

Alabama's Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes Alabama's application to the Centers for Medicare & Medicaid Services (CMS) to extend the 1115 Family Planning Waiver Demonstration for a period of five (5) years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

 X **Section 1115(a) extension with no program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period January 1, 2015 through December 31, 2017 (i.e., Demonstration Years 15, 16 and 17).

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.
- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.

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Appendix A: A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

The Plan First Program was predicated on the recognized need for continued family planning services once Medicaid eligibility for pregnancy ended and for those women who would not otherwise qualify for Medicaid unless pregnant. Women were able to obtain family planning services during their pregnancy related eligibility period, but often lost benefits when postpartum eligibility ended. The Plan First Program afforded the state the ability to extend Medicaid eligibility after the birth of the baby and provided an avenue for extending eligibility to women who may not otherwise qualify for Medicaid. The program goal is to reduce unintended pregnancies.

Recipients have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services. There are to be no co-payments on prescription drugs/supplies that are designated as family planning.

When the program began, approximately 60,000 women were automatically enrolled. Enrollment increased steadily for the first five years of the program to over 100,000 women, after which there was a decline. The requirement to re-enroll annually, which was implemented in the beginning of the second Demonstration period, caused enrollment initially to decline, as did the requirement for citizenship and identification in 2006. The Alabama Medicaid Agency (AMA) implemented a Social Security Administration data match effective January 2010 to verify citizenship. This has helped streamline the enrollment process. In February 2013, AMA implemented automated Express-Lane Eligibility (ELE) renewals for Plan First women as well as children. This expedited renewal process, completed by the system, requires no participation from the case worker or recipient, enhancing the enrollment process.

AMA uses the Federal hub services (IRS, SSA, Equifax), SSN, citizenship and alienage, (DHS) as well as other sources (SVES, SDX, PARIS, SNAP, TANF, EDB, vital statistics,) to verify income and other points of eligibility as listed in the Alabama verification plan.

Alabama also has a hub waiver through which we use The SAVE web system (Systematic Alien Verification for Entitlements) for the VLP (verify lawful presence) steps 2 and 3 as needed. VLP 1 is completed through the federal hub. Alabama uses the hub service for on-line identity verification.

For income, Alabama uses the following reasonable compatibility model:

1. If available databases find no match, self-attestation will be accepted.
2. If individual self-attestation of income and data match are both below the Medicaid/CHIP MAGI eligibility level, individual will be determined eligible for Medicaid/CHIP benefits.

3. If individual self-attestation of income and data match are both above the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible, and account transferred to FFM for APTC eligibility.
4. If individual self-attestation of income is above Medicaid/CHIP MAGI level, but data match puts applicant below the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible and account transferred to FFM for APTC eligibility.
5. If individual self-attestation of income is below Alabama Medicaid/CHIP MAGI level, but data match puts applicant above the Medicaid/CHIP MAGI eligibility level, reasonable compatibility level of 10% will be applied. If less than 10% difference, data is considered reasonably compatible and individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual can provide a reasonable explanation (either already indicated on the application, or after formal request from the state), the individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual cannot provide a reasonable explanation, the individual will be determined ineligible for Medicaid/CHIP.

Individuals may also renew on-line and receive a real-time eligibility renewal without worker intervention with real time eligibility verification through the federal hub. Upon eligibility approval, recipients receive an award letter informing them of their Medicaid coverage. A letter is also generated if the recipient's services are denied, terminated, suspended, or changed. Appeal rights are included in the letter.

The current Plan First 1115 Demonstration Waiver was approved for three (3) years, effective December 29, 2014 through December 31, 2017. During this renewal, two new covered services were added, removal of migrated or embedded intrauterine devices in an office setting or outpatient surgical facility and coverage of vasectomies for eligible males 21 years of age or older.

Services under this Demonstration is designed to improve the well-being of children and families in Alabama by extending Medicaid eligibility for family planning services to eligible women between the ages of 19-55 whose income is at or below 141% of the Federal Poverty Level (FPL). A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

Eligible individuals are females of childbearing age between 19 through 55 and men ages 21 or older who meet the eligibility criteria described below. Men can receive vasectomies/vasectomy related services only under this Demonstration.

Group 1

Women 19 through 55 years of age who have Medicaid eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer "yes" to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

Group 2

Poverty level pregnant women 19 through 55, whose pregnancy ends while she is on Medicaid. The Plan First Waiver system automatically determines Plan First eligibility for every female

Medicaid member entitled to Plan First after a pregnancy has ended. Women automatically certified for the Plan First Program receive a computer generated award notice by mail. If the woman does not wish to participate in the program, she can notify the caseworker to be decertified. Women who answered “no” to the Plan First question on the application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at initial application and re-verified at re-certification of their children. Eligibility is redetermined every 12 months.

Group 3

Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. A Modified Adjusted Gross Income (MAGI) determination will be completed using poverty level eligibility rules and standards. Recipient declaration of income will be accepted unless there is a discrepancy. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the recipient’s declaration and the income reported through data matches, the recipient will be required to provide documentation and resolve the discrepancy. Eligibility is redetermined every 12 months.

Group 4

Males, ages 21 and older, wishing to have a vasectomy may complete a simplified shortened Plan First application (Form 357). An eligibility determination must be completed using poverty level eligibility rules and standards. Eligibility will only be for a 12-month period; therefore, retro-eligibility and renewals are not allowed. If the individual has completed the sterilization procedure but has not completed authorized follow-up treatments by the end of the 12-month period, a supervisory override will be allowed for the follow-up treatments. If the individual does not receive a vasectomy within the 12-month period of eligibility, then he will have to reapply for Medicaid eligibility.

Women can check on their initial application whether they want to renew their eligibility automatically up to 5 years using income data from tax returns.

Eligible women qualify for most family planning services and supplies, including birth control pills, the Depo-Provera shot, vaginal ring, diaphragm, contraceptive patch, doctor/clinic visits (for family planning only), smoking cessation products and counseling, and tubal ligations. Reference Attachment H for a list of covered smoking cessation products. Recipient may also receive smoking cessation services through the Alabama Tobacco Quitline. The Quitline offers online and telephone counseling services at QuitNowAlabama.com for any Alabamian who is ready to quit tobacco. Those who begin counseling can receive, if medically eligible, a free, eight-week supply of the nicotine patch to assist in their attempt to quit. The Quitline is not a waiver service.

Eligible men qualify for doctor/clinic visits related to vasectomy services only as a waiver service. The Plan First Program does not cover any other medical services, and individuals who have been previously sterilized are not eligible to participate in this program. See Attachment F for a list of covered services.

Participation in the Plan First Program is open to any provider who wishes to be Medicaid enrolled and executes a Plan First agreement. Only those Plan First enrolled providers are able to

service Plan First eligibles. Providers can be clinics, private physicians, nurse midwives, nurse practitioners, or physician assistants. As of December 2016, there were 2,727 Plan First Provider locations servicing Plan First recipients. Providers are bound by the requirements in the Appendix C, Family Planning Chapter of the Alabama Medicaid Provider Manual and the approved 1115 Plan First Demonstration Waiver.

Medicaid maintains a listing of all providers who have enrolled to provide services to Plan First eligibles. The list, which includes the addresses and telephone numbers, is made available to all Plan First care coordinators and staff of the Plan First toll free hotline, and any other party who may be assisting individuals in locating a Plan First provider. The list is available online at the Alabama Medicaid Agency's web site (www.medicaid.alabama.gov) as well as in printed form.

Direct services are augmented with care coordination and tracking for “high risk” and “at risk” women to ensure compliance with the woman's chosen birth control method. Care coordination allows for enhanced education on appropriate use of the chosen method and further assurance of correct and continued usage. Care coordination services are designed to provide special assistance to those women who are at high risk for an unintended pregnancy and allow for enhanced contraceptive education, encouragement to continue with pregnancy spacing plans and assistance with the mitigation or removal of barriers to successful pregnancy planning. Care coordination services are available to all Plan First recipients, except males, regardless of the service provider. These services must be provided by licensed social workers or registered nurses associated with the Department of Public Health. Should care coordination services be needed, a referral can be made by calling the local health department and asking for the Plan First Care Coordinator.

The goal of care coordination is to form a partnership with the recipient to address impediments to successful family planning. The bio-psychosocial model of care coordination is used to achieve this goal and includes:

- A bio-psychosocial assessment and development of case plan for all patients who accept care coordination.
- Counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial issues identified in the assessment, such as substance abuse or domestic violence.
- Referrals and follow up to ensure appointments are kept, including subsequent family planning visits.
- Answers to general questions about family planning.
- Low-literacy family planning education based on the PT+3 model.
- Consultation with providers regarding problems with the selected family planning method.

The care coordinator work diligently with family planning providers to ensure that recipients receive care coordination services in a timely manner. All female recipients are eligible to receive an initial risk assessment to determine if and what type of care coordination services is needed.

In November 2016, the AMA submitted a Waiver amendment to CMS to add care coordination for males as a covered service. The care coordination for males will provide assistance with the application process for Plan First through the AMA, identify Medicaid approved vasectomy providers, facilitate the initial appointment process, and provide appointment reminders. Services

will be provided as encounters and will consist of face to face contact, telephone contact, and sending letters and postcard reminders. The state is awaiting an approval of this request.

By several measures, the Plan First Program continues to reduce the likelihood that potentially Medicaid eligible women will become pregnant. Compared to estimates of the number of babies that would have been born to Plan First service users if their fertility rates reflected those of the general population before the start of the program, Plan First averted an estimated 11,215 births in DY10, decreasing slightly to 10,703 averted births in DY11, a result of an increase of births to Demonstration participants. In DY14, 8,406 births were averted. Using a cost estimate of \$7,000 per birth, including the infant’s first year of life, Plan First resulted in overall savings of \$58,842,000 over what would have been spent without the program. As evaluated, birth rates to Plan First recipients met the performance target of 100 births or less per thousand per enrollee.

AMA identified six (6) goals and objectives for Demonstration Years 15, 16 and 17. The goals and how these goals were met /not met are outlined below:

Goal 1: Increase the portion of women eligible for Plan First who actually enroll, and reduce race/ethnicity and geographic disparities in enrollment.

Finding: Enrollment for African American women residents of Alabama who are ages 19-24 and 25-34 is somewhat below the target rate, at 68% and 67% of those estimated to be eligible, respectively. Enrollment is lower for Caucasian women, 51% for those age 19-24 and 56% for those age 25-34. More urban areas of the state tended to have more racial disparity in enrollment. Those most likely to renew their enrollment from one year to the next are women who had contact with a Plan First provider. See Table 1.1., for estimated portion of Plan First eligibles enrolled statewide, by age and race/ethnicity. Census estimates are based on county-level American Community Survey (ACS) data, averaged over 2010-2014.

Table 1.1. Estimated portion of Plan First Eligibles Enrolled Statewide, by age and race/ethnicity

	Age 19-24			Age 25-34			Age 35-44		
	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled
White	45,356	23,007	50.7	42,591	23,744	55.7	33,786	6,856	20.3
Black	38,084	26,038	68.4	45,999	30,662	66.7	30,616	9,446	30.9
Other	7,632	1,949	25.5	10,818	1,967	18.2	7,042	747	10.6
Total	91,133	50,994	56.0	99,465	56,373	56.7	71,502	17,049	23.8

Goal 2. Maintain a high level of awareness of the Plan First Program among enrollees.

Finding: The awareness of Plan First among enrollees exceeds the target of 90%. The percentage of those who are aware of Plan First and know that they are enrolled in program meets the 85% target. Overall awareness of Plan First remains quite high (>90%) among enrollees. However, just over 20% of enrollees are not aware of their enrollment status,

including the 7% who report they have never heard of Plan First, and another 14% who have heard of the program but did not know they were enrolled. Some of these are women who prefer not to use contraception and thus do not have an incentive to learn about Plan First. However, others are women who do use contraception, and have concerns about affordability and access to services which reflect the fact that they are not aware of their enrollment status. See Table 2.1., for results of the enrollees who are aware of Plan First Program.

Table 2.1. Awareness of Plan First

Demonstration Year	Had heard of Plan First Before Call (%)	Aware of enrollment (%)	
		Among all surveyed	Among those who had heard of Plan First
DY1	76.8	56.2	73.1
DY2	82.5	64.2	77.9
DY3-4	81.0	64.9	80.2
DY5	85.3	63.6	74.9
DY6	86.8	70.2	82.5
DY7	92.9	80.8	87.1
DY8	88.9	85.3	85.9
DY9	90.8	79.7	87.8
DY10	88.7	78.3	88.2
DY11	90.1	79.3	88.1
DY12	88.7	77.2	87.0
DY13	89.9	79.9	88.9
DY14	90.1	74.9	83.2
DY15	92.6	78.8	85.0

Goal 3. Increase the portion of Plan First enrollees who use family planning services, both in the initial year of enrollment and in subsequent years. Increase the portion of Plan First enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return visits for care. Our goal is to have 70% utilization of services by the end of the three year period, along with a 70% rate for 12 and 24 month return visits for individuals using services during the renewal period.

In previous Plan First evaluations, overall rates of participation without exploring differences across sub-groups of enrollees, and without differentiating between participation for first year enrollees and for enrollees in subsequent years were reported. With this analysis, it is clear that there is a sub-group of enrollees whose participation meets the target rate of 70% use: enrollees who have used shorter acting reversible contraception (e.g. Depo, pills) for at least a year. Women using long-acting reversible contraception (LARC) for at least a year also participate in subsequent years, but at a lower rate (45%). Participation is also lower for new enrollees who

are not postpartum (56%). Women with no evidence of any use of contraception services in previous years have the lowest participation (<15%). Women with Plan First participation but no actual clinical service use are evenly divided between those with case management contact only, and those who fill contraceptive prescriptions but have no clinical contact. Reference Table 3.1., for utilization assessment for Demonstration Year 15.

Table 3.1. Utilization Assessment for Demonstration Year 15

	N (%)	% Initial Plan First Participation	% Participation 12 months after initial visit	% Participation 24 months after initial visit
All Enrollees, DY15	128,473		40.3% Contact 31.3% Service	
New DY15 Enrollee, Postpartum	7,080 (5.5)	33.4% contact 23.0% service	--	--
Received LARC postpartum	17 (0.2)	100% contact 100% service	--	--
Received other method postpartum	36 (0.5)	100% contact 88.9% service	--	--
Received no method postpartum	7,027 (99.2)	32.9% contact 22.5% service	--	--
New DY15 Enrollee, Not Postpartum	7,971 (6.2)	55.7% contact 48.1% service	--	--
Enrolled DY14 & DY15	27,963 (21.8)		35.6% contact 26.5% service	--
Received LARC DY14	731 (2.6)	--	45.5% contact 31.7% service	--
Received other method DY14	10,204 (36.5)	--	100% contact 100% service	--
Received no method DY14	17,028 (60.9)	12.8% contact 0.7% service	--	--
Enrolled DY13 - DY15	85,461 (66.5)		41.0% contact 32.1% service	

Received LARC DY13 or DY14	4,112 (4.8)	--	--	47.6% contact 36.8% service
Received other method DY13 or DY14	43,792 (51.2)	--	--	100% contact 100% service
Received no method DY13 or DY14	37,557 (44.0)	13.9% contact 1.0% service	--	--

-- Not applicable

Goal 4. Increase the portion of Plan First enrollees who receive smoking cessation services.

By report of enrollees, there has been an increase over time in the extent to which smoking cessation is discussed in family planning settings, and in the concrete advice that providers give to clients about quitting tobacco use. In DY 15, 64% of smokers reported receiving either a prescription for a Nicotine Reduction Therapy or a referral to the Quit Line. However, based on claims data, there is relatively little use of prescriptions among Plan First enrollees, and a very small percentage of the estimated smokers (<1%) have contacted the Quit Line and indicated they were referred by their care coordinator.

Enrollee survey data from Demo Year 15 shows a slight decrease in the portion of survey respondents who reported they were smokers. The percentage who were asked about smoking by their Plan First provider and the percentage that were advised by their provider to quit smoking were similar to the previous year, and notably higher than in DY11-DY13 when we began reporting on these outcomes. Although the portion receiving either a referral to the Quit Line or an NRT product did not meet the target 85% (currently at 64%), there was an increase from the previous year. Reference Table 4.1., Smoking Cessation Based on Enrollee Survey Data.

Table 4.1. Smoking Cessation Based on Enrollee Survey Data

	DY11 (baseline) N (%)	DY12 (NRT covered) N (%)	DY13 (NRT covered) N (%)	DY14 (NRT covered) N (%)	DY15 (NRT covered) N (%)
Reported Smoking	343 (36.3)	317 (30.8)	312 (30.5)	283 (28.6)	269 (25.8)
Asked about smoking at FP visit	313 (91.2)	281 (88.6)	268 (85.9)	265 (93.6)	248 (92.2)
Advised to quit by FP provider	245 (71.4)	267 (84.2)	215 (68.9)	212 (80.0)	205 (82.7)
Received NRT	94 (27.4)	104 (32.8)	100 (32.0)	111 (41.9)	121 (48.8)
Referred to Quit Line	115 (33.5)	122 (38.5)	119 (38.1)	110 (41.5)	132 (53.2)

Received either NRT or Quit Line referral	148 (43.1)	155 (48.9)	151 (48.4)	149 (56.2)	158 (63.7)
Paid out of pocket for NRT products	--	--	--	--	30 (12.1)

-- Not asked in Enrollee Survey

Goal 5. Maintain birth rates among Plan First participants which are lower than the birth rates estimated to have occurred in the absence of the Plan First demonstration. Birth rates vary from year to year, but remain low enough for Plan First to be budget neutral. In DY 14, the most recent year for which a count of the births occurring to participants during the demonstration year can be counted, overall birth rates for participants was 58.3 per thousand and the birth rate for women who were enrolled but did not use services was 84.9 per thousand. In contrast, the estimate of expected births, given the fertility rates before the start of the Plan First demonstration, was 203.1 per thousand for the women enrolled in the program. Reference Table 5.1., for birth rates per 1000.

Table 5.1. Birth Rates per 1000

	Estimated birth rate if fertility rates continued at pre-waiver levels	Actual birth rates all enrollees – pregnancies starting during DY	Actual birth rates service users – pregnancies starting during DY	Actual birth rates non-service users – pregnancies starting during DY
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9

Goal 6. Make sterilization services available to income-eligible men over age 21. There were no claims for vasectomy services in DY15, the first year the service was covered by Plan First. The majority of women who get counseled about female sterilization do not receive counseling about vasectomy as well. By report of female enrollees who do not want more

children, 20% of male partners may be interested in vasectomy if they could get the procedure covered by Plan First.

In the DY15 enrollee survey, we asked several questions to assess the potential demand for vasectomy services. Less than one-third (29%) of the 202 women who reported counseling about female sterilization also reported that they received counseling about vasectomy, and a higher percent of women who were seen at the health department reported vasectomy counseling than those who went to a private doctor or other source of care. Among the 465 women who reported that they do not want more children, 20% said their male partner may be interested in getting a vasectomy through Plan First. Reference Table 6.1., vasectomies provided to men through Plan First and Table 6.2., counseling female partners and their perception of men’s interest in vasectomy.

Table 6.1. Vasectomies provided to men through Plan First

	DY15 (10/14-9/15)
Number of men enrolled	n/a
Number obtaining vasectomy	0
% enrolled obtaining vasectomy	--

n/a – information on gender was not included in the enrollment files

Table 6.2. Counseling female partners and their perception of men’s interest in vasectomy

	DY15 N (%)
Women who received counseling about female sterilization & vasectomy	58 (28.7)
Health Department	26 (34.2)
Private Doctor	25 (25.0)
Other source	7 (28.0)
Partner would be interested in vasectomy through Plan First, among women who do not want more children	
Yes	94 (20.2)
No	232 (49.9)
Don’t know	124 (26.7)

Goals for Demonstration Year 18, 19, 20, 21 and 22:

- | |
|--|
| <p>(1) Increase the portion of women eligible for Plan First who enroll, and reduce race/ethnicity and geographic disparities in enrollment. The program goal is to enroll 80% of eligible women under age 40 into Plan First.</p> |
|--|

- (2) Maintain a high level of awareness of the Plan First Program among enrollees. The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be aware that they are enrolled in the program.
- (3) Increase the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and in subsequent years. The program goal is to achieve 70% in the initial year and increase service use to 60% in subsequent years.
- (4) Increase the portion of Plan First enrollees who receive smoking cessation services or nicotine replacement products. The program goal is to have 85% of smokers receiving these services.
- (5) Maintain birth rates among Plan First participants, which are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.
- (6) Increase the number of income-eligible men age ≥ 21 years who are enrolled in the Plan First program and the proportion of male enrollees undergoing vasectomy by assisting with the application process for Plan First through AMA, identifying Medicaid approved vasectomy providers, facilitating the initial appointment process, and providing appointment reminders. The goal is that the number of men enrolled in Plan First for vasectomies and vasectomy related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year. This goal will be evaluated based on the number of male enrollees, claims for care coordination and sterilizations performed statewide.

H1.1: Use of vasectomy services by male enrollees will increase with increased provision of care coordination services.

	DY15 (10/14-9/15)	DY16 (10/15-9/16)	DY17 (10/16-9/17)	DY18 (10/17-9/18)
Number enrolled				
Number obtaining vasectomy				
Received care coordination				
No care coordination				
Number not obtaining vasectomy				
Received care coordination				
No care coordination				
% enrolled obtaining vasectomy				

Track the number of care coordination hours billed for male Plan First enrollees.

	DY17 (10/16-9/17)		DY18 (10/17-9/18)	
Received Care Coordination?	No	Yes	No	Yes
Number (%) of male clients				
Mean number of encounters (hours of contact)				

Appendix B: Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state’s Medicaid and State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state’s actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.

See Attachment G - Budget Neutrality Worksheet.

Appendix C: Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state’s achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state’s interim evaluation must meet all of the requirements outlined in the STCs.

The number of women participating (having any paid claim) in the Plan First Program declined slightly in DY15, to 58,009 women, compared to 68,199 in DY14. Enrollment in the program also decreased slightly, but the portion of enrollees participating in the Plan First Program was similar to DY14, 45.1% vs 46.1%. The portion of women with deliveries in the previous two years who used Plan First services decreased across all Maternity Care District. Participation in Plan First by non-Title X agencies (private physicians and community health centers) increased, but the portion of total visits and total participants using services in the non-Title X sector decreased slightly.

The decrease in participation and enrollment in the Plan First Program is contributed to the change in FPL guidelines which made more Plan First recipients eligible for full Medicaid coverage.

Use of any contraceptives and use of effective contraceptives remained stable in DY15 (86% and 81% respectively), according to the annual enrollee survey. The primary reason for not using contraceptives, as identified by survey respondents, is that they are not sexually active (38%), they don’t think they can get pregnant (17%), or they want to get pregnant (14%). Some women do report that they do not use birth control because they can’t afford it (10%) or can’t find a provider that they want to see (9%). Affordability and difficulty finding a preferred provider are also listed as reasons for not making a visit to a family planning provider in the past year.

The portion of Plan First participants with a risk assessment, completed either in DY15 or in previous years, reached a high of 73% in DY 15. Risk assessment coverage remains high for users of Health Department services (>90%) and decreased slightly for users of private sector services. Almost all of the clients assessed as high risk received some form of care coordination services, and those with care coordination more frequently received HIV counseling and effective contraception.

The portion of women with non-family planning medical problems who received referrals from their family planning providers for primary care was 61% (compared to a target of 80%). As in past years, about 60% of women with medical issues reported receiving primary care, with inability to afford care as the primary reason cited for not obtaining services.

Finally, this evaluation continues the approach of estimating birth rates from pregnancies starting during the Demonstration Year separately for enrollees who did and did not participate in Plan First, and, among participants, for clients visiting different provider types and whether they received risk assessment and/or care coordination. All participants except those with no clinical services had birth rates that were lower than the rates for enrollees without services. Participants with the lowest birth rates are those who received risk assessments or care coordination, who use Title X family planning services.

The state will continue its evaluation its interim evaluations of the overall impact of the demonstration that includes evaluation activities and findings for the requested extension period. The interim evaluation for the requested extension period will also contain evaluations for males receiving vasectomy related services. It is the state's goal that the interim evaluation will provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program.

Reference Attachment I for a full Interim Evaluation of Plan First Program for Demonstration Year 15 (October 2014 through September 2015).

Appendix D: Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.

AMA has a consistent and coordinated framework for authority and oversight to deliver timely, appropriate quality family planning services to Medicaid recipients. The Services under this Demonstration Waiver are administered by various providers, however, AMA maintains authority over monitoring and oversight of the Plan First Program

The Demonstration Waiver has four major goals for quality assurance and monitoring:

- To assure accessibility of family planning services to eligible recipients
- To assure that recipient assessments include the assessment and care plan appropriate for the risk level
- To assure that the family planning encounters provided through enrolled providers follows the guidelines in the Provider Manual, Appendix C, Family Planning and the approved Waiver Demonstration.
- To ensure that an effective complaint and grievance system is in place for both providers and recipients
- To ensure quality and utilization management

- To ensure satisfaction of family planning services

Listed below are quality activities performed by AMA and its partnering Agency, Alabama Department of Public Health.

Internal Evaluations

The Demonstration Waiver has provisions for University of Alabama at Birmingham (UAB) to assist in providing outcome and summary reports to support effectiveness of the Program. This will enable comparisons between different sectors of populations and historical data.

UAB conducts ongoing internal evaluations for this Demonstration Waiver. The primary contact person is Dr. Kari White, Health Care Organization & Policy, University of Alabama at Birmingham. Her responsibility is to evaluate the program. UAB has designed data collection tools that collect, compile and analyze data, providing feedback annually to AMA and the Department of Public Health on program operation and outcomes. With UAB's assistance, a yearly Demonstration progress report that illustrates progress, goal achievement, and other areas for continued improvement. UAB is not involved in direct patient care for the Plan First Program. See Attachment I for details related to the Annual Demonstration Evaluation.

Monitoring

Public Health Area supervisors audit Plan First care coordination patient records quarterly utilizing a standardized audit tool. These audits are submitted to the Public Health Central Office and are available for review by Medicaid. All care coordination patient records are documented electronically and the Central Office conducts an annual desk review of the patient records for each Care Coordinator, submitting a written report to supervisors. Six weeks after Care Coordinators complete certification training, the Central Office training staff reviews their documentation and submits a written report to their supervisor. The Public Health Program Integrity staff randomly reviews patient records in county health departments for compliance with travel reimbursement, billing of appropriate time for services, and ensuring that all time coded to Plan First has appropriate documentation to justify billing. A total of 6,464 record reviews were conducted by the Medicaid's monitoring agency during DY15 and DY16 with a reported compliance rate of 99%. An example of Plan First Care Coordination monitoring and utilization is noted in Attachment M.

Complaints and Grievances

AMA has the primary responsibility of monitoring overall program performance, complaints and grievances. No complaints were received from recipients during this Waiver Demonstration period. Reference Attachment L, the Plan First Volume Indicator Report.

Claims Data Review

The agency conducted a review of claims to ensure appropriate billing of Procedure Codes. As result of this review, it was noted that a procedure Code for extended family planning counseling was not being utilized according to program description and guidelines. A complete analysis of claims for FY16 was requested from the provider. At the conclusion of this review, the provider agreed with the findings and claims were adjusted to reflect repayment of funds back to AMA.

Monthly Meetings

Monthly meetings are held with the ADPH to discuss program related concerns and updates related to the Plan First Program.

Comprehensive Desk Medical Record Reviews

Comprehensive desk medical record reviews were completed to monitor compliance with program guidelines. A random selection of records were requested from providers. The following findings were identified:

- Finding-Providers did not have a mechanism for documenting complaints and grievances for auditing purposes.

Action taken by the Agency-Education was provided regarding documentation of complaints and grievances.

- Finding-Although documentation of recipient education was noted, providers were not documenting the use of PT+3 Teaching Methodology.

Action taken by the Agency-Education was provided regarding documentation of PT+3 Teaching Methodology.

- Finding-Provider records did not contain documentation of family planning consent for services.

Action taken by the Agency-Education was provided regarding obtaining written consent for family planning services.

AMA will continue to work to maintain a quality program and educate providers regarding the requirements of the Plan First Program.

Utilization of Services

The state did not note any trends to indicate overutilization or underutilization of the Demonstration Waiver services. A random sampling of records were reviewed to determine if services were provided according to guidelines as outlined in the Provider Manual. This review provided an opportunity to provide education regarding the program requirements. Because it was difficult to determine face to face encounters, telephone and activities without a complete care coordination record review, effective May 1, 2017, Medicaid implemented program changes to mandate that the provider apply modifiers to care coordination CPT Procedure Codes. This data will be queried quarterly and will be used to conduct focus reviews.

Appendix E: Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

Post Award Forum

Within six months of the demonstration’s implementation, the state provided the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state published the date, time and location of the forum in a prominent location on its website. During this public forum, nine (9) attendees obtained knowledge about the progress of the demonstration through presentation and dialogue and were provided the opportunity to ask questions about the Demonstration.

The public notice announcement was posted on Medicaid’s website on May 8, 2015. This notice can be viewed by accessing the following link: http://www.medicaid.alabama.gov/news_detail.aspx?ID=9624. The six month Post Award Public Forum presentation is noted as Attachment E. No comments were received as a result of this Forum.

Annual Public Forum

An annual Public Forum was held on July 21, 2016. At least 30 days prior to the date of the planned public forum, the state published the date, time and location of the forum in a prominent location on its website. During this public forum, eight (8) obtained knowledge about the progress of the demonstration through presentations and dialogue. The public notice announcement was posted on Medicaid’s website on June 15, 2016. This notice can be viewed by accessing the following link: http://www.medicaid.alabama.gov/news_detail.aspx?ID=10570. The state’s presentation is noted as Attachment A and the questions and response are noted in Attachment B.

Waiver Extension Public Notice Placeholder

A letter of notice was forwarded to the Tribal Government on April 20, 2017. See Attachment C.

Appendix F: Special Terms and Conditions and Expenditure Authority currently approved by the Centers for Medicaid and Medicaid Services that Alabama is seeking to renew for a period of five years, i.e., through December 31, 2022.

Attachment J and Attachment K, Special Terms and Conditions (STCs) and expenditure authorities, are applicable to the current waiver period of January 1, 2015 through December 31, 2017 (i.e., Demonstration Years 15, 16 and 17).

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Attachment G - Budget Neutrality Worksheet.

5 YEARS OF HISTORIC DATA						
SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:						
Medicaid Pop 1	2012	2013	2014	2015	2016	5-YEARS
TOTAL EXPENDITURES	40,057,737	41,344,489	38,224,716	33,748,696	26,500,617	\$ 179,876,255
ELIGIBLE MEMBER MONTHS	1,149,592	1,277,918	1,301,043	1,194,096	1,069,348	
PMPM COST	\$ 34.85	\$ 32.35	\$ 29.38	\$ 28.26	\$ 24.78	
TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE
TOTAL EXPENDITURE		3.21%	-7.55%	-11.71%	-21.48%	-9.81%
ELIGIBLE MEMBER MONTHS		11.16%	1.81%	-8.22%	-10.45%	-1.79%
PMPM COST		-7.15%	-9.19%	-3.80%	-12.32%	-8.17%
						89,112

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					2017	2018	2019	2020	2021	
Medicaid Pop 1										
Pop Type:	Medicaid									
Eligible Member Months	-1.8%		1,069,348	-1.8%	1,050,207	1,031,408	1,012,945.77	994,814	977,007	
PMPM Cost	-8.2%	0	\$ 24.78	-8.2%	\$ 22.76	\$ 27.02	\$ 24.81	\$ 22.78	\$ 20.92	
Total Expenditure					\$ 23,902,704	\$ 27,865,052	\$ 25,131,185	\$ 22,661,864	\$ 20,438,984	\$ 119,999,788

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS								
ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			2017	2018	2019	2020	2021	
Medicaid Pop 1								
Pop Type: Medicaid								
Eligible Member								
Months	1,069,348	-1.8%	1,050,207	1,031,408	1,012,946	994,814	977,007	
PMPM Cost	\$ 24.78	-8.2%	\$ 22.76	\$ 27.02	\$ 24.81	\$ 22.78	\$ 20.92	
Total Expenditure			\$ 23,902,704	\$ 27,865,052	\$ 25,131,185	\$ 22,661,864	\$ 20,438,984	\$ 119,999,788
NOTES								
For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.								

Budget Neutrality Summary						
Without-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	2017	2018	2019	2020	2021	
Medicaid Populations						
Medicaid Pop 1	\$ 23,902,704	\$ 27,865,052	\$ 25,131,185	\$ 22,661,864	\$ 20,438,984	\$ 119,999,788
With-Waiver Total Expenditures						
	DEMONSTRATION YEARS (DY)					TOTAL
	2016	2017	2018	2019	2020	
Medicaid Populations						
Medicaid Pop 1	\$ 23,902,704	\$ 27,865,052	\$ 25,131,185	\$ 22,661,864	\$ 20,438,984	\$ 119,999,788