

**Integrated Provider System Protocols
(Attachment B to Special Terms and Conditions)
Draft – Pending CMS Final Approval**



October 20, 2016

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A. Integrated Provider System Program Purpose and Objectives

On February 9, 2016, CMS approved Alabama’s 1115 demonstration waiver for the implementation of a Regional Care Organization (RCO) program, which aims to improve the delivery of care and health benefits of its beneficiaries by moving from a fee-for-service delivery system to enrollment in managed care under locally-administered provider-based RCOs. The Integrated Provider System (IPS) program approved through the waiver is one of the primary vehicles for statewide delivery system transformation. Like the RCO program, the IPS program is intended to improve care coordination, efficiency of service delivery and beneficiary outcomes. The IPS Protocols supplement the requirements set forth in the Special Terms and Conditions (STCs) from CMS that approved funding for the IPS program for the first three demonstration years (DYs), which run from January 2017 through December 2019.

As set forth in greater detail in the STCs, the intent of the IPS program is to finance the implementation of IPS projects that support at least one of the following demonstration/RCO program objectives:

- Improved prevention and management of chronic disease;
- Improved access to and care coordination of health services;
- Improved birth outcomes; or
- Healthcare delivery system financial efficiency.

More specifically, IPS projects should be designed to support the improvement goals listed below as the Alabama Medicaid Agency’s (AMA) continued receipt of demonstration funding is contingent upon meeting these goals. The improvement goals for DY 1 and DY 2 are:

- DY 1: A fully risk-bearing RCO is able to accept capitation payments in each of the five regions of the State.
- DY 2: RCOs have implemented an All Patient Refined Diagnostic Related Group (APR-DRG) hospital payment or similar approved payment methodology.

The following improvement goals for DY 3 and DY 4 can only be achieved by changes in provider care:

- DY 3: Increase well-child visits by 7.22 percentage points from the current baseline of 59.65 percent for children ages 3-6
- DY 3: Increase well-care visits for adolescents age 12-21 by 4.8 percentage points from current baseline of 40.5 percent
- DY 4: Reduce rate of ambulatory care-sensitive condition admissions by 9 percentage points from current baseline of 1,226 per 100,000
- DY 4: Increase percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment by 16.0 percentage points from the current baseline of 64.4 percent

Commented [KG1]: Baseline and target calculations are pending discussion with CMS

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AMA will post information and updates regarding the IPS program to its IPS webpage: http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.7.3.9_RCO_IPS.aspx. AMA will also provide targeted communications regarding the IPS program to RCOs through the RCO Portal and to Medicaid providers through provider alerts.

B. Role of RCOs and Providers in IPS Program

RCOs and Medicaid providers will work together throughout the IPS program, from the development of the IPS application through the duration of IPS funding. It is the State’s desire that RCOs and participating providers continue to partner to sustain project performance outcomes after IPS funding ends. A participating provider is defined as a contracted provider that will receive payment from an RCO for implementing an IPS project. As described further below, RCOs are the change agents for transformation and will serve as the administrative leads, coordinating entities and primary points of accountability to AMA for the IPS program. Provider responsibilities include implementing and sustaining the IPS project.

1. Role of RCOs in IPS Program

RCOs are responsible for working with participating providers to develop proposals for IPS work plans/projects that support the goals identified in the STCs. RCOs, as the coordinating entities, will accept and review properly submitted work plans from providers for proposed IPS work plans/projects and thereafter submit to AMA for consideration IPS work plans/projects on behalf of the providers up to the limits described in Section D. The RCO can choose not to support a provider’s IPS work plan if it does not meet AMA’s specifications and goals identified in the STCs and/or the provider’s IPS work plan is not identified as a priority project to submit to AMA due to the funding limitations described in Section D. The following table summarizes RCO responsibilities both before and after the IPS project is approved:

Table 1. RCO Responsibilities

Before IPS Project Approval	After IPS Project Approval
<ul style="list-style-type: none">• Ensure that IPS applications will support improvements in one or more of the program objective areas identified in the STCs• Ensure IPS applications meet the overall needs of the RCO’s region based on needs assessment studies and evaluations• Collaborate with participating providers (and potentially other RCOs) in the	<ul style="list-style-type: none">• Work with providers throughout the IPS project to report on the progress of the IPS project and ensure providers are on track to meet milestones and reach measure targets• Distribute IPS payments to participating providers• For selected RCO Quality Measures, calculate and report measure performance at both the individual

Before IPS Project Approval	After IPS Project Approval
<p>development of IPS applications and ensure that each application meets all of AMA-specified requirements</p> <ul style="list-style-type: none"> • Submit IPS applications to AMA for review and scoring. An RCO must prioritize the IPS applications that it submits to AMA so that the IPS applications’ maximum project awards do not sum to more than the total maximum available funding in the RCO’s region (see Section D for more information) • Ensure that the RCO’s decisions regarding which IPS work plans/projects to forward to AMA are fair and impartial and are made in strict conformance with all conflict of interest requirements (see Section J for more information) 	<p>provider level and in aggregate for all participating providers that are relevant to the measure (e.g., the RCO would not calculate measure performance for hospitals on the timeliness of prenatal visits measure)</p> <ul style="list-style-type: none"> ○ For all other selected performance measures (i.e., measures other than RCO Quality Measures), the RCO and providers receiving IPS funding must jointly develop the approach for accurately reporting on the measures at both the individual provider level in aggregate for all participating providers (see Section G for more information) • Provide ongoing budget reporting on IPS project spending, which will be submitted through the quarterly work plan status reports • Host learning collaboratives to share learnings from IPS projects with other relevant RCO network providers, including providers who may not be participating in IPS projects • Serve as the liaison between AMA and participating providers, communicate program policies and requirements and provide feedback to AMA on program elements that may require policy changes • Perform beneficiary education and outreach on IPS project components

2. Role of Providers in IPS Program

Providers are primarily responsible for the development and successful implementation and achievement of outcomes for each IPS project. The following table summarizes provider responsibilities both before and after the IPS project is approved:

Table 2. Provider Responsibilities

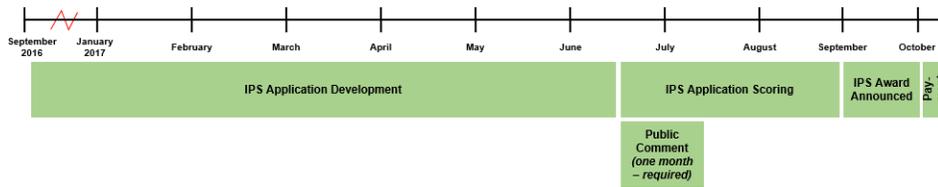
Pre-IPS Project Approval	Post IPS Project Approval
<ul style="list-style-type: none"> • Propose an IPS work plan to the sponsoring RCO, using the format prescribed by the sponsoring RCO and by the deadline imposed by the sponsoring RCO • Develop and submit an IPS application, including required IPS attestations and other documents, in coordination with the sponsoring RCO; the development of the IPS application is a shared responsibility between the sponsoring RCO and participating providers 	<ul style="list-style-type: none"> • Assure successful implementation and ongoing administration of the IPS project, with administrative support from the sponsoring RCO • For all other selected performance measures (i.e., measures other than RCO Quality Measures), the RCO and providers receiving IPS funding must jointly develop the approach for accurately reporting on the measures at both the individual provider level in aggregate for all participating providers (see Section G for more information) • Develop the mechanisms to assure accurate and timely reporting to the sponsoring RCO through quarterly work plan status reports. This includes but is not limited to: <ul style="list-style-type: none"> ○ Progress on selected performance measures ○ Progress towards achieving project milestones ○ Barriers ○ Budget updates • Achieve IPS project milestones and demonstrate progress to continue to receive IPS funding • Share learnings from IPS project interventions, strategies and approaches, identify leading practices and participate in learning collaboratives

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C. IPS Program Implementation Milestones in Demonstration Year 1

The following timeline illustrates the major IPS program implementation milestones.

Figure 1. IPS Timeline



The following table provides additional detail regarding IPS program implementation milestones.

Table 3. IPS Timeline and Roles

Timeline Component	Lead	Description
Education on IPS Program	AMA	AMA will host webinars and other meetings with RCOs, providers and stakeholders on topics such as an overview of the IPS program and an overview of how to complete the IPS application. AMA will also respond to stakeholder questions on the IPS program through an email inbox (RCOQuality@alabama.medicaid.gov) and post frequently asked questions. All information about webinars, frequently asked questions and other program information will be available on AMA’s IPS webpage.
IPS Letter of Intent (LOI)	RCOs	RCOs must submit an LOI(s) by April 15, 2016, indicating their intention to work with participating providers to develop and submit an IPS application(s).
Provider Submission to RCOs	Providers	Using a format prescribed by the sponsoring RCO and by the deadline imposed by the sponsoring RCO, providers must submit information on their proposed IPS work plan/project to the sponsoring RCO. Providers may contact the RCOs in their region for more information. RCO contact information is available on AMA’s IPS webpage.
RCO IPS Application Submission to AMA	RCOs and Providers	Once a sponsoring RCO has received a provider submission, the RCO is responsible for coordinating the provider submissions to develop a complete IPS application, using the

Timeline Component	Lead	Description
		IPS application template provided by AMA. Providers are expected to contribute to the development of the complete IPS application.
Public Comment	Interested stakeholders	Interested stakeholders may provide comments on the IPS applications submitted to AMA. AMA will post the IPS applications on its IPS webpage, along with instructions on how to submit comments on the IPS applications.
IPS Application Scoring	AMA, with assistance from independent evaluator	An independent evaluator will perform the initial IPS application scoring, with final review and approval of the scoring by AMA. See Section F for more information on the IPS application scoring process.
Awards	AMA	AMA will distribute IPS initial awards to RCOs based on the approved IPS applications. AMA will distribute subsequent awards on a quarterly basis based on its review of the quarterly work plan status report submissions.
Work Plan Status Report Submissions	RCOs	RCOs must submit work plan status reports to AMA on a quarterly basis and must work with providers to obtain the information necessary for these status reports. See Section G for more information.
Ongoing Monitoring	AMA/RCOs	AMA and the RCOs will continually monitor the progress and results of the IPS work plans/projects. See Section G for more information on the monitoring process.

D. Maximum IPS Awards by Region

As described in STC 85, each RCO region’s combined maximum award will be based on a proportionate share of beneficiaries in the region. The estimated maximum available funding per region is illustrated in Table 4. This allocation by region is subject to change at AMA’s discretion. Each RCO must prioritize the applications that it submits to AMA so that the IPS applications’ maximum project awards do not sum to more than the total maximum available funding in the RCO’s region. For example, an RCO in Region A should not submit IPS applications whose maximum project awards sum to more than \$48,943,000.

Table 4. Estimated Available IPS Funding by Region

Region	Estimated Maximum Available Funding
A	\$ 48,943,000
B	\$ 90,045,000
C	\$ 24,948,000
D	\$ 69,971,000

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Region	Estimated Maximum Available Funding
E	\$ 44,218,000
Total	\$ 278,125,000

E. IPS Application Requirements

As described in Section B above, RCOs will accept and review properly submitted work plans from providers and thereafter submit IPS applications which the RCO has chosen to sponsor to AMA for consideration on behalf of the providers.

To be eligible to submit an IPS application, RCOs must have met the following criteria:

- A LOI must be submitted by the RCO no later than April 15, 2016, indicating its intention to work with participating providers to develop and submit one or more IPS applications
- A representative of the RCO that will be involved in implementing the IPS project and participating providers must view mandatory IPS-related webinars provided by AMA on 3/10/2016 titled "Overview of IPS Program and Application Process" and on 3/16/2016 titled "Question & Answer Session on IPS Program" (webinar recordings are posted on the AMA IPS webpage)

In addition, IPS applications must meet the following criteria to be reviewed and scored by an independent evaluator and AMA:

- Submitted by close of business June 15, 2017
- Addressed all application elements including submitting a Participating Provider's Letter of Commitment from all of the IPS work plan/project's participating providers (see Exhibit B-2 for the Participating Providers Letter of Commitment)
- Used the IPS application template and instructions provided by AMA (see Exhibit B-1 for the IPS application)

The IPS application includes the following sections:

1. Cover Letter

The Cover Letter section consists of the following elements:

- 1.1 Overview (e.g., IPS project name, IPS project duration)
- 1.2 Primary RCO contact information
- 1.3 Primary participating provider contract information
- 1.4 Documents checklist

2. Executive Overview

The Executive Overview section consists of the following elements:

- 2.1 A brief executive summary of the IPS project
- 2.2 A description of which of the following RCO program objective(s) the IPS project will impact:
 - Improved prevention and management of chronic disease
 - Improved access to and care coordination of health services
 - Improved birth outcomes
 - Healthcare delivery system financial efficiency
- 2.3 A description of which of the following Designated State Health Program (DSHP) target measures the IPS project will impact:
 - Increase well-child visits in the third, fourth, fifth and sixth years of life
 - Increase adolescent well-care visits
 - Reduce rate of ambulatory care-sensitive condition admissions
 - Increase percentage of deliveries that receive a prenatal care visit in the first trimester or within 42 days of enrollment
- 2.4 An indication of the categories of provider types included in the IPS project
- 2.5 If “other providers” are included in the IPS project, a description of those providers
- 2.6 A three year goal statement that includes specific goals for the IPS project
- 2.7 A five year goal statement what includes specific goals for the IPS project

3. Beneficiary Impact

The Beneficiary Impact section consists of the following elements:

- 3.1 The Medicaid target population of the IPS project
- 3.2 The specific program interventions and approach, including how beneficiaries will be identified and contacted for participation in the IPS project
- 3.3 A description of how the proposed IPS project meets community or health delivery needs; this element must address and consider the findings from the *2015 State of Alabama Community Health Assessment*¹ developed by the Alabama Department of Public Health and how those needs will be addressed by the IPS project
- 3.4 A description of how the IPS project will use evidence-based methods and practices to improve outcomes

¹ The *2015 State of Alabama Community Health Assessment* is available at the following link: http://www.adph.org/accreditation/assets/CHA2015_Final_RevAugust_R.pdf

- 3.5 The estimated average number of Medicaid beneficiaries for each county affected by the IPS work plan/project. If the IPS project will impact RCO-eligible beneficiaries other than those projected to be enrolled in the sponsoring RCO, those RCO-eligible beneficiaries may be included in the estimated average number of RCO beneficiaries, as long as the IPS project's participating providers attest that they will have a valid contract with the other RCO(s) in the region by the time they receive any IPS funding. Otherwise, the estimated average number of Medicaid beneficiaries should only include beneficiaries projected to be enrolled in the sponsoring RCO.
- 3.6 The methodology used to calculate the number of estimated RCO beneficiaries in the RCO region affected
- 3.7 A description of how the estimated number of beneficiaries affected or the number of counties served will change over the five year demonstration period

4. Work Plan

The Work Plan section consists of the following elements:

- 4.1 The key activities and milestones to be accomplished over the duration of the IPS project and the dates by which each activity and milestone will occur; quarterly IPS payments may be based on the achievement of these milestones
- 4.2 A description of the degree to which the IPS project can be adopted and applied by other providers and how fast that adoption could occur, as well as the related barriers and accelerators to scaling this IPS project for use by other providers
- 4.3 A description of how the applicant will identify and disseminate leading practice discoveries and offer shared learning and educational opportunities to other providers to accelerate improvement in care delivery across the region and State

5. Monitoring and Governance

The Monitoring and Governance section consists of the following elements:

- 5.1 A description of the approach to IPS project governance and oversight
- 5.2 If applicable to the IPS project, this section should specifically address the development of the following:
 - Health information technology (HIT) protocols including how the IPS work plan/project will increase electronic information sharing (including sharing of specific medical and care plan information) for care coordination and treatment planning
 - Care coordination protocols that demonstrate coordination between Primary Medical Providers (PMPs), relevant specialists and hospital

clinical staff for patients admitted and discharged from hospital inpatient, outpatient and emergency department facilities

- Transition of care protocols to ensure the coordination and continuity of health care for patients as they transfer between different locations or different levels of care, including but not limited to hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities; protocols should also include development of a comprehensive care plan for patients in transition, which is used to coordinate logistical arrangements, educate the patient and family, and coordinate among health professionals involved in the transition

5.3 A description of how participating providers and beneficiaries will be managed for adherence to the protocols developed as part of the IPS project

6. **Provider Collaboration, Participation and Funding Distribution**

The Provider Collaboration, Participation and Funding Distribution section consists of the following elements:

- 6.1 A description of the process by which RCOs conducted outreach and education with participating providers to develop the IPS application and a description of how the collaboration will continue over the duration of the IPS project
- 6.2 A listing of the participating providers who will participate in the IPS work plan/project. A participating provider is defined as a contracted provider that will receive payment from an RCO for implementing an IPS project. Each provider listed must have an associated Provider Letter of Commitment. The listing must include:
 - The names, addresses and National Provider Identification numbers, Medicaid identification numbers, and Tax Identification Numbers of the provider(s) by practice
 - The provider and specialty type
 - The percentage of the provider's total practice revenue from Medicaid
 - The total number of Medicaid beneficiaries currently seen by the provider(s)
 - The role of each provider in the IPS project
 - The percentage of the total IPS award that will be distributed to each of the provider(s) participating in the IPS project

7. **Budget**

The Budget section consists of the following elements:

- 7.1 The total estimated project costs and RCO administrative cost estimates during the IPS project period; the project costs should not include any costs incurred prior to the approval and award of the IPS project
- 7.2 A description of the roles and responsibilities of the full time equivalents (FTEs) identified in the budget calculation
- 7.3 A description regarding how the RCO will spend its administrative portion of the IPS award to support the implementation of the IPS project
- 7.4 Description of how the RCO and/or participating providers will contribute 10 percent, at a minimum, of the total IPS project cost
- 7.5 If applicable, a detailed listing of capital expenditures included in budget/project cost calculation

8. Return on Investment and Sustainability

The Return on Investment (ROI) and Sustainability section consists of the following elements:

- 8.1 A simple ROI calculation
- 8.2 The methodology, assumptions and data sources used in calculating the ROI
- 8.3 A description of how the IPS project will be sustainable after the IPS work plan/project has been fully implemented. The description should include considerations for how the IPS work plan/project will address the following:
 - Cultural assimilation, or the ability to maintain the learnings and approaches from the IPS work plan/project and incorporate them into daily work activities to sustain positive program outcomes beyond the period of IPS funding
 - Ongoing performance measurement that supports the objectives of the IPS work plan/project
 - Economic continuation, or the ability to staff and finance the level of effort needed to support the continuation of the IPS work plan/project beyond the period of IPS funding
 - Organization leadership support, or how the RCO and provider organization(s) involved in the IPS work plan/project will demonstrate a commitment to supporting the benefits of this work plan/project during the IPS funding period and beyond
- 8.4 A sustainability budget

9. Quality Measures

For all quality measures selected by the RCO and provider IPS applicant to monitor and evaluate the IPS project (i.e., RCO Quality measures, other performance measures), the

IPS applicant must develop the measure baseline calculations and identify the measure targets for each demonstration year, as listed in the section elements below. The Quality Measures section consists of the following elements:

- 9.1 The RCO Quality Measures that will be used to monitor and evaluate the IPS project. The RCO Quality Measures are listed in Exhibit B-3. AMA may evaluate performance on these measures when determining IPS payment over the duration of the IPS project. The IPS applicant must provide:
 - The RCO quality measures that will be used to evaluate the IPS work plan/project
 - Measure baseline calculations
 - How measure baseline was or will be developed
 - Measure targets for each demonstration year
 - How measures will be monitored over time and how the RCO/IPS management will know that the IPS work plan/project is working
 - How the measure performance will be calculated and reported (e.g., by the provider, by the RCO, what data will be used) and how frequently the measure will be reported to AMA
- 9.2 If applicable, other performance measures that will be used to monitor and evaluate the IPS work plan/project, in addition to the RCO Quality Measures. AMA will evaluate performance on these measures when determining IPS payment over the duration of the IPS work plan/project. The IPS applicant must provide:
 - Specifics regarding the measure used, a description of the measure and which of the IPS targeted areas the measure will impact
 - Measure baseline calculations
 - How measure baseline was or will be developed
 - Measure targets for each demonstration year
 - How measures will be monitored over time and how the RCO/IPS management will know that the IPS work plan/project is working
 - How the measure performance will be calculated and reported (e.g., by the provider, by the RCO, what data will be used) and how frequently the measure will be reported to AMA
- 9.3 A description of how all quality measures will be communicated to participating providers, beneficiaries and RCO project management.

Table 5 below categorizes measures into four priority levels. Priority levels 1-3 include all 42 RCO Quality Measures and the lowest priority level, level 4, includes all other measures used by the IPS applicant. AMA will use these priority levels when evaluating

IPS applications. Each IPS applicant may propose different measures and measure targets as part of their IPS project, however the measure targets will be subject to AMA approval.

Table 5. Measure Priority Level

Priority Level (1 = Highest Priority)	Measures
Priority Level 1 (Designated State Health Program [DSHP] Funding Accountability Measures)	<ul style="list-style-type: none"> • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Adolescent Well-Care Visits • Ambulatory Care-Sensitive Condition Admissions • Timeliness of Prenatal Visits
Priority Level 2 (Other RCO Quality Withhold Measures)	<ul style="list-style-type: none"> • Comprehensive Diabetes Care: HbA1c Testing • Medication Management for People with Asthma • Postpartum Care • Cervical Cancer Screening • Percentage of Live Births Weighing Less Than 2,500 Grams • Antidepressant Medication Management • Follow-Up After Hospitalization (within 30 days) (Behavioral Health-Related Primary Diagnosis)
Priority Level 3 (Other RCO Quality Measures)	An RCO Quality Measure other than those listed in Priority Level 1 and Priority Level 2 above (optional)
Priority Level 4 (Other Measures Proposed by IPS Applications)	To be developed by IPS applicant if additional measures are needed to monitor the performance of the IPS work plan/project (optional)

10. Bonus Points

An IPS application may receive up to 25 bonus points based on the number of low-income uninsured patients impacted by the IPS work plan/project. Low-income is defined as individuals with incomes at or below 138 percent of the Federal poverty level. This section does not need to be completed if the IPS work plan/project does not impact the uninsured population.

11. Existing Grant Information

The IPS applicant must provide a list of any federal grants or funding that the RCO or participating providers currently receive or will receive during the IPS project period which may be duplicative and/or complement the IPS work plan/project.

12. RCO Attestations

12.1 The RCO must certify that the return on investment calculation was calculated using a sound and generally accepted methodology (signed by the RCO's CEO/CFO or an Actuary or Accounting Firm)

12.2 Other attestations

- The RCO must certify that all of the information included in the IPS application is current, true, correct, and complete.
- The RCO must certify that it will fully and timely comply with all applicable terms and conditions set forth in the Transition Pool Terms, a copy of which is attached hereto as Exhibit B-4. The Transition Pool Terms sets forth the terms and conditions for all expenditures, or proposed expenditures, of IPS funds and is discussed further in Section I.
- The RCO must certify and acknowledge that an award for an IPS work plan/project will cover no more than 90 percent of the IPS work plan/project budget, up to a maximum of \$20 million. The RCO and/or participating provider(s) will contribute the remaining funds to implement the IPS work plan/project. The RCO and/or participating provider(s) currently have sufficient funds or resources available to enable them to fund, at a minimum, 10 percent of the IPS work plan/project budget.
- The RCO must certify that it will ensure that the IPS funding it receives will be used to improve quality and beneficiary outcomes by supporting at least one of the demonstration/RCO program objectives.
- The RCO must certify that all decisions related in any way to the IPS application and the IPS work plan/project shall be and have been made in compliance with the conflict of interest requirements contained in Alabama Medicaid Administrative Code Rule 560-X-62-.08 (Conflict of Interest Policy for Directors and Officers of Regional Care Organizations), a copy of which is attached hereto as Exhibit B-5, and in compliance with the RCO's approved conflict of interest policy. Alabama Medicaid Administrative Code Rule 560-x-62.08 provides, in part, for the adoption by each RCO of a conflict of interest policy for directors and officers, including, at a minimum, the requirements set forth in the Rule, and is discussed further in Section J.
- The RCO must certify that members from the RCO, whom will be involved in implementing this IPS work plan/project, have viewed the IPS related webinars provided by AMA on 3/10/2016 titled "Overview of IPS Program and Application Process") and on 3/16/2016 titled "Question & Answer Session on IPS Program," available on AMA's IPS webpage.

- The RCO must certify that the funds the RCO would receive under the IPS project are not duplicative with any federal grants or funding received by participating providers and the RCO.

13. Participating Providers Letters of Commitment

The IPS applicant must provide letters of commitment from participating providers using the template provided by AMA. This template includes the following attestations:

- The participating provider is committed to implementing and supporting the IPS project(s) as described in the IPS application submitted to Alabama Medicaid Agency. The participating provider has read and shall comply with all applicable terms of the Alabama Medicaid's Transition Pool Terms, IPS Protocols and other applicable regulations and policies. The participating provider understands that the maximum IPS award will cover no more than 90 percent of the approved IPS budget up to a maximum of \$20 million. The RCO and/or participating provider(s) will contribute the remaining funds to implement the IPS work plan/project.
- The participating provider will ensure that the IPS funding received will be used to improve quality and beneficiary outcomes by supporting at least one of the demonstration/RCO program objectives.
- The participating provider attests that the funds received under this IPS work plan/project are not duplicative to other federal grants or funding received.
- The participating provider has viewed the trainings provided by the Alabama Medicaid Agency on 3/10/2016 titled "Overview of IPS Program and Application Process" and on 3/16/2016 titled "Question & Answer Session on IPS Program."
- The participating provider will have a signed and executed contract with the RCO submitting the IPS application and coordinating and monitoring this IPS work plan/project by the time the provider receives IPS funding.
- If the IPS project includes Medicaid beneficiaries projected to be enrolled in RCOs other than the sponsoring RCO, the participating provider will have a valid contract(s) with the other RCO(s) in the region by the time the provider receives any IPS funding. The participating provider will also share with the sponsoring RCO all data necessary to calculate performance on quality measures, even if the data are for services the provider provided to Medicaid beneficiaries enrolled in RCOs other than the sponsoring RCO.

14. Letters of Support from Major Stakeholders (optional)

The IPS applicant may provide letters from Alabama provider associations, advocacy groups or other stakeholders indicating support of the IPS work plan/project.

F. IPS Application Scoring

AMA will calculate the final IPS application scores with assistance from an independent evaluator through a contract between AMA and a third party vendor. The independent evaluator will complete the initial review of IPS applications and will ensure that applications include all of the required application elements listed in Section E above. If an application does not include all of the required application components, it will be rejected and the IPS applicant will have no further recourse to appeal the rejection decision.

After the initial review, the independent evaluator will score the application components, using a scoring sheet to be approved by AMA, based on the elements outlined in this Attachment B and the IPS application template, in Exhibit B-1. Each IPS application will be scored out of 200 possible points, with the opportunity to earn up to 25 bonus points. The evaluator will use a panel of two or more reviewers who will each independently review each IPS application. The panel will include individuals with clinical or clinical performance improvement and financial experience. Individual reviewers must declare that they have no conflict of interest before reviewing each application. Individual reviewers will evaluate each IPS application for the following considerations:

1. Validate that all sections of the IPS application were completed
2. Analyze the IPS project rationale/business case and work plan including roles and responsibilities of the RCO and providers
3. Analyze the IPS project's potential to impact RCO program objectives
4. Assess feasibility of three and five year project goals and projections for speed, scope and ability to scale the IPS project for adoption by other similar providers
5. Analyze the proposed IPS and RCO performance measures to assess if they are appropriate to evaluate ongoing progress to meet stated goals
6. Analyze geographic reach and impact on beneficiaries to determine the magnitude of the projects' potential to impact RCO program objectives
7. Analyze IPS project supporting documentation to ascertain the degree to which the project proposes to use evidence-based practices or seeks to develop evidence-based practices
8. Analyze the degree to which the project addresses needs identified in the community or healthy delivery needs assessment
9. Determine the reasonableness of the IPS project budget
10. Determine the reasonableness of the IPS project's ROI estimate, including projections of potential savings and ROI assumptions
11. Determine the reasonableness of the IPS project sustainability plan

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Once all independent reviews of an application have been completed, the panel of reviewers together will calibrate scores to arrive at an overall application score. The panel will then rank each IPS application in order of highest score to lowest score overall, by RCO program objective, and by RCO region. The panel will also document areas that may require further clarification before AMA makes a funding decision and recommend changes in IPS project approach or measurement.

Table 6 below summarizes the maximum points associated with each application component. Scoring will be based on the quality of the responses to each application component.

Table 6. Summary of Scored IPS Application Components and Associated Points

Components	Points Possible
Section 1: Cover Letter	NA
Section 2: Executive Overview	Up to 10 Points
Section 3: Beneficiary Impact	Up to 50 Points
Section 4: Work Plan	Up to 15 Points
Section 5: Monitoring and Governance	Up to 15 Points
Section 6: Participating Providers	Up to 15 Points
Section 7: Budget	Up to 20 Points
Section 8: ROI and Sustainability	Up to 50 Points
Section 9: Quality Measures	Up to 25 Points
Section 11: Existing Grants	NA
Section 12: Attestations	NA
Other Materials Submitted (e.g., provider letter of commitment and Letters of Support from Major Stakeholders)	NA
Total	Up to 200 Points
Section 10: Bonus Points	Up to 25 Points

After the panel scores each IPS application, the independent evaluator will provide AMA with its scoring materials and recommendations for IPS projects to fund. The independent evaluator will participate in AMA funding allocation decisions considering the available pool of IPS funding, by demonstration year and by RCO region. AMA will make the final IPS award decisions based on the recommendations of the independent evaluator and its determination of which IPS projects are in the best interest of the program. AMA reserves the right to have additional discussions with an IPS applicant that is recommended for funding by the independent evaluator. AMA may adjust the IPS award amount from the amount requested by the IPS application to ensure funding for an appropriate mix of IPS projects in each RCO region and across the State.

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In accordance with STC 83, redacted IPS applications will be posted on AMA’s IPS webpage for 30 days following the IPS application deadline. As stated in the IPS application, RCOs and participating providers may submit a separate redacted version of the IPS application with redacted information which is claimed to be proprietary or trade secrets in the application. However, the RCOs and participating providers acknowledge and agree that any material submitted to AMA could be required to be released if it is determined under the Alabama Open Records Act to not qualify as confidential information.

AMA will notify IPS applicants in writing regarding awards for each IPS application and will post a listing of all IPS awards on AMA’s IPS webpage. In accordance with STC 85, each IPS award will be no greater than 90 percent of the approved IPS project budgeted cost up to a maximum of \$20 million (and may be less than 90 percent of the approved IPS project budgeted cost based on available IPS funding).

G. Performance Measurement and Progress Tracking

AMA will monitor progress on IPS projects through the methods outlined below:

1. As described in STC 84, RCOs must submit quarterly work plan status reports to AMA. The status reports must reflect the implementation status and progress for each IPS project according to approved project milestones, performance measures and related timeframes. RCOs must have a method to gather requisite status report information from participating providers and must provide status reports in a format approved by AMA. AMA will provide further guidance on the work plan status report format through notices to RCOs and through AMA’s IPS webpage.

For all RCO Quality Measures selected to monitor an IPS project through the IPS application process, RCOs must calculate and report measure performance on behalf of participating providers using data from administrative systems, medical records, electronic records or through other approved processes, in accordance with AMA specifications. RCOs must calculate measure performance both at the individual provider level and in aggregate for all participating providers that are relevant to the measure (e.g., the RCO would not calculate measure performance for hospitals on the timeliness of prenatal visits measure). Because many of the RCO Quality Measures, including the DSHP accountability measures, are annual measures, these measures will only be available to be reported once a year. RCOs must have processes in place to validate that the data they receive from providers for milestone and measure progress reporting is complete and accurate. Exhibit B-3 includes a listing of all of the RCO Quality Measures and indicates which of the four RCO program objectives each of the RCO Quality Measures can be used to evaluate.

For selected performance measures other than RCO Quality Measures, the RCO and participating providers must jointly develop the approach, subject to AMA approval, for accurately reporting on the measures at both the individual provider level and in aggregate for all participating providers. RCOs must also have mechanisms for ensuring participating providers are progressing towards meeting project milestones and measure targets.

The approach for reporting and monitoring both RCO Quality Measures and other selected performance measures must be described at a high level in the initial IPS application and must be submitted to AMA for approval along with the first quarter's work plan status report.

AMA will review status reports to determine whether the IPS projects are progressing and, therefore, eligible to receive future IPS payments. Upon request, the RCO and participating providers must provide documentation to support the information included in the status report. This reporting will continue through the duration of the IPS project. Based on the quarterly status reports submitted, AMA may withdraw further IPS funding if it determines that the IPS project is not meeting its intended objectives and established goals.

AMA, or its designee, will review the IPS work plan status reports to monitor and track performance related to project milestones and performance measures. This review will include an assessment of progress and challenges identified in each status report, and an evaluation as to whether any modifications to the IPS project approach are necessary to accelerate progress. AMA will post summary information from these reviews on AMA's IPS webpage. AMA staff will work collaboratively with RCOs and participating providers to proactively identify strategies to improve milestone progress and measure performance. These findings will be used to identify opportunities for learning collaboratives, during which RCOs will share learnings from IPS projects with relevant RCO network providers, including providers who may not be participating in IPS projects.

2. AMA will require RCOs to report on IPS project spending and the distribution of IPS funds to providers throughout the duration of the IPS project through work plan status reports.
3. In accordance with STC 38, AMA will submit quarterly progress reports to CMS. One of the elements of these quarterly progress reports is a summary of how many IPS work

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plans have met the payment criteria at each payment milestone interval. These quarterly progress reports will also provide updates to CMS on challenges and key achievements related to the IPS program.

4. In accordance with STC 67, AMA will work with an independent evaluator to complete a final evaluation report for the overall demonstration. This evaluation report will include an evaluation of the IPS program and an assessment of the impact of the approved IPS projects on the RCO program objectives and DSHP accountability metrics.
5. In partnership with AMA, RCOs participating in the IPS program will be responsible for developing learning collaboratives to provide training and education on topics related to IPS projects and facilitate peer-to-peer learning. The learning collaboratives will be especially valuable in sharing leading practices and lessons learned for similar IPS projects across RCO regions. The primary audience for the learning collaboratives is Medicaid providers who are participating in the RCO program. Once learning collaboratives are scheduled, notification of the dates, locations, and relevant audiences will be communicated through AMA's IPS webpage and other targeted communication.
6. In addition, outside of the IPS program, AMA requires through the RCO Contract that RCOs submit annual, quality measure data that has been audited by the AMA-contracted external quality review organization. This requirement extends beyond the duration of the demonstration and will be a mechanism through which AMA tracks progress on the RCO Quality Measures. AMA will closely evaluate performance of these quality measures, with particular attention to the DSHP accountability measures which are a primary focus of the IPS program.

H. Distribution of IPS Payments

The maximum payment amount for an IPS project will be determined in accordance with the formula in STC 85.

AMA will distribute IPS payments for each IPS project on a quarterly basis over the duration indicated in the approved IPS application (not to exceed beyond December 2019). The amount of each IPS payment will be based on completing required elements of the quarterly work plan status reports and the amount of progress made, using a status report format approved by AMA. AMA may consider progress towards achievement of milestones and measure targets in the approved IPS application as part of the IPS payment determination. AMA will provide further guidance on the payment determination process through notices to RCOs and through AMA's IPS webpage.

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RCOs will retain their administrative percentage of each IPS payment (up to 10 percent of the total payment) and distribute the remaining amount to providers in accordance with the approved IPS application. Payments from the RCO to providers must occur within 30 calendar days of the RCO's receipt of payment from AMA.

I. Transition Pool Terms

By executing an RCO Contract with AMA, the RCO acknowledges and agrees that the Transition Pool Terms, attached hereto as Exhibit B-4, shall apply and control all expenditures, or proposed expenditures, of IPS funds, including, but not limited to, any suspension, delay, reduction, termination or recoupment of expenditures of IPS funds. As a condition for submitting an application related to an IPS work plan/project, a provider must agree to accept the terms and conditions of the Transition Pool Terms, which shall apply to and control, all expenditures, or proposed expenditures, of IPS funds to the provider. It is the RCO's responsibility to ensure that all providers submitting applications to the RCO for IPS funds bind themselves to the applicable terms of the STCs and the Transition Pool Terms.

J. RCO Conflict of Interest Policy

The RCO's application review process must be fair and impartial, including, but not limited to, strictly following the conflict of interest requirements set forth in Alabama Medicaid Administrative Code Rule 560-X-62-.08 (referenced above and attached as Exhibit B-5), as well as the RCO's own conflict of interest policy that has previously been approved by the AMA.

K. IPS Appeals Processes

Any provider whose application is not selected by the RCO for submission to AMA may make a written request for review of the RCO's decision to the Medicaid Quality Assurance Committee in accordance with the proposed Alabama Medicaid Administrative Code Rule 560-X-62-.27, a copy of which is attached hereto as Exhibit B-6. The Medicaid Quality Assurance Committee may request of both the provider and RCO any information and documents necessary for its review. The RCO's decision shall be entitled to a presumption of correctness, and the Medicaid Quality Assurance Committee shall only reverse the RCO's decision if it finds the application in question satisfies all other requirements and either of the following: (i) that the decision was made on unreasonable grounds or without proper consideration or (ii) any applicable conflict of interest policy was violated during the RCO's decision making process. The Medicaid Quality Assurance Committee's decision shall be final and conclusive, and not subject to further review. With regard to any proposed work plan the Medicaid Quality Assurance Committee determines should have been sponsored by the organization, the provider(s) and organization shall thereafter work together to finalize an application for the proposed work plan which shall be forwarded to the Agency for consideration pursuant to section (5) of Alabama Medicaid Administrative Code Rule

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560-X-62-.27. No member of the Medicaid Quality Assurance Committee who also served as an officer or director of the RCO that reviewed the application that is at issue or is an officer, director, agent, or employee of the provider that submitted the application shall be entitled to vote on or participate in the Medicaid Quality Assurance Committee’s review of that application. If the Medicaid Quality Assurance Committee determines that an application should have been sent to AMA by the RCO for award consideration, the application will not be subject to the RCO’s maximum project award submission amount described in Section D.

In accordance with Section 7 of the proposed Alabama Medicaid Administrative Code Rule 560-X-62-.27, an RCO that has submitted an application that has been rejected by AMA, or the provider or group of providers whose work plan is the subject of such application, may submit a written request for reconsideration to AMA. Such written request shall be submitted to the AMA no later than 5 business days after AMA’s decision has been published, and shall state with specificity the issues that the RCO or provider(s) believes warrant a reconsideration by the AMA. AMA shall respond to a reconsideration request within a reasonable time.

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Exhibit B-1. IPS Application

Available in separate file

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Authorized Signature

Date Signed

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Exhibit B-3. RCO Quality Measures by RCO Program Objective

The table below lists the RCO Quality Measures and indicates which of the four RCO program objectives each of the RCO Quality Measures can be used to evaluate. While all of the RCO Quality Measures are included in this table, as part of the IPS program, AMA will give higher priority to IPS projects that impact the DSHP accountability measures and the RCO quality withhold measures as described in Table 5 above.

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
1	Access to Care/ Equitable Health Outcomes	Adults' Access to Preventive/Ambulatory Services [All Ages]	This measure is used to assess the percentage of members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each age stratification and product line (commercial, Medicaid and Medicare) and a total rate.	X	X		
2		Ambulatory Care, ED Visits	This Measure summarizes the utilization of Emergency Department Visits for the Medicaid population. Numerator is the number of ED visits, Denominator is the eligible population. Reported as a ED rate	X	X		X
3	Cardiovascular/ Obesity	Adult BMI Assessment	Percentage of adults 18 years old or older with valid BMI documentation in the past 24 month.	X	X		
4		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Percentage of children 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of: 1) body mass index (BMI) percentile documentation, 2) counseling for nutrition and 3) counseling for physical activity during the measurement year.	X	X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
5	Care Coordination	HBIPS-6 Post Discharge Continuing Care Plan Created	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created.		X		X
6		HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge.		X		X
7	Chemical Dependency	Assessment and Management of Chronic Pain	This measure is used to assess the percentage of patients age 16 years and older diagnosed with chronic pain who are screened for chemical dependency before being prescribed opioid medication.	X	X		
8		Identification of Alcohol and Other Drug Services	The number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization and outpatient or ED.		X		
9		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or		X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
			more additional services with a diagnosis of AOD within 30 days of the initiation visit.				
10		Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	X	X	X	

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
11	Inpatient Care	Ambulatory Care-Sensitive Condition Admission (1)(2)	Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.	X	X		X
12		Elective Delivery	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.			X	X
13		Plan All-Cause Readmission	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance	X	X		X
14	Internal Medicine	Cervical Cancer Screening (2)	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	X	X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
15		Comprehensive Diabetes Care (2)	The percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing (NQF#0057), HbA1c poor control (>9.0%) (NQF#0059), HbA1c control (<8.0%) (NQF#0575), HbA1c control (<7.0%) for a selected population, Eye exam (retinal) performed (NQF#0055), Medical attention for nephropathy (NQF#0062), Smoking status and cessation advice or treatment	X	X		X
16		Medication Management for People with Asthma (2)	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. Percentage of members who remained on an asthma controller medication for at least 50% of the treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of the treatment period	X	X		X
17		Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer [AQM is 42-69 with two-year look-back period]	X	X		
18		ER Utilization Rate for Asthma Patients	ER Utilization rate for Asthma patients, this is the same metric currently used by PCNAs.	X	X		X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
19	Maternity/Infant Mortality	Prenatal and Postpartum Care (1)(2)	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. 1. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. 2. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.		X	X	X
20		Percentage of Live Births Weighing Less Than 1,500 Grams	The percentage of births with birth weight <1,500 grams			X	
21		Percentage of Live Births Weighing Less Than 2,500 Grams (2)	The percentage of births with birth weight <2,500 grams			X	X
22		Frequency of Ongoing Prenatal Care	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: •<21 percent of expected visits •21 percent–40 percent of expected visits •41 percent–60 percent of expected visits •61 percent–80 percent of expected visits •=81 percent of expected visits		X	X	X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
			This measure uses the same denominator as the Prenatal and Postpartum Care measure.				
23	Mental Health/ Behavioral Health	Antidepressant Medication Management (2)	<p>The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.</p> <p>a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).</p> <p>b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).</p>	X	X		X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
24		Follow-Up After Hospitalization (within 30 days) (Behavioral Health-Related Primary Diagnosis) (2)	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Rate: The percentage of members who received follow-up within 30 days of discharge.		X		X
25		Adherence to Antipsychotic Medications for Individuals With Schizophrenia	This measure is used to assess the percentage of members 19 to 64 years of age with schizophrenia during the measurement year who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.		X		X
26		Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 years through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.		X		
27		Diabetes Screening for people With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	The percentage of individuals 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.	X	X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
28		Follow-Up Care for Children Prescribed ADHD Medication	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: 1. Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. 2. Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.		X		X
29		Mental Illness: Risk-Adjusted Rate of Readmission Following Discharge for a Mental Illness	This measure is used to assess the risk-adjusted rate of readmission following discharge for a mental illness for individuals 15 years and older. A case is counted as a readmission if it is for a selected mental illness diagnosis and if it occurs within 30 days of the index episode of inpatient care. An episode of care refers to all contiguous hospitalizations and same-day surgery visits in general hospitals.		X		X

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
30		Screening for Clinical Depression and Follow-up	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented. Follow up: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.		X		
31	Oral Health	Rate of Dental Procedures Performed in Surgical Units	Rate of inpatient claims with dental procedures performed in the hospital. Limit the population to only children <19, with the denominator to be total population.		X		X
32		Total Eligibles Who received Preventive Dental Services (ages 1-20)	The total unduplicated number of children receiving dental preventive services		X		
33	Patient Safety	Patients Who Reported that Staff "Always" Explained about Medicine before Giving it to Them	Patients who reported that staff "Always" explained about medicine before giving it to them. This is a standardized question from HCAHPS.		X		
34		Patients Who Reported that YES, They were Given Information about what to do During Their Recovery at Home	Patients who reported that YES, they were given information about what to do during their recovery at home. This is a standardized question from HCAHPS.		X		

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
35	Pediatrics	Adolescent Well-Care Visits (1)(2)	At least one comprehensive well-care visit with a primary care practitioner or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member.	X	X		
36		Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (1)(2)	Percentage of members 3–6 years of age who received one or more well-child visits with a PCP during the measurement year	X	X		
37		Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	X	X		
38		Children's and Adolescents' Access to Primary Care Practitioners	This measure is used to assess the percentage of members 12 months to 24 months, 25 months to 6 years, 7 years to 11 years and 12 years to 19 years of age who had a visit with a primary care practitioner (PCP).	X	X		-
39		Developmental Screening in the First Three Years of Life	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing	X	X		-

Ref #	Topic Category	RCO Quality Measure Notes: (1) = DSHP Measures (2) = Incentive Measures	Description	RCO Program Objective/IPS Targeted Areas			
				1. Improved Prevention and Management of Chronic Disease	2. Improved Access to and Care Coordination of Health Services	3. Improved Birth Outcomes	4. Health Delivery System Financial Efficiency
			whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.				
40		Immunizations for Adolescents	The percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday	X	X		
41		Well-Child Visits in the First 15 Months of Life	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: <ul style="list-style-type: none"> •No well-child visits •One well-child visit •Two well-child visits •Three well-child visits •Four well-child visits •Five well-child visits •Six or more well-child visits 	X	X	X	
42	Transition of Care	Care Transition – Transition Record Transmitted to Health Care Professional (2)	Care transitions: percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	X	X		X

Exhibit B-4. Transition Pool Terms

ALABAMA MEDICAID AGENCY

ALABAMA MEDICAID TRANSFORMATION (PROJECT NUMBER 11-W00299/4)

TRANSITION POOL TERMS

1. INTRODUCTION

The Centers for Medicare & Medicaid Services (“CMS”) has approved Alabama’s request for a five year section 1115 demonstration entitled, “Alabama Medicaid Transformation”, Project Number 11-W00299/4 (the “Project”). CMS’ approval of the demonstration is conditioned upon compliance with the special terms and conditions for the Alabama Medicaid Transformation, including all attachments thereto (the “STCs”), which detail the operation of the demonstration, including the nature, character, and extent of anticipated federal involvement in the Project. Under the demonstration, the state aims to improve care to and the health of its beneficiaries by moving from a fee-for-service delivery system to enrollment in managed care under locally-administered, provider-based Regional Care Organizations (each an “RCO”). To support the implementation of this new service delivery system, CMS has authorized expenditure authority for a time-limited Transition Pool for the first three years of the demonstration. The Transition Pool allows federal match for additional payments to RCOs and providers in order to improve medical services to Medicaid beneficiaries and reward RCOs and providers who have met the reporting, operational, and quality measures described in the STCs. The Transition Pool contains two components – the transition payments to RCOs (the “Start-up Cost Component”) and transition payments to selected providers (the “Integrated Provider System Component” or “IPS Component”). Transition Pool funds are to be used only to support the goals of the transformation under the demonstration.

2. WHEN AN RCO OR PROVIDER IS DEEMED TO ACCEPT THESE TERMS

By executing the Regional Care Organization Contract (the “Risk Contract”) with the Alabama Medicaid Agency (the “Agency”), the RCO acknowledged and agreed that these Transition Pool Terms (these “Terms”) shall apply to and control all expenditures, or proposed expenditures, of funds from the Transition Pool. The RCOs shall ensure that all providers that submit applications for the award of any Transition Pool funds shall bind themselves to the applicable terms of the STCs and these Terms; provided, however, that by submitting to an RCO an application for an award of any funds from the Transition Pool, a provider shall be deemed to have accepted, and these Terms shall apply to and control, all expenditures, or proposed expenditures, of funds from the Transition Pool. If

a provider DOES NOT wish to be subject to these Terms, the provider shall not furnish to an RCO any application for an award or otherwise accept (directly or indirectly) any funds from the Transition Pool.

3. GENERAL REQUIREMENTS FOR TRANSITION POOL EXPENDITURES

The expenditure of Transition Pool funds shall be governed by the STCs, as they may be amended from time to time, including, but not limited to, the requirements, conditions, restrictions, methodologies, and annual limits contained in section XIII of the STCs applicable to the Transition Pool funds (currently STCs 77-88), by these Terms (and any material referenced herein), and any applicable provision of the Risk Contract. All such expenditures are subject to CMS approval and each RCO and provider receiving Transition Pool funds acknowledge that their receipt and retention of any such Transition Pool expenditures is conditioned upon such approval. RCOs and providers acknowledge reviewing and understanding the STCs and these Terms, and agree to fulfill all requirements and conditions contained therein which are applicable to each. Without limiting the foregoing, the RCOs and providers shall provide to the Agency, within the time and in the manner established by the Agency, all reports and other information required by them in the STCs, or needed by the Agency to fulfill its obligations to CMS, including, but not limited to, the requirements set forth in STCs 38 (Quarterly Progress Reports), 75 (Consequences to RCOs for Failing to Fulfill Requirements or Meet Performance Standards), 80 (Methodology for Determining Payment to RCOs), 84 (Reporting work plan status to Alabama Medicaid Agency), 85 (Methodology for Determining Payment to Participating Providers), and 86 (Quality Metrics for Provider Work Plans). Further, the RCOs and providers shall cooperate with and assist the Agency in fulfilling its monitoring, intervention, and remediation obligations contained in the STCs, and shall cooperate fully with any intervention and/or remediation plan established by the Agency and/or CMS, as referenced in STC 75b. (Intervention to Improve Quality).

Any commitment by the Agency of funds from the Transition Pool shall be contingent upon receipt by the Agency of such funds from CMS. Without limiting the foregoing, payment by the Agency of any funds from the Transition Pool is contingent upon the availability of federal and state monies lawfully applicable for such purposes. If the Agency, in its sole discretion, determines at any time that sufficient funds are or will not be lawfully available for the Agency to make payments from the Transition Pool, including, but not limited to, those included in an award of funds from the IPS Component for provider work plan(s), the Agency shall notify the affected RCO(s) to that effect, whereupon the amount of payments from the Transition Pool shall be reduced, in

whole or in part, to an amount the Agency determines, in its sole discretion, is available to fund such expenditures.

As a condition precedent to the receipt of each and every disbursement of Transition Pool funds, an RCO and, if applicable, the provider(s) participating in an approved IPS work plan, must be in full compliance with all applicable terms of the STCs, these Terms, and the terms of the Risk Contract, and all providers participating in an approved IPS work plan must have an existing provider contract with the sponsoring RCO. If at any time prior to final payment of an approved IPS work plan the provider contract of any provider participating in an approved IPS work plan is terminated, both the sponsoring RCO and relevant provider(s) shall notify the Agency in writing of such termination within 3 business days of the termination. In addition, both the sponsoring RCO and relevant provider(s) shall submit with such notice a proposal for the continuation, or termination, of the IPS work plan. The Agency, in its sole discretion, shall thereafter decide whether, and under what conditions, such IPS work plan shall be continued or terminated, all subject to CMS's approval.

No Transition Pool funds awarded may be assigned or transferred by the recipient thereof, except in accordance with the express terms of the STCs. No RCO or provider awarded Transition Pool funds may assign, delegate or transfer their responsibilities under an award without the advance written approval of the Agency.

4. SUSPENSION, DELAY, REDUCTION OR TERMINATION OF EXPENDITURES FROM THE TRANSITION POOL

All Transition Pool expenditures, and any commitments made by the Agency regarding Transition Pool expenditures, may be withdrawn, suspended, reduced, delayed, amended or terminated (in whole or in part and in the sole discretion of the Agency) as follows:

- a) To the same extent CMS withdraws, suspends, reduces, delays, amends, or terminates the terms of the demonstration or the Agency's expenditure authority thereunder;
- b) The Agency discovers the RCO or provider submitted inaccurate or incomplete information with its application for an award of any funds from the Transition Pool; or
- c) The Agency determines by audit or other investigation that Transition Pool funds have been misused by the RCO or provider.

In addition, the Agency may withdraw approval and further funding of a work plan in accordance with STC 86 (Quality Metrics for Provider Work Plans).

The Agency may terminate all payments, and terminate, suspend, delay or otherwise amend the terms of any commitments with respect to future payments, made by the Agency regarding Transition Pool expenditures, including, but not limited to, those included in an awarded IPS work plan, should the RCO or, if applicable, the provider(s) receiving funds, directly or indirectly, from the IPS Component, breach any applicable and material provision of the STCs, these Terms, or the terms of the Risk Contract.

Upon early termination of the Risk Contract for any reason under Section 5 of the Risk Contract, the Agency shall immediately and permanently withhold all future payments of Transition Pool funds to the RCO. Should the Risk Contract be terminated pursuant to Subsection 5.1.2 of the Risk Contract at any time during the initial term of the Risk Contract, all Start-Up Component payments previously paid to the RCO shall be promptly refunded to the Agency, in addition to any other amounts owed to the Agency under the Risk Contract. Should the Risk Contract be terminated pursuant to Subsection 5.1.6.3 of the Risk Contract, recoupment or repayment of Start-Up Component shall be made in accordance to the terms of that section, in addition to any other amounts owed to the Agency under the Risk Contract.

Should an RCO receive any funds from the Start-up Cost Component and thereafter not provide any Covered Services as defined in the Risk Contract, the RCO shall refund to the Agency all funds it received from the Start-up Cost Component.

Should the Risk Contract of an RCO that has been awarded an IPS work plan be terminated prior to final payment of the IPS work plan, the Agency, in its sole discretion, shall thereafter decide whether, and under what conditions, such IPS work plan shall be continued or terminated, all subject to CMS's approval.

5. RECOUPMENT BY THE AGENCY OF TRANSITION POOL EXPENDITURES DISTRIBUTED TO RCOs AND PROVIDERS

Expenditures from the Transition Pool are subject to recoupment or recovery if it is determined that such funds were misused and/or information relied upon for payment was in error or misreported to the Agency or if the Agency made an error in determining payment. Further, Transition Pool payments are subject to recoupment or recovery to the extent CMS: (a) withholds or revokes approval for such payment or (b) recoups, recovers or makes a negative payment adjustment of such amount from the Agency.

6. REQUIREMENT TO MAINTAIN AND PRODUCE RECORDS AND AGENCY AUDIT RIGHTS

RCOs and providers receiving awards shall maintain timely and accurate financial and administrative records related to all Transition Pool funding received. Unless a longer period of time is required by applicable statute or regulations, records shall be maintained for at least 10 years from the date funds are received.

Audits may be performed by the Agency and CMS to validate submissions made to the Agency and performance metrics regarding Transition Pool expenditures. Adjustments may be made to payments from the Transition Pool, and recoupment or recovery of amounts already paid, based on the findings of the audit. The Agency and CMS shall have the right of access to all pertinent books, contracts, documents, papers, and records of the RCOs and providers for the purpose of making audits, financial reviews, examinations, excerpts and transcripts. This right also includes timely and reasonable access to RCO's and provider personnel for the purpose of interview and discussion related to such matters and documents. This right of access is not limited to the demonstration period, but shall last as long as the records are required to be maintained under these Terms.

7. PROCEDURES, REQUIREMENTS, AND CONDITIONS REGARDING TRANSITION POOL EXPENDITURES

In order to obtain funds from the Transition Pool, RCOs and providers must strictly follow the procedures set forth in the STCs, the Integrated Provider System Protocols (*see* STC 88) (the "IPS Protocols"), these Terms, and any applicable regulations and policies promulgated by the Agency. The amount of Transition Pool payments shall be calculated and made in accordance with the terms of the STCs and IPS Protocols, and is subject to reallocation and reconciliation as provided therein, including, but not limited to, the terms of STC 80 (Methodology for Determining Payment to RCOs) and 85 (Methodology for Determining Payment to Participating Providers).

IPS work plan applications properly submitted to the Agency will be scored as described in the IPS Protocols. By submitting an application to the Agency, the RCO and applicable providers acknowledge and agree that, due to the limitations, conditions and restrictions contained in the STCs, the Agency will likely be unable to approve all qualified work plans seeking IPS Component funding which are submitted to it, and that approval or denial of IPS work plans will be based upon the scoring method referenced in the IPS Protocols and the Agency's determination, made at its sole discretion, of which plans are in the best interest of the Program, and that the Agency may adjust the IPS award amount from the amount requested by the IPS application to ensure funding for an appropriate mix of IPS work plans in each RCO region and across the State, and to the extent the Agency determines such adjustment is in the best interest of the Program. Other than the

reconsideration process referenced in Alabama Medicaid Administrative Code Rule 560-X-62-.27 and the IPS Protocols, the Agency's decision whether to approve or award an IPS work plan, including the amount thereof, shall be final and conclusive. In the event of a reconsideration, the Agency's decision on reconsideration shall be final and conclusive, and not subject to further review.

RCOs will retain their administrative percentage of each IPS payment (up to 10 percent of the total payment) and distribute the remaining amount to providers in accordance with the approved IPS application. In the event an RCO's obligation to administer and monitor a work plan per the requirements of STC 86 (Quality Metrics for Provider Work Plans) shall terminate prior to full implementation or completion of such work plan, for any reason whatsoever, and including, but not limited to, the termination of the Risk Contract, then the RCO shall forfeit all rights with respect to any portion of the Management Fee that remains unpaid as of such date. No later than 30 days after an RCO receives payment from the Agency pursuant to an approved IPS work plan, such RCO shall pay to the participating provider(s) its/their share of such payment.

RCOs and providers acknowledge and agree that all expenditures of funds from the IPS Component made to them will be spent in strict conformance with the terms of the awarded IPS work plan.

Each RCO and provider acknowledges and agrees that it has been provided equal notice and opportunity to develop and submit work plans in accordance with the STCs, these Terms and the IPS Protocols. RCOs acknowledge and agree that all information provided to the Agency related in any way to the Transition Pool, including, but not limited to, all information submitted in connection with the IPS Component and IPS work plans, may be released by the Agency to CMS and released publically for comment in accordance with the requirements of the STCs.

8. MISCELLANEOUS PROVISIONS

RCOs and providers shall be bound by all decisions of CMS which relate in any way to the Transition Pool, to the same extent the Agency is bound by such decisions. Further, RCOs and providers shall be bound by any and all amendments to the STCs.

To the extent allowable under the law, should the Agency be entitled to the recoupment of any Transition Pool expenditures made to an RCO, the Agency shall be entitled to withhold such amount from payments under the Risk Contract.

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RCOs and providers shall be responsible for complying with all applicable laws, ordinances, codes and regulations of the Federal, State and local governments, including, but not limited to, the Beason-Hammon Alabama Taxpayer and Citizen Protection Act (§ 31-13-1, *et seq.*, Code of Alabama 1975) and those described in section 26.2 of the Risk Contract.

To the extent a conflict exists between the terms of the STCs and these Terms, the terms of the STCs shall control. If any provision of these Terms shall contravene any statute or Constitutional provision or amendment, either now in effect or which may, during the demonstration be enacted, then that conflicting provision in these Terms shall be deemed null and void. These Terms shall be automatically amended to reflect changes or amendments to the STCs, and to reflect any changes in relevant federal or state law, regulation or policy during the demonstration period. Without limiting the foregoing, some or all expenditures from the Transition Pool may be reduced to reflect any similar reduction or amendment made by CMS.

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Exhibit B-5. Rule No. 560-X-62-.08 Conflict of Interest Policy for Directors and Officers of Regional Care Organizations

- (1) A regional care organization (RCO) and an organization with probationary RCO certification shall adopt a conflict of interest policy for directors and officers. The conflict of interest policy shall require all directors and officers to conduct their activities as directors or officers so that they do not advance or protect their own interests, or the interests of others with whom they have a private or professional relationship, in a way that is detrimental to the interests of, or to, the RCO or organization with probationary RCO certification, and the conflict of interest policy shall provide for the removal of any director or officer whose conduct violates such policy, unless a remedial action shall be sufficient to bring the director or officer into compliance with the policy. The conflict of interest policy shall require each director and officer to disclose in a written statement all employments, associations, commitments and financial interests within the preceding two years on the part of the director or officer, or his or her immediate family member, including spouse, dependents, adult children and their spouses, parents, spouse's parents, siblings and their spouses, that could reasonably be perceived, directly or indirectly, as a conflict of interest with the RCO or organization with probationary RCO certification. The statement shall also disclose whether the director or officer or his or her immediate family member as described in the preceding sentence is a current or former employee of, consultant with, or lobbyist for the Medicaid Agency. Each director and officer shall file such disclosure statement with the RCO's or organization's board of directors and the Medicaid Agency on an annual basis.
- (2) The conflict of interest policy must also:
 - (a) Require each director or officer to disclose relevant financial interests;
 - (b) Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and
 - (c) Address remedial action for directors or officers that fail to comply with the policy.
- (3) A RCO and an organization with probationary RCO certification and each of its directors and officers must complete and submit to the Medicaid Agency the Disclosure Statement required by Act 2001-955 prior to the RCO entering into a contract with the Medicaid Agency.
- (4) All employees and agents of the Medicaid Agency who have responsibilities relating to contracts with a RCO or an organization with probationary RCO certification must comply with applicable provisions of the state ethics laws including, but not limited to, Sections 36-25-5, -7, -8, -11, -12, and -13 of the Alabama Code.
- (5) The Medicaid Agency may require a RCO or an organization with probationary RCO certification and each of its directors and officers to comply with additional conflict of interest requirements and policies the Medicaid Agency determines to be necessary to satisfy State and Federal requirements or necessary to address issues of noncompliance with the requirements of this Conflict of Interest Rule.

**Exhibit B-6. Rule No. 560-X-62-27 Integrated Provider System Application Selection Process
– NEW RULE**

(1) The Integrated Provider System (“IPS”) application process shall be conducted in accordance with the special terms and conditions issued by CMS (the “STCs”) and the IPS Protocols approved by CMS pursuant to STC 88.

(2) The probationary or fully certified regional care organization’s (hereinafter collectively referred to as “organizations”) review of proposed work plans (hereinafter “proposed work plans”) submitted to it by providers or groups of providers (hereinafter collectively referred to as “providers”) must be conducted pursuant to a fair and impartial process, including, but not limited to, the organization strictly following the conflict of interest policy for directors and officers of the organization as set forth in Alabama Medicaid Administrative Code Rule 560-X-62-.08, as well as the organization’s own conflict of interest policy that has been approved by the Agency.

(3) Each demonstration year, the Agency shall establish a date for each organization to publish and distribute a notice regarding the proposed work plans received by the organization. Such notice must be published and distributed to the Agency and to all providers that submitted proposed work plans to the organization and include a summary of each proposed work plan and the disposition of each proposed work plan (i.e., whether the organization intends to sponsor the proposed work plan and submit a completed application to the Agency pursuant to section (5) below).

(4) Any provider whose proposed work plan is not selected for sponsorship may, no later than seven (7) calendar days after an organization’s publication referenced in subsection (3) above, make a written request for review of the decision to the Medicaid Quality Assurance Committee, in accordance with this rule, Alabama Administrative Code Rule 560-X-62-.13(12) and all other applicable rules, policies, protocols, and procedures adopted by the Agency, and on a form provided by the Agency. The provider(s) shall provide the organization a copy of its written request for review at the same time it submits its request to the Medicaid Quality Assurance Committee. The Medicaid Quality Assurance Committee’s review shall be conducted in accordance with the following:

(a) No later than seven (7) calendar days after receipt of the provider’s request for review, the relevant organization shall submit to the Medicaid Quality Assurance Committee and the provider(s), on a form provided by the Agency, the reason or basis for its decision, as well as any other material or information it believes supports its decision. The provider(s) shall thereafter have seven (7) calendar days within which to submit to the Medicaid Quality

Assurance Committee and organization any additional material or information it believes supports its claim.

(b) The organization's decision shall be entitled to a presumption of correctness, and the Medicaid Quality Assurance Committee shall only reverse the organization's decision if it finds the proposed work plan in question satisfies the requirements contained herein, and in the STCs and IPS Protocols, and either of the following exist: (i) that the decision was made on unreasonable grounds or without proper consideration or (ii) any applicable conflict of interest policy was violated during the organization's decision making process. The Medicaid Quality Assurance Committee shall make and announce its decision on all review requests submitted to it no later than the date established by the Agency for such decisions for each respective demonstration year. The Medicaid Quality Assurance Committee shall notify, in writing, the provider(s), the Agency, and the organization of its decision. With regard to any proposed work plan the Medicaid Quality Assurance Committee determines should have been sponsored by the organization, the provider(s) and organization shall thereafter work together to finalize an application for the proposed work plan which shall be forwarded to the Agency for consideration pursuant to section (5) below. The Medicaid Quality Assurance Committee's decision shall be final and conclusive, and not subject to further review.

(c) No member of the Medicaid Quality Assurance Committee who also served on an officer or director of the RCO that reviewed the application that is at issue or is an officer, director, agent, or employee of the provider that submitted the application shall be entitled to vote on or participate in the Medicaid Quality Assurance Committee's review of that application.

(5) On each demonstration year, the Agency shall establish a date each organization shall submit to the Agency, on the form and in the manner designated by the Agency, a fully completed application for each sponsored IPS work plan.

(6) Applications properly submitted to the Agency will be evaluated, scored and considered by the Agency as described in the IPS Protocols. Except for the reconsideration process described in subsection (7) below, the Agency's decision whether to accept and/or award applications shall be final and not subject to further review or appeal.

(7) An organization that has submitted an application that has been rejected by the Agency, or the provider(s) whose work plan is the subject of such application, may submit a written request for reconsideration to the Agency. Such written request shall be submitted to the Agency no later than 5 business days after the Agency's decision is announced, and shall state with specificity the issues that the organization or provider(s) believes warrant a reconsideration by the Agency. The Agency shall respond to a reconsideration request within a reasonable time.

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The Agency’s decision on reconsideration shall be final and not subject to further review or appeal.

Author: Stephanie Lindsay, Administrator, Administrative Procedures Office.

Statutory Authority: Code of Alabama, 1975 Section 22-6-150 et seq.

History: Emergency Rule Filed: [DATE]

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