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JIM REDDOCH, J.D.  
COMMISSIONER

MEMORANDUM

To: Center for Medicare and Medicaid (CMS)

From: Commissioner James F. Reddoch, J.D. *JFR/ABS*  
Alabama Department of Mental Health

Date: July 16, 2014

Re: Section 1115 Demonstration Proposal Comments

The Alabama Department of Mental Health (ADMH) is pleased to submit comments in response to the Alabama Medicaid Agency's (AMA) application to the Center for Medicare and Medicaid Services (CMS) for a Section 1115 Demonstration Waiver. ADMH is designated as the single state agency in Alabama authorized to receive and administer any and all funds available from any source to support the provision of mental health services and other activities within the scope of its statutory authority. This authority includes planning, supervising, coordinating, and establishing standards for all operations and activities of the state related to mental health and intellectual disability and the provision of services for these populations. ADMH leads the state's efforts to enhance the health and well-being of individuals, families, and communities impacted by mental illnesses, developmental disabilities and substance use disorders.

ADMH supports AMA's goals of improving patient experience, improving health and reducing costs in Alabama's Medical Assistance Program. Although AMA has expressed its belief that these goals can be achieved through approval and implementation of an 1115 waiver, it is critical for the agency to fully understand the potential impact of its proposed strategies on beneficiaries who have mental illnesses, serious emotional disturbances, substance use disorders, and intellectual disabilities, including those committed to ADMH for care.

During the past several months members of the executive staffs of the ADMH and the AMA have jointly assembled for discussion of AMA's plans to restructure its service delivery system, establish Regional Care Organizations (RCOs) to manage access to care for Medicaid beneficiaries and submit an application to the Centers for Medicare and Medicaid Services (CMS) for an 1115 Demonstration Waiver to acquire financial assistance to support these efforts. At each of these meetings ADMH's staff has attempted to relay the significance of appropriately addressing behavioral health disorders to the success of AMA's planned initiatives and to clearly convey the strengths and needs of Alabama's current behavioral health system of care.

When AMA's draft 1115 Waiver Application became available for public input at the State level, ADMH responded through submission of a sixteen (16) page document detailing its comments, questions, and concerns. AMA's 1115 Waiver Application, as submitted to CMS on June 13, 2014:

- Only partially responds to the majority of the issues presented by ADMH during the State's period of public comment and during the months of meetings that preceded the Application's submission. Most of the comments, questions and concerns posed by ADMH received responses that indicated they would be addressed through further discussions and/or through the contractual process with AMA and the Regional Care Organizations. Even though weekly meetings have occurred, to date the only area that has been addressed is care coordination; access, quality outcomes and the financial processes have barely been touched upon;
- Does not provide adequate assurance that care for Medicaid beneficiaries who have mental illnesses and substance use disorders will not be significantly disrupted. As proposed, service fragmentation is likely to increase to a greater extent than it presently exists as described in the Application;
- Does not provide assurance of the availability of an adequate network of service providers to establish the continuum of care needed for Medicaid recipients who have substance use disorders; and
- Defers too often to the future process of contract development between the AMA and the RCOs to explain the lack of essential details provided in the Application about matters that will significantly impact the State's system of care for behavioral health disorders. As a result of such deferrals, the ability of the ADMH, and the public, to provide meaningful comments on the full scope of the planned Waiver Demonstration is hindered.

Thus, through this opportunity for public input at the Federal level, ADMH is continuing its efforts to communicate to AMA, as well as to CMS, the need to ensure that Alabama's proposed 1115 Demonstration Waiver Application incorporates strategies that appropriately and effectively address the needs of Medicaid beneficiaries who have mental illnesses and substance use disorders, and provides for full disclosure of the behavioral health care financing, care management and service delivery processes planned for delivery through the RCOs which are currently managed by the ADMH.

With those objectives in mind ADMH, hereby, submits the following comments, concerns and recommendations to CMS, based upon its extensive review of *AMA's Section 1115 Demonstration Proposal, Alabama Medicaid Transformation* dated June 13, 2014 (hereinafter referred to as the Application):

- A diagram describing the flow of patient care is needed. It is critical for ADMH to understand the flow of patient care for individuals who have mental illnesses (SMI), serious emotional disturbances (SED) and substance use disorders (SUD) in light of the application's provisions for the Regional Care Organizations (RCOs) to begin delivery of services for mental illnesses (MI) in 2016 and for substance use (SA) disorders in FY 2019. Several

diagrams were added to the Application but none that depict the coordinated and integrated process between primary care and behavioral health care.

- The Application refers to “RCO’s and other providers”, however it is still unclear how the “other providers” will be defined and determined. It is recommended that ADMH certified and funded behavioral health providers be identified as definite participants in the RCO network. This includes both Community Mental Health Centers and free-standing substance abuse treatment programs that provide ADMH certified ASAM levels of care and are currently enrolled as Medicaid providers. Although the Application states on page 13 that these entities are “expected to be participants,” the RCO provider network rules established by AMA do not provide specific requirements for inclusion of behavioral health providers.
- It is recommended that ADMH certified and funded providers be identified as eligible participants for any federal funding made available by CMS for Designated Health Programs (DSHP), Transition Payments, and for Delivery System Reform Incentive Payments (DSRIP). ADMH has specifically requested the identification and inclusion of its behavioral health provider network in the Application as eligible for transition payments and DSRIP payments. As indicated in the Application to CMS, this request has not been included and AMA has not provided its rationale for this decision. At the request of ADMH, the AMA did agree to identify “...incentives for behavioral health providers who have not qualified for meaningful use incentives” as an “example of a potential DSRIP project.” At the same time, AMA has actively pursued the identification of ADMH funded DSHP behavioral health services and the amount of State dollars dedicated to support these programs. As indicated, this information is included in the Application. Yet, AMA’s planned use of Federal matching payments for these funds, if made available, excludes participation by ADMH or its providers.
- The Application states that Health Homes will expand statewide, but only probationary RCOs can become Health Homes. Apparently RCOs are not required to become Health Homes because the application also states an RCO can contract with a Health Home in its service area. Each of these entities has care management as a primary function. It remains unclear to ADMH what entity will have primary responsibility for managing the care of the patient and how this will impact the patients for whom we currently provide care management.
- The scope of Medicaid’s Mental Health Rehabilitation Option services is unclear in relationship to AMA’s objective of reducing service fragmentation and its goal of improving the patient experience. It is our understanding that until the RCOs assume full responsibility for delivery of behavioral health services, the Rehabilitation Option (RO) will remain available for the use by State agencies which are currently enrolled as RO providers. The services provided by these agencies will be phased into the RCO process at different points in time, according to the Application. This is particularly troublesome for ADMH with its MI services and SA services being phased in two years apart and for individuals who have a co-occurring mental illness and substance use disorder.

At the same time, RO services will need to continue to be available for provision by State agencies for Medicaid beneficiaries who will be excluded from the RCO process such as dual eligibles, children in foster care and children committed to the Alabama Department of Youth Services (DYS). How will these problems be addressed to minimize further service fragmentation and ensure continued coordination with the state agencies that have developed systems to serve shared populations (DHR and DYS)?

- Fragmentation is identified as a problem, but not clearly described in the application. We believe that strategies put forth in the application may actually increase service fragmentation for individuals who have behavioral health disorders. For the target populations served by ADMH our current system is more seamless relative to the provision of behavioral healthcare. ADMH continues to have concerns that with the issues of (1) excluded populations, (2) the phasing in of mental illness and substance abuse services at different times for a shared population and in our case within the same ADMH Division, and (3) the mandate for ADMH to continue to serve the indigent population, the proposed process for the RCOs' delivery of behavioral health services may actually fragment the provision of care to a point of it being detrimental and potentially causing harm.
- Access to care is likely a major factor in the rates provided in the application for poverty, obesity, diabetes, hospital admissions, inpatient days, and emergency department utilization. This application does not address access to care, a leading health indicator, as contributing to the health of Alabamians and the data reported. The State has decided not to expand Medicaid eligibility as part of this demonstration; and it has also decided not to modify its Medicaid eligibility criteria. If the Alabama Medicaid Agency is not making any changes in these areas, data should be provided in this application that represents the health outcomes and service utilization rates of current Medicaid beneficiaries as its baseline. This would then provide a more precise indication of the real impact of the planned demonstration project.
- Under Delivery System Infrastructure, service fragmentation is again cited, including fragmentation for individuals who have co-occurring medical and behavioral health disorders, but not explained. If fragmentation is identified as a problem justifying the need for the demonstration, it should be described in detail. The application should, then, propose a solution for this fragmentation, especially for individuals who have mental illnesses and substance use disorders which AMA identifies as some of the State's most vulnerable populations. It does not. In fact there is no mention of how care will be provided to address the continuum of needs of those served by ADMH to prevent service fragmentation.
- The application provides little information about the needs of the demonstration population and primarily emphasizes financial solutions, provider payments and incentives as the means for improving health outcomes. Please identify these needs and specify planned solutions other than those related to provider reimbursement.
- Clarification is needed on how to achieve controlled cost for the populations listed, such as aged, blind, and disabled. What does this cost control statement mean for medical and SMI inpatient costs because for some outpatient services, ADMH pays the state match. Over the

past several years, ADMH has had reduced funding and has already shifted funds from more to less expensive services. A restriction (“opportunity to control costs”) in the utilization of behavioral health services could have the reverse effect on state psychiatric hospital downsizing seen in the current and recent fiscal years.

- Under “Regional Care Organizations,” people with substance use disorders have been identified as being a vulnerable population with a fragmented service delivery system. Yet services for this population are excluded from the demonstration for the first two years. Individuals who have substance use disorders, however, will still be enrolled in RCOs. It is still unclear if the Medical or Health Home will be involved in the management of their SA treatment or how this will be coordinated with the current SA treatment process and resources that exist outside of Medicaid reimbursement.
- Under “Children’s Specialty Clinic Services”, this seems to be referencing Rehab Option services. Even though this question has been posed several times, it continues to be unclear how AMA will identify the Medicaid recipients involved in multiple systems, such as, ADMH, the Department of Human Resources (DHR) and the Department of Youth Services (DYS), who phase-in at different times. There will also be the exclusion of foster care or DYS. With ADMH providing some of the services and state match dollars for some of the excluded populations, it is even more vital to have clear understanding of how the financial process will work and not dismantle the system that currently services multiple state agencies. It seems most appropriate to phase-in all the state agencies who access the Rehab Option at the same time, excluding them the first two years. At this point, the proposed strategy seems overly complicated and is likely to create service fragmentation between the agencies who share treatment responsibilities.
- On Page 9, RCOs are vaguely described as business entities that are incorporated under Alabama law, with brief statements about their governing boards and collaborators. This concept represents a major shift in the way in which Medicaid does business. More detailed documentation seems needed about the RCOs in that they will serve as the core components of this system change initiative.
- Under “Serve most Medicaid Beneficiaries” (Page 10): The application lists the excluded care categories. However, post-commitment care provided by ADMH is NOT listed. ADMH requested to AMA that Court-Ordered Post-Commitment Care remain the direct responsibility of ADMH which would include post-commitment care in state hospitals and state contracted facilities, to include Designated Mental Health Facilities (DMHF). ADMH stands willing to further discuss and determine the language and care process needed for these populations. However, AMA’s response within the Application submitted to CMS did not exclude this population. ADMH remains concerned about how we will be able to meet our legally mandated requirements if the funds we now utilize are shifted away from our budget to the RCO funding process.
- Under “Health Home Program”: The current Health Home model indicates this work will be with ADMH involvement and with our Community Mental Health Centers (CMHCs) and

free standing substance abuse providers. However, with AMA's new requirements for the Board structure of the Health Home to be the Board structure of the RCO, two currently mandated Board positions, a community mental health center provider and a substance abuse provider, will be eliminated. ADMH is concerned that the bi-directional care management and treatment coordination as outlined in the 2703 Health Home will be altered in a manner that is detrimental to the patients that would be served in the bi-directional process outlined.

- Under "PCN (Health Home) Program": There is a reference to case management services. Will case management change as it is currently being provided by agencies which put up the state match (Medicaid Chapter 106 – Targeted Case Management) after 2018?
- Although AMA's partnership with ADMH is addressed, more documentation and understanding between the agencies is needed about the role of ADMH in certifying Substance Abuse and Mental Health providers (those not exempt from our certification requirements) who participate in the RCO provider networks. In addition, ADMH would like to see a requirement (rather than just an expectation) for RCOs to contract with our safety net providers and for our program certification standards to be accepted as appropriate credentials for their participation.
- Under "Partnership with ADMH," the application indicates that ADMH and AMA will work together to develop payment mechanisms and services that support and incentivize the transition of individuals from institutional-based care to community-based behavioral health care settings. Does this mean that funding from the 1115 Waiver will be used for this to be achieved? The Application does not indicate that any additional funds secured by AMA will be utilized to develop behavioral health infrastructure that is needed to achieve the goals outlined therein.
- Language was added to this Application that indicates "AMA will work with ADMH and other stakeholders to develop policies and protocols to ensure seamless coordination of case management services. This has not been addressed to date.
- Under "at-risk model incorporating value-based purchasing strategies": How is this going to work for those behavioral health providers that have previously been paid fee-for-service through the Rehab Option?
- Under "at-risk model incorporating value-based purchasing strategies": In regard to the comment "such as DRG type of"...," would Serious Mental Illness (SMI) be a diagnosis, thereby creating support payments to ADMH providers to keep consumers out of private, as well as, state hospitals?
- The application references the ability to shift funds across the transition payment and DSRIP pools and from the designated state health program (DSHP) funding to the transition payment, etc. More information is needed on how this would occur and the impact on the agencies putting up the state match for the DSHP dollars.

- The application added language that now states “The goals of the DSRIP pool are to incentivize activities that support RCOs’, hospitals’, and providers’ collaborative efforts to improve access to care and the health of the patients and families they serve, **including patients outside of the Medicaid delivery system.**” ADMH has repeatedly emphasized our concern for addressing the Indigent population as it is more than 60% of our current service population. ADMH is unclear what the additional comment is referencing and how it impacts the patients we currently serve and/or the funds that we have to serve this population.
- ADMH continues to have concerns with the dismantling of our state/federal funds without more direct analysis of how this could negatively impact our system as it pertains to commitments, non-Medicaid services (such as residential), and INDIGENT CARE. There are no dollars identified in the Application to ensure that our population of committed and indigent patients will have the proper infrastructure in place to insure continuity of care. Movement of dollars to the RCOs could unhinge the system in place for the provision of indigent care. These concerns will remain until an in-depth analysis of this issue is conducted and a viable solution developed.
- There seems to be overlap in the purposes for the transition payments and the DSRIP program. DSRIP payments made for the purpose of “Infrastructure development: to support transformation to a new delivery system through investments in people, places, processes and technology” seem to be the same planned use for transition payments. Please clarify.
- Under “Hypotheses and Evaluation Design”, what strategies will AMA utilize to integrate services between physical health services and behavioral health services, including substance abuse treatment services, that will improve quality in covered Medicaid services?
- The application indicates who is excluded. However, post-commitment care provided by ADMH is NOT listed. ADMH requested to AMA that Court-Ordered Post-Commitment Care remain the direct responsibility of ADMH which would include post-commitment care in state hospitals and state contracted facilities, to include Designated Mental Health Facilities (DMHF). DYS had the same request and was allowed to have this excluded. However, ADMH was not allowed this same consideration. ADMH stands firm in our request to have the Court-Ordered Post Commitment Care be the direct responsibility of ADMH.
- The “Implementation Schedule” presented is essentially non-responsive to the application’s directions which state, “Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.” As consistent throughout the application, the schedule provides little detail. It is as though CMS will send AMA millions of dollars in October 2014, the RCOs will automatically begin operation in 2016, and the health outcomes of Medicaid beneficiaries will instantly improve. There are so many major milestones that must occur that could have been listed, such as, the details of infrastructure changes to be implemented at Medicaid; collaboration with ADMH in regard to development of care protocols for our patients; the network establishment process; RCO contract development; development of

rules to address CMS managed care standards; RCO application development, solicitation, and review; beneficiary outreach, education, and enrollment, etc., etc. More details of the implementation process are needed.

- Under “Describe how potential Demonstration participants will be notified/enrolled into the Demonstration”, ADMH strongly recommends that the application specifically state that all communications and services will conform to the standards for Culturally and Linguistically Appropriate Services (CLAS).
- Under IGT Agencies, more specificity is needed. How will this work with ADMH funds in that part of its services will be RCO services, while others will remain fee-for-service? The Application also states “AMA will not pay fee-for-service rates, but instead will pay the RCOs based on an at-risk capitated payment system.” DMH is unclear how this will be accomplished when using IGTs from other state agencies and how the financial process will flow.

### **ADMH Developmental Disabilities Division 1115 Waiver Comments**

- The numbers being counted for waiver recipients (for dual eligibles) are less than the total number of waiver recipients for the two waivers we at ADMH administer (5260 ID Waiver slots and 569 Living at Home slots). Why is this so, if waiver recipients (another form of LTC) are excluded from the RCO? Shouldn't there be another category for non-dual eligible that is also listed?
- Similarly, how will the RCO medical care coordination and targeted case management for waiver services interact for the EI Program?
- Has there been any discussion/feedback/analysis of the impact on Medicaid providers, i.e., being reduced for those who may only desire to operate one payment system (the RCO) which provides the bulk of their payments? If not, will there be? Counterparts in other states have warned us that if people needing LTSS don't get their healthcare the way everyone else in Medicaid does, these excluded, vulnerable groups of people end up with much less access to healthcare. If so, what's the answer or plan?
- In the Aid Category Codes, Rainbow Omega is identified. It correctly states that it appears not to be a state ICFMR. First, is it clear that ADMH, not Medicaid, has been paying that match? Second, Rainbow Omega has just gotten a new ICFMR approved for CON, and we understand, certified by Public Health. DMH sees ICFMR care as not supported in the intent of the Olmstead case and the mandate being enforced vigorously under the Americans with Disabilities Act to serve people in the most integrated setting. That is why ADMH closed all of its state ICFs and why all of DMH's contract agencies have closed theirs except Rainbow Omega (and we paid their match too). All of those funds we used as match for the other ICFs have been shifted to waiver match as, generally; waiver services attain better outcomes at less cost. DMH is working with Rainbow Omega and all I/DD providers to move to more community integrated settings for all services, as there is no existing funding for expanded

ICF services and less and less federal funding will support congregate I/DD care in the future.

- Since apparently all TCM will be merged in two years with the RCOs, how is it envisioned that RCO care coordinators will participate in the much more de-centralized and intensive, hands on meeting and coordination requirements for LTSS-needing waiver recipients?

### **Summary Comments and Recommendations**

ADMH is statutorily authorized to act in any prudent way to provide mental health and intellectual disability services for the people of Alabama and therefore is concerned about the AMA's 1115 Demonstration Waiver Application as currently published. The Application speaks consistently of the need for service integration, but minimizes the participation of ADMH behavioral health providers in its system change initiative and the significant role played by behavioral health in the overall health of Medicaid beneficiaries. With that thought in mind, our agency's staff makes the following summary comments and recommendations:

1. Although the AMA and ADMH have met frequently during the last eighteen (18) months to discuss RCOs, the 1115 Waiver, and various related topics, the needs of Medicaid beneficiaries who have behavioral health disorders, and those of providers in the current provider system of care seem not to have been understood and/or viewed as significant enough for adequate representation in the Application. This Application, as the blueprint for transformation of Alabama's Medical Assistance Program, does not adequately provide assurance that care for Medicaid beneficiaries who have behavioral health disorders will not be significantly disrupted.
2. During ADMH's meeting with AMA on April 1, 2014, AMA stated it was "yet to be determined" if ADMH's safety net providers would be able to participate in Transition payments and Delivery System Reform Incentive Payments (DSRIP) as described in the Application. Funding is assured for hospitals and other providers, but not for behavioral health providers. It is recommended that the Application be amended to identify ADMH certified and funded providers as eligible participants for any federal funding made available by CMS for Designated Health Programs (DSHP), Transition Payments, and for Delivery System Reform Incentive Payments (DSRIP). Funding would support the following needs:
  - Establishment of entities in each RCO region to serve as the single point of contact for assessment of substance use disorders and referral to appropriate to programs;
  - Availability of a full continuum of treatment for substance abuse services in each planned RCO region. This will necessitate:
    - Development and implementation of a case management benefit for substance use disorders;
    - Increasing the availability of medication assisted treatment for substance use disorders;
    - Increasing the availability of community-based detoxification programs;
    - Increasing the availability of co-occurring enhanced treatment programs;

- Increasing the availability of substance abuse crisis response services.
  - Availability of a full continuum of care for mental illness services that enhances and expands the current efforts of maintaining recipients within the community which are in line with Olmstead. This will necessitate, but not limited to:
    - Development and expansion of outreach and mobile services;
    - Increasing the availability of psychiatric and nursing services;
    - Development and expansion of community-based recovery oriented resources such as evidenced based practices and meaningful day resources such as supported employment;
    - Development and expansion of more integrated housing opportunities with the needed mental health supports.
  - Development and implementation of Peer Support Services for mental illnesses and substance use disorders;
  - Increased capacity for telehealth services for treatment of mental illnesses and substance use disorders.
  - Increased access to the current Medicaid screening, brief intervention, and referral to treatment (SBIRT) benefit for all RCO enrollees by all Medicaid providers;
  - Implementation of workforce development and training activities to assist community providers in transitioning to an integrated service delivery system, providing enhanced levels of care, and providing evidence based services that conform to quality indicators.
  - Acquisition and implementation of Electronic Health Records systems and related infrastructure modifications necessary to link the systems to Alabama’s One Health Record as specified in the Application.
  - Administrative and staffing infrastructure modifications necessary to transition to a managed care payment delivery system.
3. We believe that plans for utilization of the dollars that will be made available through the Application do not adequately address the need for infrastructure building to better serve our target populations, although there is a great need for transformational care to address the costly needs of these Medicaid beneficiaries. The Application identifies individuals who have co-occurring medical and behavioral health disorders as “some of the state’s most vulnerable populations.” The Application needs to do more to demonstrate AMA’s commitment to fund system enhancements to address the needs of this population.
  4. ADMH staff is continuing to recommend that they have a more active and vital role in assisting AMA in the development of contract language for the RCOs.
  5. ADMH has developed an intricate system of care and funding, that has over the last 4-5 years shown it can produce the agency’s desired outcomes. These outcomes have increased community expenditures while decreasing overall state expenditures, resulting in overall cost savings. If the RCOs in turn reduce community expenditures, will new utilization or services be as effective and efficient? This is a major concern for ADMH, as; the system has been developed to serve both the Medicaid and the non-insured equally. The concern is the financial viability of services if the funding is splintered from

its current utilization or its current providers. ADMH has reduced and closed hospitals over the past few years and the ability to handle an influx of patients, either Medicaid or non-insured, would cost the state a significant amount of additional funds (more than budgeted before the closure of the hospitals) to appropriately manage. Medicaid reimbursement alone does not cover the cost of meeting the needs of their beneficiaries who need behavioral healthcare.

6. Despite the significance of Alabama's behavioral health service delivery system to the transformation of the Medicaid system in Alabama, there is no statement in either the initial legislation that creates the RCOs or in the Application that establishes the necessity of participation or that defines the role of the state mental health agency, community-based behavioral health providers, or behavioral health patients and family members in RCO creation and governance. It is recommended that for true systemic integration of behavioral health administrative processes and direct care services to occur, established mental health agencies, providers, and patients must be specifically represented in all aspects of the RCO development, governance and service delivery.
7. The waiver does not take into account the costs to state agencies that will be associated with and incurred by integration of services at the state agency level. It is recommended that agencies such as ADMH, that are expected to be key partners in the process of Medicaid transformation in the state, receive funding to participate in the process of integration of administration and services. Such funding would assist as we partner with Medicaid to "develop standards for RCOs that incorporate ...protocols for clinical care, quality assurance, and utilization review specific to mental illness and substance abuse.
8. It is recommended that the application be amended to place primary emphasis on the needs of beneficiaries served by the system. In addition, it is recommended that additional information be included to demonstrate how those served by the system will benefit from the planned changes in response to identified needs. Of major concern is the minimum attention given to the continuum of care needed for Medicaid beneficiaries who have behavioral health disorders.
9. ADMH recommended to AMA that ADMH's mental illness Rehab Option services be phased-in for delivery by the RCOs in the same timeframe as that identified in the waiver for ADMH substance abuse services, DHR, and DYS, i.e., in FY 2019. It seems imperative for ADMH to be phased uniformly within its own agency and with the other specialized behavioral health populations to allow AMA and the RCOs the time needed to develop the infrastructure to appropriately meet the needs of the Medicaid beneficiaries who have behavioral health disorders, and to avoid further service fragmentation for this population.

When AMA's leadership met with ADMH to assure this agency of the need to keep the MI Rehab Option services included as part of the RCO start-up in 2016, it was with the assurance that ADMH would be directly involved in the development of RCO contract language and financial/funding processes. This has not occurred and ADMH's

participation as assured is still needed. Without this assurance and completion of this process, ADMH would recommend that the MI Rehab Option services be phased-in in FY 2019 as outlined above.

10. ADMH is requesting that the means for determining which state agency will be responsible for the state match for each beneficiary receiving behavioral health services be specified in the Application to assure that inappropriate cost shifting does not occur. The Application is not responsive to ADMH's repeated requests to AMA for this information.
11. ADMH is requesting that post-commitment care NOT be a part of the RCO process for ADMH committed patients (civil and criminal/NGRI) and that ADMH, in regard to its role for these patients, be granted the same status as that granted for the Department of Youth Services (DYS) in this regard. ADMH has legal responsibilities and must continue to fulfill these responsibilities through its state hospitals and within the community based Designated Mental Health Facilities. The process of serving this population is not addressed in the Application and development of strategies to assure proper coverage of this population is critical. The Application is not responsive to ADMH's repeated requests to exclude the specified population from RCO enrollment.
12. ADMH is authorized to establish standards and promulgate standards for all operations and activities of the state related to the provision of prevention, treatment, and care of mental illness, substance used disorders, and intellectual disabilities. Under this statutory authority, the ADMH requires entities that hold themselves out as providers of the aforementioned services to comply with its established rules and to be certified as eligible to provide the state services. ADMH fully expects to continue to maintain its authority in this regard and to conduct administrative and programmatic on-site reviews for entities that provide such services within the State of Alabama.

We sincerely appreciate the opportunity to comment on the AMA's proposed 1115 Demonstration Waiver Application. We look forward to working with AMA and CMS to improve its content and planned utilization so that all participants in Alabama's Medicaid program will benefit from its implementation.