings; 3. Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state; 4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI including through increased integration of primary and behavioral health care; and 5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

[a] **SMI/SED demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For

example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Annual Assessment of the Availability of Mental Health Services reporting

☒ The state will use data as of the following month and day of each calendar year to conduct its Annual Assessment of the Availability of Mental Health Services: **The state will use data as of March 1 each of calendar year to conduct the assessment.**

4. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

5. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SMI/SED demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective report for a state with a first SMI/SED demonstration year (DY) of less than 12 months should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocol. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first SMI/SED DYs that are less than 12 months). If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its SMI/SED demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Section 3. Narrative information on implementation, by milestone and

reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for the state to provide context for its retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the utilization of telehealth services for mental health (Metric #17) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its monitoring report (under Milestone 3) by briefly summarizing the trend and providing context that, during this period, the state implemented a grant to improve access to mental health treatment in rural areas through the use of telemedicine.

For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

Alabama 1115 Waiver Demonstration for Serious Mental Illness Evaluation Design

Document prepared by the Public Consulting Group: June 30, 2023

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

A. GENERAL BACKGROUND INFORMATION

1. DEMONSTRATION NAME AND TIMING

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

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

2. DEMONSTRATION GOALS

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

The goals of the IMD 1115 waiver for SMI are to:

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

[1] Section 1905(i) of the Social Security Act defines an IMD as a "hospital, nursing facility, or other institution of more than 16 beds, which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."
[2] Medicaid's Institutions for Mental Disease (IMD) Exclusion (congress.gov)

5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

3. DESCRIPTION

This 1115 waiver authorizes federal financial participation (FFP) for acute care services during short term stays in the two psychiatric hospitals qualifying as IMDs in Baldwin and Mobile counties, EastPointe Hospital and BayPointe Hospital. Currently EastPointe has 66 beds and BayPointe has 18 beds. The demonstration covers services provided to Medicaid beneficiaries ages 21-64 diagnosed with SMI who are being treated within these IMDs. Medicaid eligible adults will have access to a full range of SMI treatment services ranging from short-term acute care in inpatient settings for SMI, to perpetual, chronic care for SMI in cost-effective community-based settings. The state is taking a regional approach where the demonstration limits expenditure authority to inpatient services being provided within the two IMDs in Baldwin and Mobile counties, however Alabama residents across the state with SMI are eligible to access these services regardless of their county of residence. The state will concurrently implement other initiatives that expand access to community-based mental health care in order to achieve the demonstration goals on a statewide basis.

Concurrent initiatives include:

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

4. POPULATION

The demonstration target population is Medicaid beneficiaries between the ages of 21-64 with an SMI diagnosis; approximately 214,000 individuals each year statewide[3]. Some groups receive limited Medicaid benefits, and these populations are excluded from the expenditure authority under this demonstration, and thus excluded from the evaluation target group. Excluded populations are: Limited Services available to certain aliens, Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Individual (QI) Program, Qualified Disabled Working Individual Program (QDWI), Family Planning—Authorized through Alabama's Plan First 11115 Family Planning Demonstration.

5. CONTEXT

In October 2012, Greil Memorial Psychiatric Hospital in Montgomery County and Searcy Hospital in Mobile County closed due to an initiative to promote community-based mental health care and reduce reliance on state operated beds. These hospitals combined housed 1,231 individuals with psychiatric diagnoses in FY 2011, and 90% of this population shifted into local communities. The state aimed to increase infrastructure in the southern region that offered behavioral health services given in Designated Mental Health facilities to replace services that were once provided in these state-run psychiatric hospitals. Following this initiative,

[3] https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/AlabamaStateFactSheet.pdf

there was an increase in individuals diagnosed with SMI receiving treatment in community-based settings and an enhanced potential for psychiatric emergency. For individuals with SMI ages 21-64 who required inpatient care, it was difficult to find treatment since many private hospitals offering acute inpatient care either lacked the capacity to take on the patient or could not be reimbursed under Medicaid when serving this age group if they had more than 16 beds.

From July 2012 to March 2015, Alabama was selected to participate in the Medicaid Emergency Psychiatric Demonstration (MEPD), to test whether Medicaid programs could support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain inpatient services where Medicaid reimbursement had typically been unavailable. It also tested whether Medicaid beneficiaries under psychiatric distress had quicker access to appropriate care when IMDs were reimbursed for emergency care. The state's goal, aligned with CMS, was to reduce psychiatric emergency department stays and provide better continuity of care between acute care and community providers.

In 2017, the last psychiatric hospital providing services to adults in the southwest region began only serving geriatric patients, terminating care accessibility for this age group. The closest hospital with an inpatient psychiatric unit and the closest IMD to Medicaid beneficiaries in the southwest region of the state are in Crenshaw County, which is a 3-hour drive away. Bryce Hospital in Tuscaloosa, Alabama's state psychiatric hospital, is also located several hours away from the southwest region, making inpatient psychiatric care virtually inaccessible. Alabama's intention through this 1115 demonstration is to regain and sustain the benefits achieved under its participation in the MEPD.

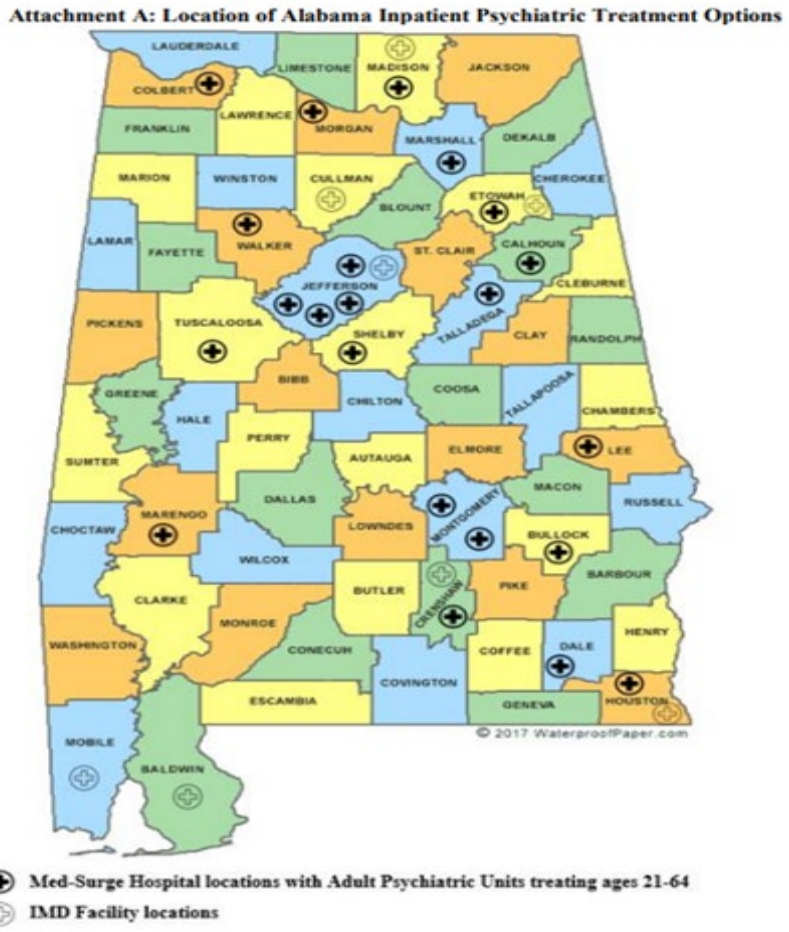


FIGURE 1. LOCATION OF ALABAMA INPATIENT PSYCHIATRIC TREATMENT OPTIONS

B. EVALUATION QUESTIONS AND HYPOTHESES

1. LOGIC MODEL

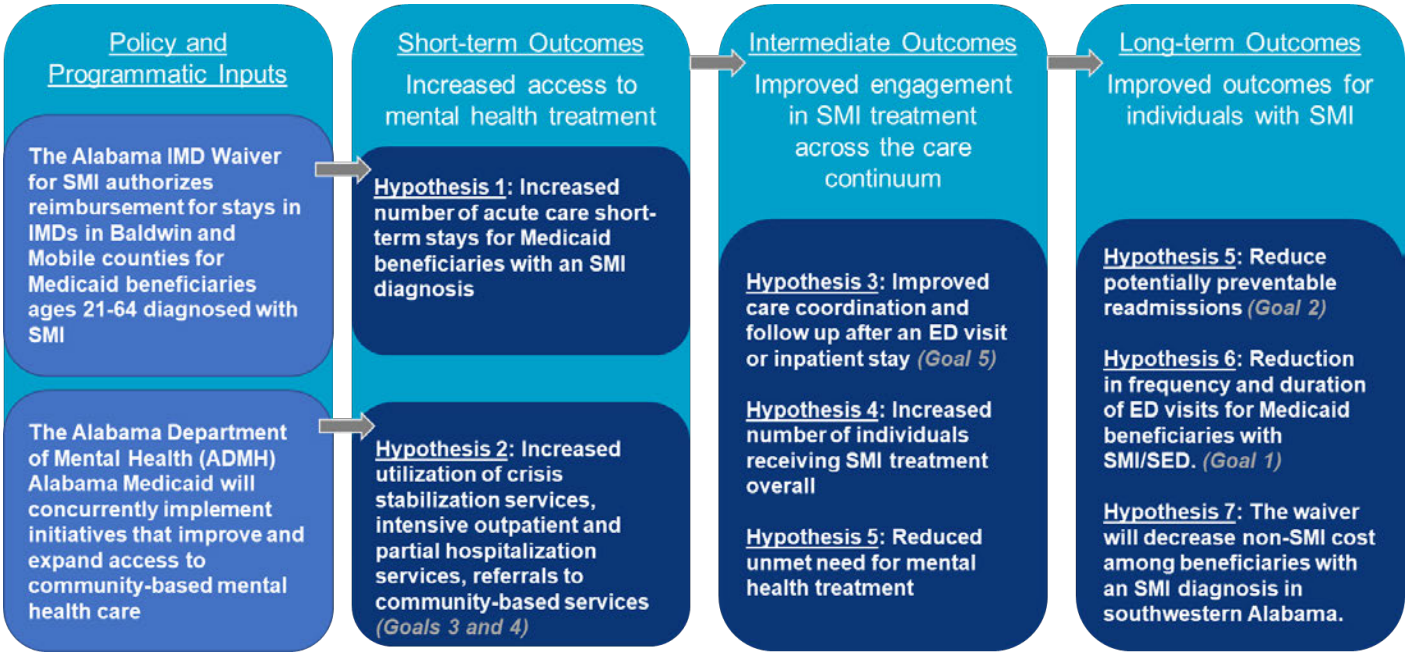


FIGURE 2. ALABAMA SMI DEMONSTRATION LOGIC MODEL

2. HYPOTHESES AND RESEARCH QUESTIONS

The overarching aim of the demonstration is to increase the number of Medicaid beneficiaries receiving treatment for SMI and reduce unmet needs for SMI treatment. The specific hypotheses and research questions are:

1. Hypothesis 1: The waiver will increase access to short-term stays in IMDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama.
    - Primary research question 1.1: Did the number of acute care short-term stays in IMDs for adult Medicaid beneficiaries with an SMI diagnosis increase in the southwest region of Alabama?
    - Primary research question 1.2: Did the waiver improve access to appropriate care for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama?
2. Hypothesis 2: The waiver will increase utilization of crisis stabilization services, intensive outpatient services and partial hospitalization services for adult Medicaid beneficiaries with an SMI diagnosis.
    - Primary research question 2.1: Did the number of beneficiaries receiving crisis stabilization services increase?
    - Primary research question 2.2: Did the number of beneficiaries receiving intensive outpatient services increase?
    - Primary research question 2.3: Did the number of beneficiaries receiving partial hospitalization services increase?

3. Hypothesis 3: The waiver will improve care coordination and follow up after an ED visit or inpatient stay.
    - Primary research question 3.1: Did the rate of follow up after ED visits increase?
    - Primary research question 3.2: Did the rate of follow up after inpatient stays increase?
    - Primary research question 3.3: Did the rate of medication continuance after inpatient stays increase?
    - Primary research question 3.4: Did referrals and overall care coordination improve for individuals with SMI?
4. Hypothesis 4: The demonstration will increase the number of Medicaid beneficiaries receiving treatment for mental health conditions and reduce unmet needs for mental health treatment.
    - Primary research question 4.1: Did the rate of Medicaid beneficiaries receiving treatment for mental health conditions increase in AL, compared to control states?
    - Primary research question 4.2: Did the prevalence of unmet needs for mental health treatment decrease in AL, compared to control states?
5. Hypothesis 5: The waiver will reduce the number of preventable readmissions to acute care hospitals and residential settings.
    - Primary research question 5.1: Did the rate of readmissions following psychiatric hospitalization decrease?
6. Hypothesis 6: The waiver will decrease the number of stays, and length of stays, in EDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama.
    - Primary research question 6.1: Did the number of stays in EDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama decrease?
    - Primary research question 6.2: Did the length of stays in EDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama decrease?
    - Primary research question 6.3: Did patient experience in the ED improve?
7. Hypothesis 7: The waiver will decrease costs among beneficiaries with an SMI diagnosis in southwestern Alabama.
    - Primary research question 7.1: Did total costs (dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis in the southwest region of Alabama decrease?
    - Primary research question 7.2: Did cost per member for SMI treatment (dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis in the southwest region of Alabama decrease?
        - *Subsidiary Research Question 7.2a*: What was the cost of IMD treatment for SMI services (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis?
        - *Subsidiary Research Question 7.2b*: Did the cost of non-IMD inpatient treatment for SMI services (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis decrease?
        - *Subsidiary Research Question 7.2c*: Did the cost of outpatient SMI treatment for SMI services (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis decrease?

- Primary research question 7.3: Did non-SMI cost per member (dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis in the southwest region of Alabama decrease?
    - *Subsidiary Research Question 7.3a: Did the non-SMI inpatient cost per member (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis decrease (excluding IMD treatment)?*
    - *Subsidiary Research Question 7.3b: Did the non-SMI outpatient cost per member (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis decrease?*

	Midpoint Assessment (Due Jul 16, 2025 to CMS)	Interim Report (Due May 17, 2026 to CMS)	Summative Report (Due Nov 17, 2028 to CMS)
Time period covered	May 20, 2022 – Nov 20, 2024	May 20, 2022 – Nov 20, 2025	May 20, 2022 – May 30, 2027
Data sources	• Administrative Data • Medicaid Encounters (MMIS)	• Administrative Data • Medicaid Encounters (MMIS)	• Administrative Data • Medicaid Encounters (MMIS) • CAHPS • NSDUH • Key Informant Interviews (KII)
Analyses	• Trend over time • Subgroup analyses	• Trend over time • Subgroup analyses	• Trend over time • Subgroup analyses • Interrupted Time Series • Difference in difference and SCM comparison to other states • Qualitative analysis
Approach	Descriptive	Descriptive	Quasi-experimental
Findings	Trends in utilization during the first two and a half years of the demonstration.	Trends in utilization during the first three and a half years of the demonstration.	Impact of demonstration

FIGURE 3. SUMMARY OF DELIVERABLES

C. METHODOLOGY

1. EVALUATION DESIGN

This mixed methods evaluation will employ quasi-experimental methods to investigate the impact of the demonstration. At the state level, results will be compared to national trends and comparison states using difference-in-difference (DiD) and synthetic control methods (SCM). Within the state, results from the southwestern region (Baldwin, Clark, Conecuh, Escambia, Mobile, Monroe, and Washington counties) will be compared to the rest of the state, and statewide results will be compared to pre-demonstration baseline using interrupted time series. To complement the quantitative results, Key Informant Interviews will be used to collect qualitative data about demonstration implementation and impact.

2. TARGET AND COMPARISON POPULATIONS

The target population for this demonstration is Medicaid eligible individuals aged 21-64 with SMI. While reimbursement for IMD stays will be limited to institutions in specific counties, residents of all counties who are treated at the facilities are eligible for coverage. PCG proposes to employ both in-state and out-of-state comparison strategies. Since a key aim of the demonstration is to address the lack of access specifically in the southwestern region of AL, in-state subgroup comparison by region will be essential to understand whether the demonstration increases access for residents of the southwestern counties (Baldwin, Clark, Conecuh, Escambia, Mobile, Monroe, and Washington counties). Claims data will be stratified by beneficiary county of residence, and grouped into regions. Additional stratification by demographic variables such as race/ethnicity will be used where appropriate.

	Estimated Number	% of Total
Individuals enrolled in Medicaid	474,673	100%
Individuals enrolled in Medicaid with SMI	15,212	3.20%
Of the individuals enrolled in Medicaid with SMI:		
Age*		
21-34	4,314	28.40%
35-44	3,815	25.10%
45-64	7,083	46.60%
Gender		
Male	8,795	57.80%
Female	6,401	42.10%
Other/NA	16	0.10%
Race/Ethnicity		
White	6,805	44.70%
Black	5,054	33.20%
Hispanic	103	0.70%
Other**	3,250	21.40%

**Age is reported as of April 30, 2023*
***Includes Asian, American Indian or Alaskan Native, other, and unknowns*

FIGURE 4. POPULATION DEMOGRAPHICS OF MEDICAID BENEFICIARIES

The IE will use national survey data from the National Survey on Drug Use and Health (NSDUH) to assess rates of SMI treatment received, and unmet need for SMI treatment. The full adult (aged 21-64) Medicaid population of AL will be the intervention group for this analysis and Medicaid beneficiaries in other states will be the controls. A three-year, pre-demonstration baseline will be used to determine the weights for the control states. The post-demonstration trend for AL will be compared to the calculated values for synthetic AL using linear regression.

3. EVALUATION PERIOD

The evaluation will include the full five years of the demonstration, from May 20, 2022 to May 19, 2027.

For interrupted time series analyses, two years of pre-demonstration claims data will be used to establish a baseline[4]. Three years of pre-demonstration data will be used to set a baseline for out-of-state comparisons.

4. EVALUATION MEASURES

The list of evaluation measures appears in the Evaluation Design Table, located in Section F.4 at the end of the document.

5.DATA SOURCES

The evaluation will use the following quantitative and qualitative data sources:

Medicaid Administrative Data
CAHPS Survey Data
National Survey on Drug Use and Health (NSDUH)
Key Informant Interviews

Medicaid Administrative Data

To analyze service utilization and related measures, PCG will use claims and other Medicaid administrative data, such as eligibility files.

The IE anticipates receiving claims and other Medicaid administrative data, such as eligibility files, from the state on an annual basis. Administrative data is expected to be of high quality, in terms of completeness and accuracy.

The IE and the state have worked together to assess the quality of Medicaid data and feasibility of the planned analysis, avoid confounding changes in data quality and completeness with changes in the outcomes of interest, and consider the framing of interpretations of evaluation evidence given any concerns with the data. Medicaid claims data will be based on FFS encounters and reported by providers. This data is reported biweekly, weekly, and monthly. The state's fiscal agent, Gainwell Technologies, runs the data through databases and the data goes through a cleaning process with the fiscal agent. To validate the data, the state's analytics team works with Gainwell Technologies and uses a four-point match system to merge records (Medicaid IDs), check for duplicates, and missing data. Once the data has been cleaned and validated by Gainwell Technologies and the state, the IE uses an additional

[4] In order to avoid confounding of the analysis by pandemic effects on utilization, trends for the baseline period will be modeled with and without the most affected months of 2020. This sensitivity analysis will help identify differential impacts. If the pattern changes observed in the first quarter of the PHE are similar for all subgroups, then confounding of the results by pandemic impacts is less likely.

process to validate population and service counts in Microsoft SQL Server and ensure that the data received from the state is complete and accurate.

Medicaid administrative data contains information such as gender, date of birth, age, and race. Approximately 88% of applications report racial data (self-reported by the applicant). This information is available in the eligibility file that can be linked to claims data. Alabama Medicaid Agency aligns with HRSA's definition of urban and rural geographic areas and uses these definitions to assign urban-rural county classifications in AMA data.

CAHPS Survey Data

To measure beneficiary experience, PCG will rely on aggregate data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys administered by plans or facilities.

The IE anticipates having access to aggregate CAHPS data collected by the health plans and reported to AMA. CAHPS data also be used to analyze differences in patient satisfaction over time, by county, and between subgroups. Because CAHPS data will be available only in aggregate, subgroup analysis will be limited to the available demographic stratifications: age, race (White and Other), ethnicity (Hispanic/ Not Hispanic), and gender.

National Survey on Drug Use and Health (NSDUH)

In order to contextualize changes that occur in AL, PCG will compare state trends to control states using national survey data. The National Survey on Drug Use and Health (NSDUH) tracks rates of substance use and mental illness, and treatment received for behavioral health conditions, at the national, state, and sub-state levels. NSDUH includes questions about receiving treatment for SMI, and about needing but not receiving treatment for SMI (unmet need) in the last 12 months. The data can be stratified by demographic, geographic, and socioeconomic factors, allowing for valuable analysis of disparities and subgroup patterns.

Key Informant Interviews

Qualitative data on program implementation will be gathered through key informant interviews (KIIs) with providers (hospital based providers, outpatient behavioral health and outpatient primary care providers) and state administrators. The IE will work with AMA to identify lists of each interviewee type. A random sample of names will be drawn from each list then reviewed for balance across region (replacements may be made to achieve balance). The IE will interview approximately 5-6 individuals for each type, yielding a sample of approximately 20-24 total interviews.

Semi-structured key informant interviews lasting 30-45 minutes per contact will be conducted by phone or videoconference, with privacy protections in accordance with CMS guidelines. Interviews will be recorded and transcribed. Interview guides will be developed by the IE in collaboration with AMA for providers, including clinicians and administrators, and for state employees involved in implementation of the waiver demonstration. Based on the interviewee's role, the interview guide and questions asked will be tailored accordingly. For example, state administrators will be invited to discuss the program rollout and feedback received from stakeholders, clinicians will be asked whether and how their experience of treating patients with SMI has changed during the demonstration, and staff at hospitals will be asked about processes for referral to community services post discharge. The IE anticipates interviewing approximately four participants from AMA staff, six from hospitals or residential treatment programs, including IMD facilities in Mobile and Baldwin counties, and six from community-based treatment providers. Interviewees at provider organizations will include both clinicians and staff involved in care coordination and referrals.

6. ANALYTIC METHODS

Quantitative Analysis

In order to provide robust conclusions, PCG will employ multiple analytic strategies to answer the research questions. PCG will utilize statistical software packages including SAS, SQL, and Stata to analyze the data, generating descriptive statistics and assessing significant differences in comparisons of interest. The IE will evaluate all measures in the Evaluation Table (Figure 9) in the Summative Report. Due to data availability, measures using data from the National Survey on Drug Use and Health (NSDUH), and qualitative measures relying on KIIs, will not be included in the midpoint or interim reports but will be included in the Summative Report.

Quantitative analysis will utilize descriptive statistics, trends over time, multiple linear regression, interrupted time-series analysis (ITS), difference-in-differences (DiD), and synthetic control methods (SCM). For most measures, the unit of analysis is number of beneficiaries submitting a claim for the service being evaluated (ex. ED, inpatient, outpatient, IMD services). For cost measures, the unit of analysis is dollars per beneficiary per month (PBPM). Hypothesis testing will be conducted for each hypothesis and associated quantitative research questions to assess statistical significance. Regression modeling (multiple linear regression) will use p-values generated as part of the regression output to assess statistical significance of results. Results will be reported at the p<=.05 level and include point estimates and confidence intervals. Covariates included in the regression models include age, gender, race, ethnicity, and urban-rural geographic classifications. However, urban-rural classifications will not be used as covariates when comparing southwest Alabama to other parts of the state in order to avoid collinearity. Inclusion and selection of covariates will depend on number of available observations; for example, if population group size is too small for including a specific demographic variable, this variable might need to be excluded from the list of covariates or collapsed into other categories.

Descriptive statistics

PCG will use descriptive statistical methods to generate summary tables of population size and characteristics, and outcomes for the three groups of demonstration participants. Data will be analyzed using standard tests such as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode). These tables will be used to develop a quantitative picture of the population, to describe raw trends, and to identify characteristics that will be included as covariates in regression modeling.

Service counts of IMD claims will determine the number and demographic characteristics of individuals receiving treatment, and the fraction of patients who come from inside or outside Mobile and Baldwin counties to receive IMD services. While residents of any county may be treated in any facility in the state, the state expects that most individuals needing treatment will seek care within the region where they reside, as previous observations have shown that long driving distance is a deterrent to seeking treatment.

Trend over time and linear regression modeling

Outcomes of interest will be plotted over time for the duration of the demonstration. Linear regression analysis will be used to evaluate trends over time (interrupted time series design). As the demonstration is intended to address access problems particularly in the southwest region of the state, the hypothesis for this analysis will be that outcomes improve more for beneficiaries residing in Mobile and Baldwin counties. Some individuals from bordering counties or elsewhere in the state may seek treatment in Mobile and Alabama counties, but the lack of access that motivated the demonstration is particular to the southwest corner of the state, where driving distance to any treatment facility is prohibitive; therefore, residents of these counties are expected to experience a proportionally greater benefit.

The null hypothesis will be that the groups (Mobile and Baldwin counties versus rest of state) have identical trends. Pre-demonstration trends across the entire state will be compared to post-demonstration trends across the entire state using interrupted time series. In addition, trends for Baldwin and Mobile counties will also be compared to the rest of the state during the demonstration using a difference-in difference analysis.

Subgroup comparisons

For subgroup comparisons, the trend for each evaluation group will be modeled using multivariate linear regression and compared. This regional subgroup analysis will use a comparative interrupted time series design. For comparison of regional changes, the reference group will be the non-southwestern counties.

In order to account for demographic characteristics such as age and gender that may differ among the groups PCG will use inverse probability of treatment weighting. Individuals in each group will be assigned weights based on the composition of the reference group, producing groups that are equivalent for measurable characteristics and allowing any difference in outcomes to be attributed to the intervention.[5]

Analyses will also partition participants by age, race/ethnicity and gender. Claims data and national survey data sets include demographics, although completeness and level of detail varies. Where possible, race will include White, Black, Asian, Latinx, and Native American populations for stratification. Due to the low prevalence of some subgroups, it may be necessary to combine non-white racial groups into an "Other" category. Ethnicity will be characterized as Hispanic/Not Hispanic. Subgroup analysis may also be conducted using geographic data; counties will be assigned either a "rural" or "urban" classification. Alabama Medicaid Agency uses HRSA (Health Resources and Services Administration) definitions of urban-rural classifications.

Regression Equation

The evaluation will use ITS analysis to test for different linear effects in the pre-demonstration and post-demonstration periods. The function for an example outcome C is presented below.

$$C = \beta 0 + \beta 1 * TIME + \beta 2 * POST + \beta 3 * (TIME * POST) + \beta i * COVAR + \varepsilon$$

In this function, TIME is a count variable that starts with the first quarter pre-demonstration period data and ends with the last quarter of post-demonstration period data. POST is an indicator variable that equals 1 if the month occurred on or after the demonstration start date. COVAR represents a set of covariates, such as age, gender, race, and month, for example.

The marginal effect and standard error for each term will be derived and reported. The average marginal effect of the interaction term, β3(TIME*POST), represents the apparent difference between the pre- and post-demonstration periods.

Difference-in-difference

In order to examine the impact of the demonstration on its overarching aim of improved access, PCG will conduct a stacked difference-in-difference (DiD) to model the effect of the demonstration in Alabama and

[5] Austin PC, Stuart EA. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. Stat Med. 2015; 34(28):3661–79. Epub 2015/08/05. https://doi.org/10.1002/sim.6607 PMID: 26238958; PubMed Central PMCID: PMC4626409.

then compare Alabama to states with SMI/SUD waivers and states without SMI/SUD waivers. Furthermore, a stacked DID model can address the different timelines of different states. This model will help better understand how Alabama compares to states that didn't have an SMI/SUD waiver and how Alabama compares to states that did have SMI/SUD waivers. Stacked DiD models can help assess the impact of the overall effect versus the effect of the demonstration on Alabama. In a stacked DID model, datasets specific to each group are "stacked" in relative time, where a value of zero linear time represents the year exactly before implementation. A value of one represents the first year after implementation, a value of two represents the second year after implementation, and so on.

Regression Equation

Stacked DiD models recently originated in labor economics scholarship, with seminal papers produced by Cengiz et al. and Deshpande et al. in 2019.[6,7] A basic example of a DiD model fitted to stacked data may look like the below equation.[8] It should be noted that this is a general example, and the model will be modified to reflect the outcomes, covariates, and time periods specific to the analysis.

$$Y_{std} = \beta_0 + \beta_1 T_{sd} + \beta_2 P_{td} + \beta_3 (T_{sd} \times P_{td}) + \epsilon_{std}$$

In the above equation, d is the sub-experiment, s is the unit treated in the sub-experiment (d), and T_{sd} is a variable indicator for this. The term P_{td} represents an indicator demonstrating that t falls in the post-period in sub-experiment d.[8]

The key outcomes will be 1) receiving treatment for mental health in the last 12 months and 2) having an unmet need for mental health treatment in the last 12 months, as reported by respondents to the NSDUH survey. All other states will be included in the model, with an indicator variable designating those states that have implemented an SMI waiver demonstration. The first model will include covariates adjusting for demographic factors such as age, education, and income. The second model will employ inverse probability of treatment weighting (IPTW). Individuals in the treatment group (AL residents) will be assigned weights based on the composition of the reference group (residents of other states), producing comparison groups that are equivalent for measurable characteristics and allowing any difference in outcomes to be more confidently attributed to the intervention.[9] Characteristics for weighting, used in both models, include respondent age, education, employment status, household size, veteran status, sex, household income, homeownership status, presence of children in the household, survey month, and whether the survey was conducted via landline or cell phone.

[6] Cengiz, Doruk, Arindrajit Dube, Attila Lindner, and Ben Zipperer. "The effect of minimum wages on low-wage jobs." The Quarterly Journal of Economics 134, no. 3 (2019): 1405-1454.
[7] Deshpande, Manasi, and Yue Li. "Who is screened out? Application costs and the targeting of disability programs." American Economic Journal: Economic Policy 11, no. 4 (2019): 213-48.
[8] Wing, Coady. "Staggered Adoption Designs Stacked Did and Event Studies - Open Scholarship." Indiana University Bloomington Libraries, 22 Oct. 2021, scholarworks.iu.edu/dspace/bitstream/handle/2022/26875/2021-10-22_wim_wing_did_slides.pdf?sequence=1.
[9] Austin PC, Stuart EA. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. Stat Med. 2015; 34(28):3661–79. Epub 2015/08/05. https://doi.org/10.1002/sim.6607 PMID: 26238958; PubMed Central PMCID: PMC4626409.

Synthetic control methods

In addition to DiD, PCG will use synthetic control methods (SCM) to estimate the association between implementation of the demonstration and the key outcomes of receiving mental health treatment and having an unmet need for mental health treatment. SCM have been employed to evaluate state-level policy impacts because they are particularly useful when estimating the impact of a policy change that affects a small number of treatment groups (i.e., a state).[10,11,12,13] These methods are a quasi-experimental approach similar to traditional difference-in-difference (DiD) estimation but require fewer assumptions to obtain estimates of association. DiD attempts to control for observed variables that may be associated with both treatment likelihood and the outcome of interest, and then assumes that any differential changes in outcomes between treated and control groups are attributable to the policy change. However, treatment and control groups may still differ in terms of outcome pre-trends and levels due to unobserved factors. This introduces potential selection issues, which may bias any estimates of association.

In contrast, SCM constructs a synthetic control from a pool of groups not exposed to the treatment of interest – in this case all other states. The synthetic control is constructed using a weighted average of the control groups, with weights chosen through a fully empirical process; weights for individual control units may range from 0 to 1 and are selected so the synthetic control is as similar as possible to the treated group in terms of outcome pre-trends. Unlike traditional regression, inclusion of covariates *is not required* to achieve equivalence between treated and control groups. The weighting process accounts for pre-demonstration differences among states, regardless of the underlying reason for the difference. That said, including covariates can help provide more reliable estimates[14].Therefore, the SCM will include covariates for "SMI/SUD waiver status" and "Medicaid Expansion status". A table will be prepared showing each state and their SMI/SUD waiver status, and Medicaid Expansion status, by date. This table will be used to compare other states' waiver and expansion status dates relative to the dates of Alabama's waiver and thus determine the correct status indicators for the covariates.

For each outcome of interest, PCG will use NSDUH data for other states for the three years prior to demonstration launch to construct a synthetic control representing AL's outcomes during the baseline period. [15] The weights derived empirically during this stage will allow PCG to generate a predicted outcome value for "synthetic Alabama" for each quarter during the demonstration period. This model will

[10] Abadie, A., 2012. *Synthetic control methods for comparative case studies: estimating the effect of California's tobacco control program. J Am Stat Assoc* 105(490):493-505. https://www.tandfonline.com/doi/abs/10.1198/jasa.2009.ap08746

[11] Rudolph, K.E., *et al.*, 2015. *Association between Connecticut's Permit-ti-Purchase handgun law and homicides. Am J Public Health* 105(8):e49-e54. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302703

[12] Santella-Tenorio, J. *et al*., 2020. *Association of recreational cannabis laws in Colorado and Washington state with changes in traffic fatalities. JAMA* 180 (8):1061-1068. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2767647

[13] Bhatt, A. *et al.* 2020. *Association of changes in Missouri firearm laws with adolescent and young adult suicides by firearms. JAMA Netw Open* 3(11). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772526

[14] Abadie, A. and Vives-i-Bastida, J. 2021. *Synthetic Controls in Action.* Whitepaper 9/17/21. https://economics.mit.edu/sites/default/files/publications/ESWC_Paper-1.pdf

[15] CMS White Paper, October 2020, "Selection of Out-of-State Control Groups and the Synthetic Control Method.

be used to find mean differences between actual AL outcomes and predicted outcome of the synthetic control during the demonstration period.

Subgroup Analyses

The evaluation will use the aforementioned data sources to understand how different subgroups of individuals with SMI are impacted by the demonstration. Analyses will partition participants by age, race/ethnicity and gender. Where possible, race will include White, Black, Asian, Latinx, and Native American populations for stratification. Due to the low prevalence of some subgroups, it may be necessary to combine non-white racial groups into an "Other" category. Ethnicity will be characterized as Hispanic/Not Hispanic. Using HRSA definitions, AMA currently designates 46 counties in Alabama to be rural counties and 21 counties to be urban counties; urban-rural classification of counties may also be used to stratify beneficiaries into subgroups.

Cost Analyses

The evaluation will utilize three levels of cost analyses: these levels are total costs, SMI versus non-SMI costs, and costs by source of treatment (see FIGURE 5 below).

Hypothesis 7 proposes that the waiver will reduce non-SMI costs among individuals with an SMI diagnosis; this hypothesis is broken down into three primary research questions. Costs are reported in dollars per beneficiary per month (PBPM).

Research Question 7.1 assesses total costs for individuals with an SMI diagnosis in southwestern Alabama. Research Question 7.2 assesses SMI costs for individuals with an SMI diagnosis and is broken down further into three subsidiary research questions that assess SMI costs for IMD treatment (7.2a), non-IMD inpatient treatment (7.2b), and outpatient treatment (7.2c).

Research Question 7.3 assesses non-SMI costs for individuals with an SMI diagnosis and is broken down into two subsidiary research questions that assess non-SMI costs for inpatient cost per member (excluding IMD treatment) (7.3a) and outpatient cost per member (7.3b).

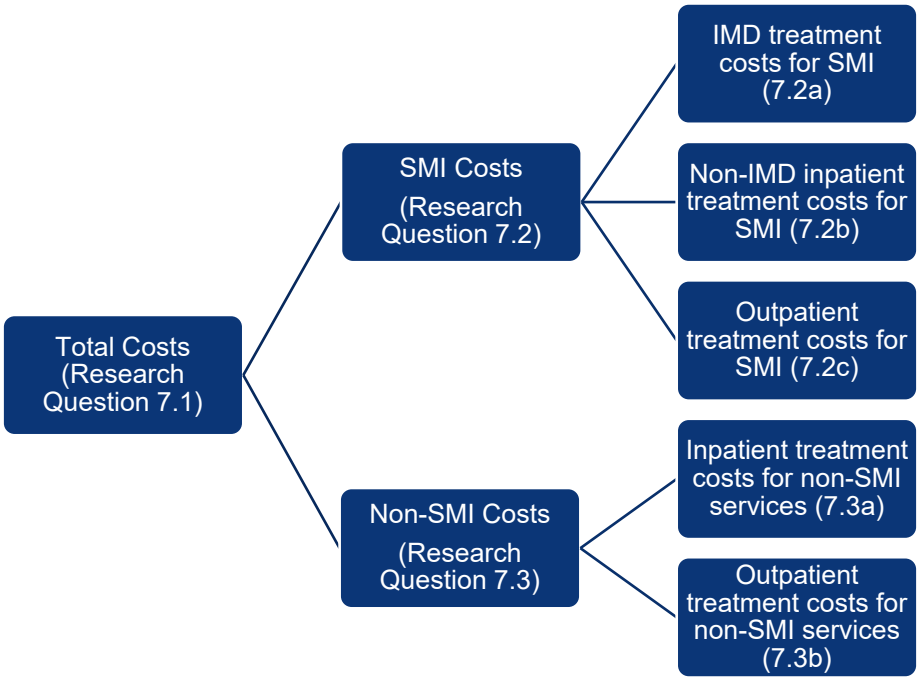


Figure 5 Levels of Cost Analysis

Sensitivity Analyses

In order to validate the use of regression models and increase confidence in estimates, the IE will conduct sensitivity testing. For difference-in-difference models, the IE plans to conduct an event study to show evidence of parallel trends and run unadjusted versus adjusted models, adding state-level linear time trends. The event study will use baseline and linear time trends, interacted by treatment status. If the interaction is significant, then a linear time trend interacted by treatment status can be fitted to the model to estimate deviation from the pre-trend. For the interrupted time-series models, the IE will conduct a similar event study to show pre-trends.

In order to conduct sensitivity testing on analyses using propensity score weighting, the IE will also explore changing the caliper width (how close of a match they have to be), the maximum number of control cases matched to each treated case, or iteratively leaving out variables from the prediction model to see how sensitive the model is to misspecification. The IE may also use inverse probability treatment weighting (IPTW) to estimate the likelihood of residing in a state with an SMI waiver in place.

For synthetic control analyses, the IE may run a variety of sensitivity analyses where certain states are excluded from the donor pool, such as states with pre-existing Medicaid income eligibility greater than or equal to 100% of the federal poverty line (FPL) prior to the ACA.

Qualitative Analysis

Qualitative analysis will be used for key informant interview transcripts. The research questions to be addressed, with corresponding example topics, are listed in Figure 6. Interviews will address these questions by probing for perspectives from providers and from administrators involved in implementing the demonstration. Thematic analysis using a coding tree derived from the demonstration logic model will be used to excerpt transcripts. Additional themes that arise during coding will be added to the analysis. Results will be stratified by interviewee role: hospital-based provider, outpatient behavioral health provider, outpatient primary care provider, and state administrator. Results of interviews will be used to add context to the quantitative findings regarding referral and care coordination processes, experience of care, beneficiary engagement, and barriers to engagement. Findings will address implementation and will inform the Evaluation Report chapter on Lessons Learned and Recommendations.

Research Question	Example topics
Was the demonstration implemented effectively?	• Perceived successes and challenges in implementation • Perceived steps towards integrating behavioral health with physical health services, e.g., screening and referrals in the ED and inpatient facilities
Primary research question 1.2: Did the waiver improve access to appropriate care for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama?	• Perceptions of barriers to access and participation in care • Management of SMI patients in the ED • Role of IMDs in the care continuum • Steps providers are taking to identify, understand, and address disparities in access and engagement
Primary research question 4.4: Did referrals and overall care coordination improve for individuals with SMI?	• Discharge planning and follow up processes • Communication among providers across the care continuum • Perceived changes in care coordination during the demonstration

FIGURE 6. RESEARCH QUESTIONS WITH EXAMPLE TOPICS

D. METHODOLOGICAL LIMITATIONS

This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

1. **Lack of a true comparison group.** The target population of this demonstration is all individuals in AL in need of SMI treatment. As such, no true comparison group for this population exists. To mitigate this limitation, the IE plans to use both in-state comparison among counties, and out-of-state NSDUH data.
2. **Sample size.** Under the demonstration, a 5-year total of approximately 10,381 individuals are expected to receive services. However, the data set for specific outcomes may not have sufficient size statistical analysis on all subgroups of interest. In particular, the data may not support analysis by race/ethnicity for all outcomes. The IE will explore disparities in outcomes by race/ethnicity within the groups where numbers are sufficient. To further investigate health equity, KII interview guides will include questions about state and providers' efforts to identify and remediate disparities in access.
3. **Out-of-state comparisons.** The use of national survey data allows for out of state comparison groups but limits the ability to specifically identify individuals enrolled in the demonstration. An approximation will be achieved by using income and Medicaid enrollment and self-reported conditions to define a sample representing demonstration participants as closely as possible.
4. **Historic effects.** The impacts of the Covid-19 pandemic/PHE are expected to persist past the formal end of the PHE, and may include exacerbation of pre-existing clinician shortages, understaffing of hospitals and residential facilities, fluctuations in Medicaid enrollment, confusion and administrative challenges during PHE unwinding, and changes to participants' ability and willingness to make and keep appointments during infection surges. All of these factors could impact demonstration goals to improve outcomes for individuals with SMI. Sensitivity analysis and regression techniques described above will be used to minimize confounding.

E. ATTACHMENTS

1. INDEPENDENT EVALUATOR

Procurement for an evaluation contractor to assist the State in executing its 1115 demonstration evaluation plan was accomplished pursuant to the State of Alabama procurement guidelines with resulting agreement contingent upon approval from Alabama's Governor. The State retains responsibility for monitoring the demonstration activities and providing oversight of the evaluation design and overall approach for the contractor. To mitigate any potential conflict of interest, the evaluation contractor is responsible for:

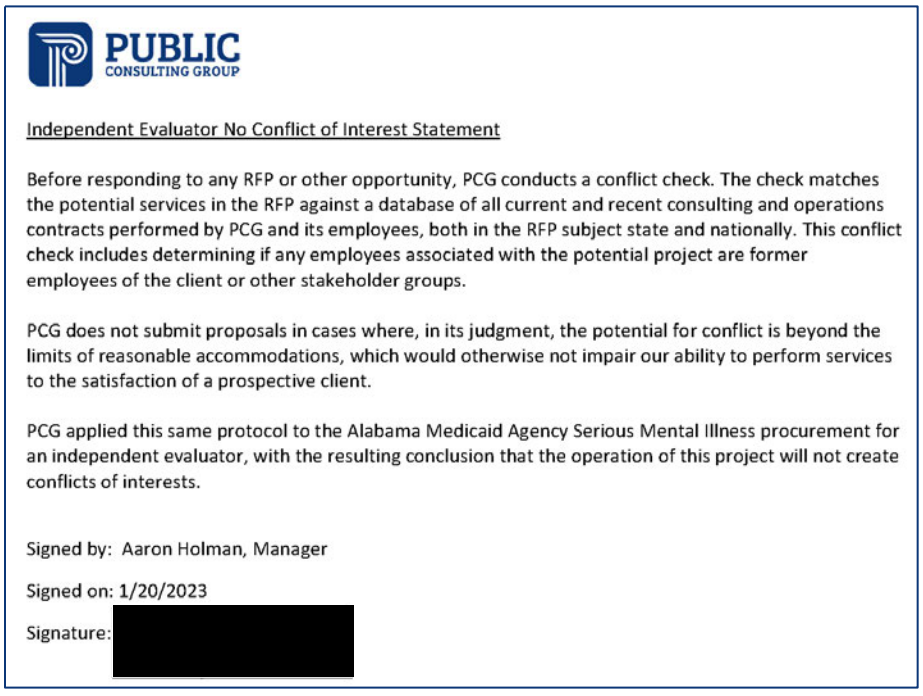
- Conducting an evaluation compliant with all requirements specified in the demonstration's Special Terms and Conditions
- Developing the evaluation design;
- Leading the implementation of the evaluation and the evaluation itself;
- Conducting all analysis of the evaluation results in compliance with CMS timelines and deliverables;
- Ensuring the validity, reproducibility, and interpretation of the results;
- Collaborating with AMA through the implementation of the waiver and the duration of all evaluation activities; and
- Producing evaluation reports.

As part of the focused independent evaluation, the evaluator is responsible for final measure selection, identifying, if viable, other State systems that may serve as comparisons, conducting all data analysis, measuring change over time, and developing sensitivity models as necessary to address study questions.

The State issued one procurement for all evaluation activities and the production of required CMS reports. As the successful bidder, Public Consulting Group (PCG) demonstrated the following qualifications:

- Provision of an Evaluation Design Plan, inclusive of an initial logic model and evaluation timeline that reflects the evaluation deliverables and deadlines required by CMS.
- An ability to comply with CMS' evaluation requirements, including proposed evaluation methods for measuring the impacts and goals of the SMI waiver program;
- A cost proposal that included all proposed costs through 2028;
- A staffing plan that identified who would be responsible for the project components and who would be the project manager and point of contact for AMA;
- A proposed project management and communication approach that met the requirements set forth by AMA; and
- Prior experience with similar evaluations.

Consistent with the requirements of 42 CFR § 431.420, AMA selected and retained PCG as an independent evaluator to complete the independent evaluation of the demonstration required under 42 CFR § 431.424. AMA utilized the State of Alabama's procurement process to contract with this evaluator and promote an independent evaluation, through the general requirements for each state contractor as well as project-specific standards. AMA Procurement staff worked with the evaluator to identify and address concerns that might arise during the administration of the contract. By requiring initial satisfaction of these standards by the contracting party in order to be awarded the contract, as well as ongoing maintenance of the requirements during the term of service, AMA is in a position to receive an objective evaluation report that is the product of a fair, impartial, and conflict-free evaluation.



PUBLIC CONSULTING GROUP

Independent Evaluator No Conflict of Interest Statement

Before responding to any RFP or other opportunity, PCG conducts a conflict check. The check matches the potential services in the RFP against a database of all current and recent consulting and operations contracts performed by PCG and its employees, both in the RFP subject state and nationally. This conflict check includes determining if any employees associated with the potential project are former employees of the client or other stakeholder groups.

PCG does not submit proposals in cases where, in its judgment, the potential for conflict is beyond the limits of reasonable accommodations, which would otherwise not impair our ability to perform services to the satisfaction of a prospective client.

PCG applied this same protocol to the Alabama Medicaid Agency Serious Mental Illness procurement for an independent evaluator, with the resulting conclusion that the operation of this project will not create conflicts of interests.

Signed by: Aaron Holman, Manager

Signed on: 1/20/2023

Signature: [redacted]

2. EVALUATION BUDGET

The estimated average budget for each year of the evaluation is $173,286.41. Qualitative and quantitative data collection and analysis represent a combined 25% of the budget and report generation represents 50% of the budget. Yearly fluctuations in actual expenses are anticipated based on the timing of deliverables and data collection activities.

Annual Total Estimated Cost		
Evaluation Activity	**Annually**	**% of Total**
Project Management	19,061.51	11%
Evaluation Design	24,260.10	14%
Key Informant Interviews, Data Collection, Cleaning and Analysis	8,664.32	5%
Quantitative Data-Collection, Cleaning and Analysis	34,657.28	20%
Midpoint Assessment Report Generation	25,992.96	15%
Interim Evaluation Report Generation	25,992.96	15%
Summative Evaluation Report Generation	34,657.28	20%
Annual Total	**173,286.41**	100%

FIGURE 7. ALABAMA SMI DEMONSTRATION EVALUATION BUDGET

3. TIMELINE AND MAJOR MILESTONES

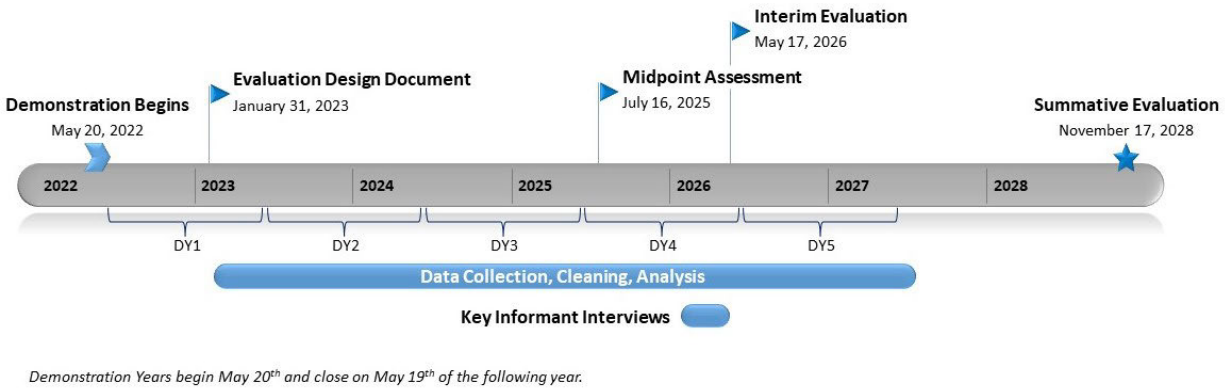


FIGURE 8. HIGH-LEVEL EVALUATION TIMELINE AND MAJOR MILESTONES

The demonstration began on May 20, 2022, and will conclude at the close of DY5 on May 19, 2027. The first major milestone is the State's submission of this document, the Draft Evaluation Design Document, to CMS on January 31, 2023. Data collection, cleaning and analysis activities take place throughout the majority of the demonstration period. Key Informant Interviews will be conducted from the fall to early winter of 2027. The results are documented in three reports, the submission of which constitute the remaining major evaluation milestones: the Midpoint Assessment, the Interim Evaluation, and the Summative Evaluation. The timeline for these deliverables is outlined in the demonstrations approved Special Terms and Conditions and shown in the figure above.

The cadence of evaluation report writing will follow the same pattern across all the three reports:

- PCG submits a draft report to AMA at least 30 days in advance of the CMS due dates.
- AMA conducts internal reviews and provides comments to PCG.

- Once the details of the report are endorsed by AMA, PCG completes any final edits and returns the final document to AMA at least 14 days prior to the CMS due date.

If CMS provides comments on a report which require a response, these steps will take place:

- Within 30 days of receipt of CMS comments, PCG prepares a response, including a revised report if applicable, and submits to AMA for internal review.
- AMA conducts internal review of the response and provides comments to PCG.
- Within 45 days of receipt of CMS comments, PCG completes any final edits and returns the response documents to AMA.
- Within 60 days of receipt of CMS comments, the State submits the response to CMS.

4. EVALUATION TABLE

AL Evaluation Design Table: SMI Waiver Demonstration				
Comparison Strategy	**Measure Name (Steward)**	**Measure Definition**	**Data source**	**Analytic Approach, Summative Report**
Hypothesis 1: The waiver will increase access to short-term stays in IMDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama.				
Primary research question 1.1: Did the number of acute care short-term stays in IMDs for adult Medicaid beneficiaries with an SMI diagnosis increase in the southwest region of Alabama?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	IMD stays (AMA)	IMD admissions (number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year) Average length of stay in IMD (AL S) among short-term stays (less than or equal to 60 days) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD	Claims Data (Annual)	Descriptive statistics, trend over time
Primary research question 1.2: Did the waiver improve access to appropriate care for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama?				
NA	Access	Qualitative perceptions of access to care	Key informant interviews	Qualitative analysis
Hypothesis 2: The waiver will increase utilization of crisis stabilization services, intensive outpatient services and partial hospitalization services for adult Medicaid beneficiaries with an SMI diagnosis.				
Primary research question 2.1: Did the number of beneficiaries receiving crisis stabilization services increase?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Crisis stabilization services (AMA)	Number of individuals receiving services	Claims (Annual)	Descriptive statistics, trend over time (MY1 - MY5)

Primary research question 2.2: Did the number of beneficiaries receiving intensive outpatient services increase?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Intensive utpatient Services (AMA)	Number of beneficiaries in the demonstration population who used intensive outpatient services related to mental health during the measurement period	Claims (Annual)	Descriptive statistics, trend over time (MY1 - MY5)
Primary research question 2.3: Did the number of beneficiaries receiving partial hospitalization services increase?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Partial hospitalization services (AMA)	Number of beneficiaries in the demonstration population who used partial hospitalization services related to mental health during the measurement period	Claims (Annual)	Descriptive statistics, trend over time (MY1 - MY5)
Hypothesis 3: The waiver will improve care coordination and follow up after an ED visit or inpatient stay.				
Primary research question 3.1: Did the rate of follow up after ED visits increase?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Follow-Up After Emergency Department isit for Mental Illness: Age 21-64 (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries ages 21-64 with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (Numerator: Number of adult beneficiaries who had a follow-up visit with a mental health provider within 30 days of the ER visit for mental illness or intentional self-harm) • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of	Claims (Annual)	Descriptive statistics, trend over time (MY1 - MY5)

		the ED visit (Numerator: Number of adult beneficiaries who had a follow-up visit with a mental health provider within 7 days of the ER visit for mental illness or intentional self-harm) Denominator (for both rates): Number of adult beneficiaries who were visited the ER for treatment of selected mental illness or intentional self-harm diagnoses		
Primary research question 3.2: Did the rate of follow up after inpatient stays increase?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Follow-up After Hospitalization for Mental Illness: Age 21-64 (FUH-AD)	Percentage of discharges for beneficiaries ages 21-64 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. <u>Two rates are reported:</u> • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge (Numerator: Number of adult beneficiaries who had a follow-up visit with a mental health provider within 30 days of discharge for mental illness or intentional self-harm) • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge (Numerator: Number of adult beneficiaries who had a follow-up visit with a mental health provider within 7 days of discharge for mental illness or intentional self-harm)	Claims (Annual)	Descriptive statistics, trend over time (MY1 - MY5)

		Denominator (for both rates): Number of adult beneficiaries who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses		
Primary research question 3.3: Did the rate of medication continuance after inpatient stays increase?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Medication Continuation Following Inpatient Psychiatric Discharge (AMA)	Percentage of psychiatric patients admitted to an inpatient psychiatric facility (IPF) for ma or depressive disorder (MDD), schizophrenia, or bipolar disorder who filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. Numerator: Number of psychiatric patients admitted to an inpatient facility for MDD, schizophrenia, or bipolar disorder who filled a prescription within 2 days prior to discharge and 30 days post-discharge Denominator: Number of	Claims (Annual)	Descriptive statistics, trend over time (MY1 - MY5)

		psychiatric patients admitted to an inpatient psychiatric facility (IPF) for MDD, schizophrenia, or bipolar disorder		
Primary research question 3.4: Did referrals and overall care coordination improve for individuals with SMI?				
NA	Care coordination	Qualitative perceptions of care coordination and referral processes	Key informant interviews	Qualitative analysis
Hypothesis 4: The demonstration will increase the number of Medicaid beneficiaries receiving treatment for mental health conditions and reduce unmet needs for mental health treatment.				
Primary research question 4.1: Did the rate of Medicaid beneficiaries receiving treatment for mental health conditions increase in AL, compared to control states?				
Alabama compared to national trends and comparison states	SMI treatment (NSDUH)	Percentage who report receiving SMI treatment in the last 12 months Numerator: Number of survey respondents indicating receiving treatment for SMI in the last 12 months Denominator: Total number of survey respondents	NSDUH (Annual)	Difference -in -difference; Synthetic Control Model
Primary research question 4.2: Did the prevalence of unmet needs for mental health treatment decrease in AL, compared to control states?				
Alabama compared to national trends and comparison states	Unmet need for treatment (NSDUH)	Percentage who report needing, but not receiving, SMI treatment in the last 12 months Numerator: Number of survey respondents indicating they were unable to receive needed SMI treatment in the last 12 months Denominator: Total number of survey respondents who report needing SMI treatment	NSDUH (Annual)	Difference -in -difference; Synthetic Control Model
Hypothesis 5: The waiver will reduce the number of preventable readmissions to acute care hospitals and residential settings.				
Primary research question 5.1: Did the rate of readmissions following psychiatric hospitalization decrease?				

Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. Numerator: Number of adult beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease that were readmitted within 30 days of hospitalization in an IPF Denominator: Number of adult beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease	Claims (Annual)	Interrupted time series; Multiple Linear Regression (MY1 – MY5)
Hypothesis 6: The waiver will decrease the number of stays, and length of stays, in EDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama.				
Primary research question 6.1: Did the number of stays in EDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama decrease?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	ED visits (EDU)	The rate per 1,000 of beneficiaries in the demonstration population who had emergency department (ED) visits during the measurement year. Numerator: The number of observed ED visits in the adult demonstration population Denominator: The number adult beneficiaries in the demonstration population	Claims Data (Annual)	Interrupted time series; Multiple Linear Regression (MY1 – MY5)
Primary research question 6.2: Did the length of stays in EDs for adult Medicaid beneficiaries with an SMI diagnosis in the southwest region of Alabama decrease?				

NA	EDU isit Duration	Qualitative perceptions of stay in ED	Key informant interviews	Qualitative analysis
Primary research question 6.3: Did patient experience in the ED improve?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Patient satisfaction (CAHPS)	Self-report survey response	CAHPS survey (Annual)	Descriptive statistics, trend over time (MY1-MY5)
Hypothesis 7: The waiver will reduce non-SMI costs for individuals with an SMI diagnosis in the southwest region of Alabama.				
Primary research question 7.1: Did total costs (dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis in the southwest region of Alabama decrease?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Total Costs Associated With All Services Among Beneficiaries With SMI/SED	Total costs for beneficiaries with an SMI diagnosis Numerator: Total costs for all individuals with SMI diagnosis Denominator: Number of beneficiaries with SMI	Claims Data (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)
Primary research question 7.2: Did cost per member for SMI treatment (dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis in the southwest region of Alabama change?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Per Member Costs Associated With SMI Services Among Beneficiaries With SMI/SED	Per member cost for SMI treatment for beneficiaries with an SMI diagnosis Numerator: Total cost for SMI treatment for beneficiaries with an SMI diagnosis Denominator: Number of beneficiaries with an SMI diagnosis	Claims (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)
Subsidiary Research Question 7.2a: What was the cost of IMD treatment for SMI services (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis?				

Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Cost of IMD treatment for SMI services	Cost of IMD treatment for SMI services in beneficiaries with an SMI diagnosis (proportion) Numerator: Cost of IMD treatment only for SMI services in beneficiaries with an SMI diagnosis Denominator: Cost of all SMI services in beneficiaries with an SMI diagnosis	Claims (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)
Subsidiary Research Question 7.2b: Did the cost of non-IMD inpatient treatment for SMI services (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis change?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Cost of non-IMD inpatient treatment for SMI services	Cost of non-IMD inpatient treatment for SMI services in beneficiaries with an SMI diagnosis (proportion) Numerator: Cost of non-IMD inpatient treatment for SMI services in beneficiaries with an SMI diagnosis Denominator: Cost of all SMI services in beneficiaries with an SMI diagnosis	Claims (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)
Subsidiary Research Question 7.2c: Did the cost of outpatient SMI treatment for SMI services (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis change?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Cost of outpatient SMI treatment for SMI services	Cost of outpatient SMI treatment for SMI services (proportion) Numerator: Cost of outpatient SMI treatment for SMI services Denominator: Cost of all SMI services in beneficiaries with an SMI diagnosis	Claims (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)
Primary research question 7.3: Primary research question 7.3: Did non-SMI cost per member (dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis in the southwest region of Alabama decrease?				

Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Per Member Costs Associated With Non-SMI Services Among Beneficiaries With SMI/SED	Per member cost for non-SMI services for beneficiaries with an SMI diagnosis Numerator: Total cost for non-SMI treatment for beneficiaries with an SMI diagnosis Denominator: Number of beneficiaries with an SMI diagnosis	Claims (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)
Subsidiary Research Question 7.3a: Did the non-SMI inpatient cost per member (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis decrease (excluding IMD treatment)?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Cost of inpatient treatment (excluding IMDs) for non-SMI services	Cost of inpatient treatment for non-SMI services among beneficiaries with an SMI diagnosis Numerator: Total cost for non-SMI treatment for beneficiaries with an SMI diagnosis Denominator: Number of beneficiaries with an SMI diagnosis	Claims (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)
Subsidiary Research Question 7.3b: Did the non-SMI outpatient cost per member (in dollars per beneficiary per month (PBPM)) for individuals with an SMI diagnosis decrease?				
Demonstration period compared to Pre-demonstration baseline; Southwestern region compared to state	Cost of outpatient treatment for non-SMI services	Cost of outpatient treatment for non-SMI services among beneficiaries with an SMI diagnosis Numerator: Cost of outpatient treatment for non-SMI services in beneficiaries with an SMI diagnosis Denominator: Number of beneficiaries with an SMI diagnosis	Claims (Annual)	Descriptive statistics, trend over time, multiple linear regression and ITS (MY1- MY5)

FIGURE 9. EVALUATION DESIGN TABLE