CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00252/6**

TITLE: **Greater New Orleans Community Health Connection (GNOCHC)**

AWARDEE: **Louisiana Department of Health and Hospitals**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Greater New Orleans Community Health Connection section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Louisiana Department of Health and Hospitals (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The amended STCs are effective November 1, 2011, through December 31, 2013, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- Program Description and Historical Context;
- General Program Requirements;
- The Greater New Orleans Community Health Connection Program;
- General Reporting Requirements;
- General Financial Requirement; and
- Monitoring Budget Neutrality.

Additionally, attachments have been included to provide supplementary information and guidance for specific STCs. In the event of a conflict between any provision of these STCs and any provision of an attachment to these STCs, the STCs shall control.

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

In the aftermath of Hurricanes Katrina and Rita, the State of Louisiana Department of Health and Hospitals (DHH) was awarded a $100 million Primary Care Access Stabilization Grant (PCASG) program for the period July 2007 through September 30. 2010. This 3-year program was designed to restore and expand access to primary care services, including mental health care services and dental care services, without regard to a patient's ability to pay, by providing short-term financial relief to outpatient provider organizations. The PCASG program was also intended to decrease costly reliance on emergency room usage for primary care services for patients who are uninsured, underinsured, or receiving Medicaid.

To be eligible to receive PCASG funding, provider organizations (Federally Qualified Health Centers, Mental Health Clinics, and Physician Groups) were required to meet several

requirements, including creating referral relationships with local specialists and hospitals, establishing a quality assurance or improvement program, and providing a long-term sustainability plan. The other eligibility requirements were to be operational and serving patients at one or more health care sites; be a public or private nonprofit organization; have a formal policy to serve all people regardless of the patient's ability to pay for services; establish a system to collect and organize patient and encounter data, and report the data to DHH through the Louisiana Public Health Institute (LPHI); and provide plans if the organization intends to relocate or renovate health care sites.

On August 6, 2010, the State of Louisiana submitted a proposal to CMS for a Medicaid section 1115 Demonstration for the continued funding of the PCASG provider organizations. -. The State proposed to reduce discretionary Disproportionate Share Hospital (DSH) funding and increase support for primary care medical homes (PCMH). The Demonstration's funding approach would permit the State to use up to $30 million (total computable) in Demonstration years (DY) 1, 2, & 3 and $7.5 million (total computable) in DY 4 for specified PCMH providers. To maintain budget neutrality, the State would ensure that these amounts, when added to payments to DSH payments would not exceed the DSH allotment calculated in accordance with section 1923 of the Social Security Act (the Act).

The Greater New Orleans area, comprised of Orleans, Jefferson, St. Bernard and Plaquemines parishes, is one of the largest population centers in the State. It is home to over 800,000 individuals, and represents roughly 20 percent of the State's population. According to the 2008 American Community Survey, nearly 40 percent of individuals living in the New Orleans area had incomes below 200 percent of the Federal poverty level (FPL) and nearly 20 percent were uninsured, making the area one of the most vulnerable in the Nation. Through the Demonstration the State proposes to:

- Preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with the PCASG funds awarded to the State by the U.S. Department of Health and Human Services (HHS);
- Advance and sustain the medical home model begun under PCASG;
- Evolve the grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, Children's Health Insurance Program (CHIP), and other payor sources as the revenue base; and
- Orchestrate change within the State in two broad phases with incremental milestones internal to each:
    - Phase 1 spans Demonstration months 1-15 (October 2010 – December 2011) and focuses on access preservation and evolution planning. By Demonstration month 10 (July 2011), the State will submit to CMS for review and approval a Demonstration Evolution plan to be implemented in Phase 2.
    - Phase 2 spans Demonstration months 16-39 (January 2012 – December 31, 2013) and focuses on Evolution plan implementation and assessment, successful transition to Medicaid and the State Health Benefits Exchange, and Demonstration phase-down.

On August 22, 2011, the State submitted an amendment to the Demonstration to remove the pharmacy benefit from the standard benefit package. During funding and reimbursement protocol discussions, the State identified other State programs such as the Louisiana Drug

Discount Card, retail pharmacy low-cost programs, AIDS Drugs Assistance Programs (ADAP), which would meet the needs of GNOCHC enrollees. The prescription drug programs are open to all residents of Louisiana and GNOCHC enrollees will be able to access benefits from the discount programs regardless of Medicaid eligibility under this Demonstration. This State indicates that this approach would maximize the annual demonstration allotment for health care services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statues.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy**. The State must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy statement, affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration, as necessary, to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC.

    b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall not be required to submit title XIX State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment,

benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in section III, paragraph 7 below.

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

    a. An explanation of the public process used by the State, consistent with the requirements of section III, paragraph 9 to reach a decision regarding the requested amendment;

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

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

    d. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

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

9. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 (ARRA), when any program changes to the Demonstration, including (but not limited to) those referenced in section III, paragraph 7, are proposed by

the State. In States with federally recognized Indian Tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, amendment and/or renewal of this Demonstration.

10. **FFP.** No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. THE GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION PROGRAM (GNOCHC)

11. **Eligibility –** Demonstration eligible for the GNOCHC program are individuals who are:
    a. Uninsured for at least 6 months;
    b. Non-pregnant
    c. Ages 19 through 64 years;
    d. Not eligible for Medicaid, CHIP, or Medicare;
    e. A resident of the Greater New Orleans region (which includes Orleans, St. Bernard, Plaquemines and Jefferson parishes);
    f. With family income up to 200 percent of the FPL; and
    g. Meet the U.S. citizenship requirements under the Deficit Reduction Act of 2005 (DRA) and CHIPRA.

12. **Screening for Eligibility for Medicaid and/or CHIP.** All Demonstration applicants must receive a pre-screening in order to determine possible eligibility for either Medicaid or CHIP programs before eligibility determination is performed for the Demonstration.

13. **Effective Date of Coverage - No Retroactive Eligibility.** Enrollees who qualify for coverage under this Demonstration will not receive retroactive coverage. The beginning effective date of coverage under the Demonstration will be the first day in which the application was received by the State.

14. **Reservation List** - The State may employ a "first come – first served" reservation list as a method of managing individuals applying for the GNOCHC program.
    a. Applications for GNOCHC will be provided to potential clients based on the projected budget limitations of the GNOCHC program.
    b. The State may impose an enrollment limit upon the GNOCHC program in order to remain under the budget neutrality limit for the GNOCHC program. The State will be required to provide written notice to CMS at least 60 days prior to changing the budget-driven ceiling.
    c. The State will be required to provide written notice to CMS at least 60 days prior to instituting any enrollment limit or re-establishing program enrollment. The notice to CMS, at a minimum, must include:
        i. Data on current enrollment levels in the program;
        ii. An analysis of the current budget neutrality agreement; and
        iii. The projected timeframe for the enrollment cap to be in effect or the period for enrollment into GNOCHC program.

d. The State will routinely perform targeted outreach to those individuals on the reservation list to afford those individuals the opportunity to sign up for other programs if they are still seeking coverage. Outreach materials will remind individuals they can apply for Medicaid and CHIP programs at any time.

15. **Eligibility Redeterminations.** Individuals enrolled in the GNOCHC program must have an eligibility redetermination at least once every 12 months. Each redetermination must include a reassessment of the individual's eligibility for Medicaid and CHIP. A GNOCHC enrollee may apply for Medicaid and CHIP at any time for any reason. The State will determine eligibility and enroll individuals in programs for which they are found eligible.

16. **Disenrollment.** Enrollees in GNOCHC shall be disenrolled if they:
    a. Exceed income limits allowed for the program at redetermination;
    b. Voluntarily withdraw from the program;
    c. No longer reside in a parish participating in the GNOCHC program;
    d. Become incarcerated or are institutionalized in an institution for mental disease;
    e. Obtain health insurance;
    f. Attain age 65; or
    g. Are deceased.

17. **Benefits for the GNOCHC.** –

a. **Standard Benefit:** Standard benefits consist of a core set of fixed services and other add-on services, which are dependent on available State or local government funds. A limited benefit package is provided to GNOCHC enrollees through the authority granted in this Demonstration The standard benefits are limited to the following services paid for and provided directly, or by, referral by a participating GNOCHC provider and include:

Service Type	Description of Coverage
Care Coordination	Covered
Immunizations and influenza vaccines	Covered
Laboratory and Radiology	Covered
Mental Health	Covered
Primary care	Covered
Preventive	Covered
Substance Abuse Services	Covered
Specialty Care	Covered with referral from Primary Care

b. Care coordination: care coordination includes services delivered by health provider teams to empower patients in their health and health care, and improve the efficiency and effectiveness the health sector. These services may include health education and coaching, navigation of the medical home services and the health care system at large, coordination of care with other providers including diagnostics and hospital services, support with the social determinants of health such as access to healthy food and exercise. Care coordination also requires health care team activities focused on the patient and communities' health including outreach, quality improvement and panel management.

c. During Phase 2 of the Demonstration, benefits will be defined in the Evolution plan which the State must submit to CMS by July 1, 2011, for review and approval.

18. **Cost Sharing Parameters for the GNOCHC** program – With the approval of this Demonstration:
    a. All Demonstration cost-sharing must be in compliance with all Federal statutes, regulation and policies.
    b. For all GNOCHC enrollees cost sharing must be limited to a 5% aggregate limit per family.

19. **GNOCHC Participating Providers** – Each participating GNOCHC provider shall:
    a. Be an existing Primary Care Access and Stabilization Grant (PCASG) funded provider;

    b. Be operational and serving Demonstration eligibles on October 1, 2010. Any PCASG provider seeking to reestablish operations as a GNOCHC participating provider after October 1, 2010, shall require CMS approval;

    c. Be a public or private not-for-profit entity (and may not be an individual practitioner in private solo or group practice);
        i. The provider shall be currently licensed, if licensure is required by the State of Louisiana.
        ii. Either the provider or its licensed practitioners are currently enrolled in Medicaid or CHIP as a participating practitioner or provider.
        iii. All health care practitioners that provide health care treatment, mental health counseling, or any other type of clinical health care services to patients must hold a current unrestricted license to practice in the State of Louisiana, and be providing such licensed services within the scope of that licensure;

    d. Have a statutory, regulatory, or formally established policy commitment (e.g., through corporate by laws) to serve all people, including those without insurance, at every level of income, regardless of the patients' ability to pay for services rendered, and be willing to accept and serve new publicly insured and uninsured individuals;

    e. Maintain one or more health care access points (service delivery sites) for the provision of health care services which may include medical care, mental health care and substance abuse services, either directly on-site or through established arrangements; and,

    f. Be capable of implementing and evaluating the effectiveness of an organization specific strategic plan to become a sustainable organizational entity by December 31, 2013, capable of permanently providing primary care or behavioral health care services to residents in the Greater New Orleans region.

g. The State will provide 45day notice to CMS of any transfer in GNOCHC clinic/ownership or provider opting out of GNOCHC Demonstration. CMS reserves the right to withhold FFP for providers who do not meet the Participating GNOCHC provider requirements defined in the STC 19.

20. **GNOCHC Providers Sustainability Plans.** GNOCHC participating providers as described in paragraph 19 must develop, implement, and evaluate the effectiveness of an organization specific strategic plan to become a self-sustaining organizational entity by December 31, 2013, capable of permanently providing primary care or behavioral health care services to residents in the Greater New Orleans region.
    a. "Sustainable" means actively developing, implementing, and evaluating the effectiveness of the organization to diversify its operating income and funding resources independent of the Demonstration funding sources.
    b. The provider must provide this sustainability plan to the State by March 1, 2011.
    c. The provider must submit semi-annual progress reports on the sustainability plan to the State during the 2nd and 4th quarter of each DY. The first semi-annual report is due in the 4th quarter of DY 1.
    d. **Penalty** - GNOCHC providers that fail to comply with this provision shall be ineligible for FFP.

21. **GNOCHC Funding and Reimbursement Protocol.** The State must maintain a CMS approved funding and reimbursement protocol (Attachment C) which explains the process the State will use to determine reimbursement methodologies for expenditures under the demonstration. The funding and reimbursement protocol must be submitted to CMS for review and approval by January 1, 2011. No FFP will be available for the Demonstration without a CMS approved funding and reimbursement protocol except as described in paragraph 23. Requirements of the funding and reimbursement protocol must include:
    a. Comprehensive description of the reimbursement methodologies developed by the State to reimburse providers for the services described in STC 17.
    b. The methodologies must identify the range of services covered by the rate to the extent that the rate developed covers multiple services as defined in STC 17.
    c. Comprehensive description of any infrastructure payments describing the types of infrastructure investments which are eligible for reimbursement under the demonstration and how the State will determine the level of payment. These descriptions should clearly identify the level and source of any other funds available to support or partially support the investment (i.e., such a Foundation funding or Federal funds such as HIT funding) that may partially support the infrastructure investment.
    d. Description of cost reporting mechanism for providers and description of annual reporting under the demonstration (costs and payments under the demonstration).
    e. Any changes to eligible services and reimbursements must be amended through the protocol and are not eligible for FFP until the amended protocol reflecting those changes is approved.
    f. Description of the sources of funding for any expenditures under the demonstration including the use of Certified Public Expenditures (CPE), Intergovernmental

Transfers (IGT) or similar processes will address the provision of demonstration eligible medical services under the GNOCHC program.

22. **FFP for the GNOCHC Program.** FFP is limited to the Federal share of $30 million (total computable) in Demonstration expenditures in each of DYs 1, 2 and 3. In DY 4, FFP is limited to the Federal share of $7.5 million (total computable). The maximum Federal funding for the demonstration is thus the Federal share of total computable expenditures of $97.5 million. The Federal share of expenditures for payments to GNOCHC providers for services will be calculated based upon the applicable Federal medical assistance percentage for the year in which the expenditures were incurred. The Federal share of expenditures for eligible administrative costs for the Demonstration, as described in paragraph 24 will be at the rate of 50 percent of expenditures. The GNOCHC program may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals, and clinics in the development of a health care delivery system to address the needs of Demonstration eligibles.

    No portion of the total award may be used for any expenditure other than the GNOCHC program. The allowable demonstration expenditures of $30 million (total computable) in DYs 1, 2 and 3 and the $7.5 million (total computable) in DY 4 are annual limits. Federal funding will not be available for expenditures in excess of these annual limits, even when the State did not reach the expenditure limit in prior years. To the extent that the State maintains a consistent accounting system, however, this paragraph does not preclude the State from including as allowable expenditures for a particular Demonstration year expenditures incurred after the end of that Demonstration year for items or services furnished (or activities performed) during that year.

23. **Urgent GNOCHC Sustainability Payments.** Notwithstanding paragraph 21, the State may make urgent sustainability payments during the 1st quarter (October – December 2010) of DY 1 to any eligible GNOCHC provider as described in paragraph 19 requiring financial support to maintain clinical operations while the State seeks to obtain CMS approval for the Funding and Reimbursement Protocol as described in paragraph 21.

    a. For each provider requiring an urgent sustainability payment, the State shall determine an average based upon that provider's three-year historical grant award received under the PCASG.

    b. The sub total of a provider's urgent sustainability payment may equal up to 25 percent of the average amount determined for that provider in paragraph 23(a).

    c. Sustainability payment calculation example:

Provider	Grant Year 1 Award	Grant Year 2 Award	Grant Year 3 Award	Average PCASG Award Over the 3 years of the Grant
ABC	$100,000	$125,000	$135, 000	$120,000

d. The urgent sustainability payment made to "ABC Provider" in the first quarter cannot exceed 25 percent of $120,000 or $30,000.

e. There will be no FFP for sustainability payments above this limit without CMS prior approval.

f. Once the Reimbursement and Funding Protocol is approved, the State must reconcile the amount of the sustainability payment paid to providers in the period of October 1, 2010 through December 31, 2010, or until the Reimbursement and Funding protocol is approved against the actual payments that would have been made to the providers based on the approved reimbursement methodology developed in STC 21. Any overpayments (i.e., the amount of the sustainability payment exceeds the amount of payment that would have been paid to a provider using the approved rate), may be offset against a providers payments in the quarter following the reconciliation. Any underpayments, (i.e., the amount of payment that would have been paid to a provider using the approved rate exceeds the amount of the sustainability payment), may be made in the quarter following the reconciliation.

g. The State must submit a document detailing the reconciliations and any over or under payments identified. This documentation must be submitted by the end of the first full quarter following the approval of the Funding and Reimbursement Protocol.

h. These sustainability payments will be applied to the $30 million (total computable) annual allotment for DY 1.

i. The total sustainability payments made in the 1st quarter of DY 1 cannot exceed $7. 5 million (total computable) for the quarter.

24. **Administrative Cost Claiming Protocol.** The State must maintain a CMS approved Administrative Cost Claiming Protocol (Attachment D) which explains the process the State will use to determine administrative costs incurred by the State for administering the GNOCHC Demonstration.
    a. The Administrative Cost Claiming Protocol must be submitted to CMS for review and approval by March 1, 2011.
    b. No FFP will be available for administrative claiming without a CMS approved Administrative Cost Claiming Protocol.
    c. CMS will provide FFP to the State at the regular 50 percent match rate for administrative costs as described in the approved Administrative Cost Claiming Protocol.
    d. The protocol must describe the administrative costs for which the State will seek FFP. The administrative costs eligible for match under this section must be for the efficient administration of the State plan and in accordance with OMB Circular A-87.

25. **GNOCHC Program Encounter Data.** Any provider/clinic participating in the Demonstration shall be responsible for the collection of all data on services furnished to Demonstration enrollees through encounter data or other methods as specified by the State, and the maintenance of these data at the clinic or provider level. By July 1, 2011, the State shall:
    a. Develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all outpatient and provider services);
    b. Establish a process to validate that encounter data is timely, complete, and accurate;
    c. Take appropriate actions to identify and correct deficiencies identified in the collection of encounter data; and
    d. Have contractual provisions in place to impose financial penalties if accurate data are not submitted by GNOCHC providers to the State in a timely fashion.

26. **Submission of Encounter Data.** The State shall submit encounter data submitted by GNOCHC providers to the Medicaid Statistical Information System (MSIS) as is consistent with Federal law, policy and regulation. The State must assure that encounter data maintained at GNOCHC providers/clinics can be linked with eligibility files maintained by the State.

27. **Agreements.** All boilerplates of new agreements with GNOCHC providers and modifications of existing agreements between the State and GNOCHC providers must have prior approval by the CMS Regional Office. The State will provide CMS with a minimum of 30 days to review and approve any Demonstration related boilerplates of provider agreements. CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the Demonstration until the agreement compliance requirement is met.

28. **Provider Reviews**. The State will forward summaries to CMS of the financial and operational reviews that the State/local government completes on any GNOCHC provider or entity receiving FFP through the Demonstration.

29. **Provider Compliance**. The State will require that no less than the same level of compliance from local governments, health plans, and Demonstration program providers receiving FFP, for any provision within these terms and conditions.

30. **GNOCHC Provider Disclosure of Ownership**. Before entering into an agreement with any provider of service, the State/local government will obtain from the provider full disclosure of ownership and control and related party transactions, as specified in sections 1124 and 1902(a)(38) of the Act. No FFP will be available for providers that fail to provide this information.

V. GENERAL REPORTING REQUIREMENTS

31. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX.

32. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all

reporting requirements for monitoring budget neutrality set forth in this agreement. The State must submit any corrected budget neutrality data upon request.

33. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR Part 438 *et seq.*, except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

34. **Accounting and Audit Protocol.** The State must submit and obtain CMS approval for accounting procedures for the Demonstration to ensure oversight and monitoring of Demonstration claiming and expenditures. These procedures shall be included as Attachment E.
    a. The Accounting and Audit Protocol must be submitted to CMS for review and approval by March 1, 2011.
    b. No FFP will be available for administrative claiming without a CMS approved Administrative Cost Claiming Protocol.

35. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to:
    a. Health care delivery system;
    b. Quality of care, access;
    c. The benefit package, cost-sharing;
    d. Audits, lawsuits;
    e. Financial reporting and budget neutrality issues;
    f. Progress on evaluations;
    g. State legislative developments; and
    h. Any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting.

    CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Central and the Regional Office) shall jointly develop the agenda for the calls.

36. **Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter (Attachment A). The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include, but are not limited to:
    a. An updated budget neutrality monitoring spreadsheet;
    b. A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;
    c. Action plans for addressing any policy, administrative, or budget issues identified;
    d. Quarterly enrollment reports for Demonstration eligibles for each Demonstration

population;
e. Evaluation activities and interim findings;
f. Plans to secure the sustainability plans and the financial sustainability of the GNOCHC Demonstration programs;
g. Updates on the State's success in meeting the milestones outlined in these STCs; and
h. Other items as requested.

37. **Affordable Care Act Transition Plan.** The State is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the ACA for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA. The State must submit a draft plan to CMS by July 1, 2012, and include updates on the implementation or revision of the plan in each quarterly report required by STC 36.

38. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 60 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted for the Demonstration year to CMS. The annual report shall also contain:
    a. Updates on the financial sustainability of the GNOCHC providers including an assessment as to whether the entities have met the milestones established in the strategic evolution plans;
    b. Data and findings of health status of the population served under the Demonstration;
    c. The number of persons served and the allocation of funds per GNOCHC provider under the Demonstration;
    d. Data and findings of cost of providing care to persons served under the Demonstration;
    e. Updates on the State's success in meeting the milestones listed in section VIII; and
    f. The progress and outcome of any GNOCHC program receiving FFP.

39. **Final Report.** Within 120 days following the end of the Demonstration, the State will submit a draft final report to CMS for comments. The State will take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 90 days after receipt of CMS' comments.

VI. GENERAL FINANCIAL REQUIREMENTS

40. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section VII (Monitoring Budget Neutrality).

41. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure limit.** All expenditures to support the State's administrative costs of the GNOCHC program and health care services approved for FFP under the Demonstration (as defined in section V above) are subject to the budget neutrality expenditure limit.

42. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality limit:

    a. **Tracking Expenditures.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (**11-W-00252/6**) assigned by CMS, including the project number extension, which indicates the DY in which services were rendered.

    b. To simplify monitoring of both Demonstration expenditures and remaining DSH payments, DYs will be aligned with Federal fiscal years (FFYs).

        i. DY-1 (FFY 2011) is defined as the period from the date of the approval letter through September 30, 2011.
        ii. DY-2 (FFY 2012) is defined as the period from October 1, 2011, through September 30, 2012.
        iii. DY-3 (FFY 2013) is defined as the period from October 1, 2012, through September 30, 2013.
        iv. DY-4 (FFY 2014) is defined as the period from October 1, 2013, through December 31, 2013.

    c. **DSH Expenditures.** To facilitate monitoring of budget neutrality and compliance with the DSH allotment, the rules below will govern reporting of DSH expenditures for the Demonstration. All DSH expenditures are subject to the DSH allotments defined in section 1923(f) of the Act.
        i. All DSH expenditures for FFYs 2011 through the first quarter of FFY 2014 are Demonstration expenditures subject to the budget neutrality, and must be

reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver for the DY corresponding to the FFY.

ii. All DSH expenditures reported on Forms CMS-64.9 Waiver or CMS-64.9P Waiver must be reported using the waiver name "State Plan DSH."

iii. All DSH expenditures not associated with the Demonstration DSH diversion are subject to the auditing and reporting requirements under section 1923(j) of the Act.

d. **Reporting of Premiums.** If applicable, the State must report premiums on Forms CMS-64.9 Waiver and CMS-64.9P Waiver, using Line 18A.

e. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

f. **Use of Waiver Forms.** From the beginning of the Demonstration through December 31, 2013, the following three (3) waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter to report title XIX expenditures associated with the Demonstrations. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

i. "GNOCHC I" expenditures for individuals with family income 0 percent through 133 percent FPL.

ii. "GNOCHC II" expenditures for individuals with family income 134 percent through 200 percent FPL.

iii. "State Plan DSH" expenditures.

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" refers to all title XIX expenditures made to support the GNOCHC program or on behalf of individuals who are enrolled in this Demonstration, including all service expenditures net of premium collections and other offsetting collections. DSH expenditures ("State Plan DSH") are also subject to the budget neutrality limit. Total Demonstration expenditures (including DSH expenditures) must not exceed the State's annual DSH allotment. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered Demonstration expenditures and must be reported on Forms CMS-64.9Waiver and/or CMS-64.9P Waiver.

h. **Title XIX Administrative Costs.** The following provisions govern reporting of administrative costs during the Demonstration.

i. The administrative costs associated with support of the GNOCHC program are subject to the budget neutrality limit and must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the DY for which the administrative services were paid. A separate

form must be submitted, using the waiver name "GNOCHC" to report expenses related to administrative support of the GNOCHC program.

i. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.

43. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

44. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the budget neutrality limits described in section XIX:

a) Administrative costs, including those associated with the administration of the Demonstration;

b) Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

45. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the timeframes set by CMS.

b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

46. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

47. **Program Integrity.** The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration.

VII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

48. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in section VI, paragraph 42.

49. **Risk.** The State shall be at risk for both the number of enrollees in the Demonstration, as well as the aggregate cost for Demonstration eligibles under this budget neutrality agreement.

50. **Budget Neutrality Expenditure Limit.** The following table gives the budget neutrality limit for each DY. The limits are expressed in terms of FFP (i.e., Federal share).

DY	Budget Neutrality Limit
DYs 1,2 and 3	Corresponding FFY DSH allotment
DY 4	¼ of the FFY 2014 FFY DSH allotment

51. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the Demonstration.

52. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality on an annual basis. If the State exceeds the annual budget neutrality expenditure limit in any given DY,

the State must submit a corrective action plan to CMS for approval and will repay (without deferral or disallowance) the Federal share of the amount by which the budget neutrality agreement has been exceeded.

VIII. MILESTONES

53. The State must meet the following milestones. All plans regarding the milestones are contingent on review and approval by CMS. Failure to meet any of the milestones listed below will result in the loss of a percentage of the $30 million (total computable) annual expenditure authority cap as described within this section.
    a. By December 1, 2010 (the 1st quarter of Demonstration Year 1), the State must develop and implement an outreach strategy to:
        i. Screen and enroll in Medicaid or CHIP eligible, but uninsured, children served by GNOCHC providers;
    b. By March 1, 2011 (in the 2nd quarter of Demonstration Year 1), the State must develop and implement an eligibility system to:
        i. Pre-screen GNOCHC applicants to determine possible eligibility for Medicaid or CHIP before determining eligibility for the Demonstration; and
        ii. Determine eligibility for the Demonstration and enroll eligible individuals into the GNOCHC program.
    c. By July 1, 2011 (in the 4th quarter of Demonstration Year 1), the State must submit to CMS for review and approval, a plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, to evolve primary and behavioral health care access restored by PCASG and preserved by the Demonstration and facilitate financial sustainability through diverse means of financing, including but not limited to Medicaid, CHIP, and other payor sources as the revenue base. The plan must outline how the State will begin evolution activities by January 1, 2012 (the 2nd Quarter of Demonstration Year 2), including:
        i. Comprehensive description of the reimbursement methodologies developed by the State to reimburse providers for services and, if applicable, infrastructure investments;
        ii. Comprehensive description of standard benefits to seamlessly evolve Demonstration enrollees to benefits available to those newly eligible for Medicaid or the State's Health Benefit Exchange in 2014, (e.g., leveraging planned State plan amendments to modernize behavioral health services); and
        iii. Criteria for provider participation and enrollment.
    d. By January 1, 2012 (the 2nd quarter of Demonstration Year 2), the State must begin implementation of the Evolution plan as approved by CMS.
        i. The schedule of implementation activities shall be established and reflect the timeline of the CMS approval process assuring sufficient time for the State to operationalize the plan (e.g., information technology system requirements).
        ii. The activities shall include ongoing reviews of Demonstration providers' sustainability preparedness (e.g., billing capacity, means of financing) and provider-specific recommendations on activities for improvement (e.g., pursuit of Federally Qualified Health Center (FQHC) or FQHC look-alike status, as appropriate).

e. By January 1, 2013 (the 2nd quarter of Demonstration Year 3), the State must begin implementation of Affordable Care Act Transition plan as described in STC 37 including but not limited to:
   i. A simplified, streamlined process for evolving eligible enrollees from the Demonstration to Medicaid or the Exchange in 2014.

f. **Penalty.** Failure to implement or operationalize the milestones listed in section VIII will result in the loss of a percentage of the annual $30 million (total computable) allowable under the expenditure authorities for the first 3 years of the demonstration. If the State fails to meet a milestone, the annual expenditure authority cap shall be reduced by the amount(s) listed in the table below.

Deadline	Milestone Reference	Annual Expenditure Authority Cap (Total Computable)	Penalty Amount As a Percentage of the Annual Expenditure (Total Computable)
DY 1 Q1	VIII. 53. a.	$30,000,000	0.10%
DY 1 Q2	VIII. 53. b.	$30,000,000	0.25%
DY 1 Q4	VIII. 53. c.	$30,000,000	0.5%
DY 2 Q2	VIII. 53. d.	$30,000,000	0.5%
DY 3 Q4	VIII. 53 e.	$30,000,000	0.25%

g. **Application of the Penalty.** CMS shall disallow claims for FFP that exceed the reduced annual expenditure authority cap, to the extent described above, if the State has not met the required milestones. Any available statutory or regulatory appeal procedures shall apply.

IX. EVALUATION

54. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval, within 120 days from the award of the Demonstration, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the Demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

a. The State shall ensure that the draft evaluation design will address the following evaluation questions and topics: How successful has the Demonstration been in:
   i. Preserving access to primary and behavioral health care;
   ii. Sustaining and advancing a community-based, medical home model of health care delivery; and

iii. Evolving primary and behavioral health care access restored by PCASG and preserved by the Demonstration to facilitate financial sustainability through diverse means of financing, including but not limited to Medicaid, CHIP, and other payor sources as the revenue base.

b. To what extent has the Demonstration reduced the rate of Medicaid or CHIP eligible, but uninsured, children served by Demonstration providers?

c. What lessons has the State learned from the Demonstration regarding the behavioral health care needs of the low-income adult population to be eligible for enrollment in Medicaid or the State's Health Benefit Exchange in 2014?

d. To what extent has the State met the milestones listed in section VII?

55. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS will provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

56. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date – Specific	Deliverable	STC Reference
12/01/2010	Begin implementation of outreach strategy for uninsured children	STC 53 a.
01/01/2011	Submit Funding and Reimbursement Protocol	STC 21
03/01/2011	Submit Draft Evaluation Design	STC 54
03/01/2011	Submit Administrative Cost Claiming Protocol	STC 24
03/01/2011	Submit Accounting and Audit Protocol	STC 34
03/01/2011	Begin implementation of eligibility system	STC 53 b.
07/01/2011	Submit plan for evolution to financial sustainability (Evolution plan)	STC 53 c.
07/01/2011	Begin implementation of program encounter data requirements	STC 26
01/01/2012	Begin implementation of Evolution plan	STC 53 d.
01/01/2013	Begin implementation of ACA Transition plan	STC 53 e.
04/01/2014	Submit draft final report	STC 39

07/01/2014	Submit draft evaluation report	STC 55

	Deliverable	STC Reference
Monthly	Conference Call with CMS	STC 35
Quarterly	Quarterly Progress Reports are due no later than 60 days following the end of each quarter	STC 36
Annual	Draft Annual Reports are due no later than 60 days after the end of each operational year	STC 38
Quarterly	Estimate matchable Medicaid expenditures on Form CMS-37	Section VI
Quarterly	Quarterly Expenditure Reports using Form CMS-64 are due 30 days following the end of each quarter	Section VI
Quarterly	Track expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System	Section VI
Quarterly	Quarterly Administrative Cost Reports using Form GNOCHC Admin	Section VI

Attachment A – Quarterly Report Requirements

In accordance with these special terms and conditions (STCs), the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – State of Louisiana (Greater New Orleans Community Health Connection Demonstration **11-W-00252/6**)

Title Line Two - Section 1115 Quarterly Report
Demonstration Reporting Period:
Example:
Demonstration Year: 1 (October 1, 2010 – September 30, 2011)

Introduction:
Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:
Please complete the following table that outlines current enrollment in each GNOCHC program under the Demonstration. The State should indicate "N/A" where appropriate.

Note: Enrollment counts should be person counts, not participant months.

GNOCHC Programs	Current Enrollees (to date)

Outreach/Innovative Activities:
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The State may also add additional program headings as applicable.

Date Submitted to CMS:

Attachment B – Evaluation Guidelines

Section 1115 Demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. CMS requires States with Demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their Demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to Demonstrations; States, Federal Government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations—these would include, but are not limited to: 1) studies that document the design, development, implementation, and operational features of the Demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or Demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the Demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes, and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality Demonstration programs. Should States have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how the plan was, or will be, developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and, whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through Quality Assurance/Quality Improvement activities into improving health service delivery; and

- Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
  - Hypothesis or research questions to be investigated;
  - Goals, such as:
    - Increase Access
    - Cost Effectiveness
    - Improve Care Coordination
    - Increase Family Satisfaction and Stability
  - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
  - The type of research design(s) to be included -
    - Pre/Post Methodology
    - Quasi-Experimental
    - Experimental
  - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
  - Enrollment and outreach records;
  - Medicaid claims data;
  - Vital statistics data;
  - Provide record reviews;
  - School record reviews; and
  - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
  - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
  - How findings will be incorporated into outreach, enrollment and education activities;
  - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
  - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the Demonstration intervention.

STATE OF LOUISIANA
GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION PROGRAM
SECTION 1115 DEMONSTRATION WAIVER
PROJECT NUMBER 11-W-00252/6

EVALUATION DESIGN

MARCH 2011
REVISED NOVEMBER 3, 2011

Attachment B: Evaluation Design

In accordance with the Special Terms and Conditions (STC) for the Greater New Orleans Community Health Connection (GNOCHC) Demonstration Waiver, project number 11-W-00252/6, Section 1115(a), the State of Louisiana, Department of Health and Hospitals (DHH), Medicaid program (the State), submits to the Centers for Medicare and Medicaid Services (CMS) this draft evaluation design document. This document fulfills STC requirement number 54 due to CMS by April 1, 2011 (revised) under the schedule established by CMS for deliverables during the Demonstration.

I. Background

Through the Greater New Orleans Community Health Connection Demonstration, the State will:

- Preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with PCASG funds;
- Advance and sustain the medical home model begun under PCASG;
- Evolve the grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, CHIP, and other payer sources as the revenue base; and,
- Orchestrate change within the State in two broad phases with incremental milestones internal to each.

Phase 1 spans Demonstration months 1-15 (October 2010 – December 2011) and focuses on access preservation and evolution planning. On June 29, 2011, the State submitted to CMS for review and approval a Demonstration Evolution plan to be implemented in Phase 2.

Phase 2 spans Demonstration months 16-39 (January 2012 – December 31, 2013) and focuses on Evolution plan implementation and assessment, successful transition to Medicaid and the Federal Health Benefits Exchange, and Demonstration phase-down.

II. Evaluation Design Requirements

As required by STC 54, this document describes the goals, objectives, and specific hypotheses being tested, including those that focus specifically on the target populations for the Demonstration. It includes the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It discusses the data sources and sampling methodology for assessing these outcomes, and includes a detailed analysis plan that describes how the effects of the Demonstration will be isolated from other initiatives occurring in the State.

The design addresses the questions posed in STC 54, including:

1. How successful has the Demonstration been in preserving access to primary and behavioral health care?
2. How successful has it been in sustaining and advancing a community-based, medical home model of health care delivery?
3. How successful has it been in evolving primary and behavioral health care access restored by PCASG and preserved by the Demonstration to facilitate financial sustainability through diverse means of financing?
4. To what extent has it reduced the rate of Medicaid or CHIP eligible but uninsured children served by Demonstration providers?
5. What lessons has the State learned from the Demonstration regarding the behavioral health care needs of the low-income adult population to be eligible for enrollment in Medicaid or the Federal Health Benefit Exchange in 2014?

It also addresses to what extent the State met the milestones in STC 53, including:

6. Develop and implement an outreach strategy to screen and enroll in Medicaid or CHIP eligible but uninsured children served by GNOCHC providers by December 1, 2010.
7. Develop and implement an eligibility system to pre-screen GNOCHC applicants to determine possible eligibility for Medicaid or CHIP before determining eligibility for the Demonstration; determine eligibility for the Demonstration; and, enroll eligible individuals into the GNOCHC program by March 1, 2011.
8. Submit to CMS a plan to evolve primary and behavioral health care access restored by PCASG and preserved by the Demonstration and facilitate financial sustainability through diverse means of financing by July 1, 2011.
9. Begin implementation of the Evolution plan as approved by CMS by January 1, 2012.
10. Begin implementation of Affordable Care Act Transition plan January 1, 2013.

III. Goals and Objectives for the Demonstration

Through the Greater New Orleans Community Health Connection Demonstration, the State will:

- Preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with PCASG funds;
- Advance and sustain the medical home model begun under PCASG; and,
- Evolve the grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, CHIP, and other payer sources as the revenue base.

IV. Demonstration Evaluation Design

The GNOCHC Demonstration began October 1, 2010, and many major components of the Demonstration have been launched since the program's effective date. However, there are still some elements in an active state of development and not yet operational. Therefore, the evaluation design will be iterative. As the remaining operational components of the Demonstration are finalized and implemented, the relevant evaluation design will be updated and submitted to CMS.

The draft design is organized in tabular and narrative manner. The narrative outlines evaluation questions and measures by goals and objectives. The table adds details on key intervention, hypotheses and data sources.

DHH will conduct the evaluation in partnership with the Louisiana Public Health Institute.

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
			PROVIDERS	
1. Preserve Primary and Behavioral Health Care Access	Access to care for Demonstration eligible populations will be preserved.	Expansion of health care coverage to eligible low income adults		
	Most organizations eligible to provide covered services to eligible individuals will enroll in the Demonstration.	Expansion of health care coverage to eligible low income adults	1.1 Number and Percentage of Eligible Provider Organizations Enrolled (Denominator: Eligible Provider Organizations)	• Baseline: PCASG organizations serving the non-elderly adult population • Demonstration: DHH/MVA MMIS Provider Enrollment • Comparison: N/A
	Most sites eligible to provide covered services to eligible individuals will enroll in the Demonstration.	Expansion of health care coverage to eligible low income adults	1.2 Number and Percentage of Eligible Provider Sites Enrolled (Denominator: Eligible Provider Sites)	• Baseline: PCASG sites serving the non-elderly adult population, exclusive of dental and ophthalmology only sites • Demonstration: DHH/MVA MMIS Provider Enrollment • Comparison: N/A
	The rate of primary care	Expansion of health care coverage to eligible low	1.3 Rate of Primary Care Access (Numerator:	• Baseline: PCASG data for uninsured,

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
	access will be preserved.	income adults	Number of Primary Care Encounters; Denominator: Total Enrollment)	non-elderly adults • Demonstration: DHH/MVA MMIS or Excel format encounter claims and MEDS • Comparison: LSU HCSD non-GNOCHC, non-elderly adult, Free Care patients
	The rate of behavioral health care access will be preserved.	Expansion of health care coverage to eligible low income adults	1.4 Rate of Behavioral Health Care Access (Numerator: Number of Behavioral Health Care Encounters; Denominator: Total Enrollment)	• Baseline: PCASG data for uninsured, non-elderly adults • Demonstration: DHH/MVA MMIS or Excel format encounter claims and MEDS • Comparison: N/A
2. Sustain and Advance Medical Home Model				
2.1 Attain NCQA PCMH Recognition	The percentage of enrolled provider sites applying for NCQA PCMH recognition will increase.	Expansion of health care coverage to eligible low income adults	2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition (Denominator: Total Provider Organization	• Baseline: PCASG organizations • Demonstration: NCQA • Comparison: N/A

Attachment B: Evaluation Design

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
			Enrollment)	
	The percentage of enrolled provider sites with NCQA PCMH recognition will increase.	Expansion of health care coverage to eligible low income adults	2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Levels 1, 2 and 3) (Denominator: Total Provider Site Enrollment)	• Baseline: PCASG organizations • Demonstration: NCQA • Comparison: N/A
	The percentage of enrolled provider sites with NCQA PCMH recognition will increase.	Expansion of health care coverage to eligible low income adults	2.1.2.1 Number and Percentage of Enrolled Provider Sites with Level 1 NCQA PCMH Recognition (Denominator: Total Provider Site Enrollment)	• Baseline: PCASG organizations • Demonstration: NCQA • Comparison: N/A
	The percentage of enrolled provider sites with NCQA PCMH recognition will increase.	Expansion of health care coverage to eligible low income adults	2.1.2.2 Number and Percentage of Enrolled Provider Sites with Level 2 NCQA PCMH Recognition (Denominator: Total Provider Site Enrollment)	• Baseline: PCASG organizations • Demonstration: NCQA • Comparison: N/A
	The percentage of enrolled provider sites with NCQA PCMH recognition will increase.	Expansion of health care coverage to eligible low income adults	2.1.2.3 Number and Percentage of Enrolled Provider Sites with Level 3 NCQA PCMH	• Baseline: PCASG organizations • Demonstration: NCQA

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
			Recognition (Denominator: Total Provider Site Enrollment)	• Comparison: N/A
2.2 Provide Enrollees with a Medical Home	Enrollees will have a medical home.	Expansion of health care coverage to eligible low income adults	2.2.1 Number and Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012 (Denominator: Total Enrollment)	• Baseline: N/A • Demonstration: DHH/MVA MMIS • Comparison: N/A
	All enrollees will utilize their PCMH as their usual source of care.	Expansion of health care coverage to eligible low income adults	2.2.2 Number and Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH Linkage (Denominator: Total Primary Care Encounter Claims Submitted by Enrolled Providers)	• Baseline: N/A • Demonstration: DHH/MVA MMIS • Comparison: N/A
2.3 Provide Care Coordination Services	Enrollees will be provided with care coordination services by their PCMH	Expansion of health care coverage to eligible low income adults	2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed (Denominator: Total Primary Care Encounter Claims)	• Baseline: N/A • Demonstration: DHH/MVA MMIS • Comparison: N/A

Attachment B: Evaluation Design

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
2.4 Integrate Primary and Behavioral Health Care Services	The number of enrollees with both primary care and behavioral health encounters will increase.	Expansion of health care coverage to eligible low income adults	2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters (Denominator: Total Enrollment)	• Baseline: PCASG data for uninsured, non-elderly adults • Demonstration: DHH/MVA MMIS and MEDS • Comparison: N/A
	The number of enrollees with a "warm hand off" between enrolled primary care and behavioral health care providers will increase.	Expansion of health care coverage to eligible low income adults	2.4.2 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters on the Same Date of Service (Denominator: Number of Enrollees with Both Primary Care and Behavioral Health Encounters)	• Baseline: PCASG data for uninsured, non-elderly adults • Demonstration: DHH/MVA MMIS and MEDS • Comparison: N/A
3. Evolve Grant-Funded Model to Financial Sustainability Through Diverse Means of Financing	The rate of uninsurance in the population eligible for the Demonstration will decrease.	Expansion of health care coverage to eligible low income adults		
	Enrolled provider sites (exclusive of mobile sites) will become Certified Medicaid Application Centers.	Expansion of health care coverage to eligible low income adults	3.1 Number and Percentage of Enrolled Provider Sites (exclusive of mobile sites) Certified as Medicaid Application Center (Denominator:	• Baseline: Enrolled PCASG sites, exclusive of mobile sites • Demonstration: DHH/MVA MMIS

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
			Total Provider Site Enrollment, exclusive of mobile sites)	Provider Enrollment and Eligibility Supports • Comparison: N/A
	The percentage of patients enrolled in the Demonstration will increase.	Expansion of health care coverage to eligible low income adults	3.2 Number of and Percentage of Patients Enrolled in the Demonstration (Denominator: Total Patient Population of Enrolled Provider Organizations)	• Baseline: PCASG data • Demonstration: DHH/MVA Provider Sustainability Plans • Comparison: LSU HCSD Interim LSU Public Hospital data
	The number of uninsured, non-elderly adult patients will decrease.	Expansion of health care coverage to eligible low income adults	3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients (Denominator: Total Patient Population of Enrolled Provider Organizations)	• Baseline: PCASG data • Demonstration: DHH/MVA Provider Sustainability Plans • Comparison: LSU HCSD Interim LSU Public Hospital data
	Demonstration revenues will increase.	Expansion of health care coverage to eligible low income adults	3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees (Denominator: Total Claims Submitted for Enrollee Encounters by Enrolled Providers)	• Baseline: PCASG data • Demonstration: DHH/MVA Provider Sustainability Plans • Comparison: N/A

Attachment B: Evaluation Design

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
			POPULATION GROUPS	
4. Increase access to health care coverage				
4.1 Increase access to health care coverage to populations eligible for the Demonstration	The number of Demonstration enrollees will increase.	Expansion of health care coverage to eligible low income adults	4.1.1 Total Enrollment	• Baseline: N/A • Demonstration: DHH/MVA MEDS • Comparison: N/A
	A majority of Demonstration enrollees will have income below 133% FPL.	Expansion of health care coverage to eligible low income adults	4.1.2 Number and Percentage of Enrollment in MEG 1 (0-133% FPL) (Denominator: Total Enrollment)	• Baseline: N/A • Demonstration: DHH/MVA MEDS • Comparison: N/A
	A minority of Demonstration enrollees will have income above 133% FPL.	Expansion of health care coverage to eligible low income adults	4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL) (Denominator: Total Enrollment)	• Baseline: N/A • Demonstration: DHH/MVA MEDS • Comparison: N/A
4.2 Reduce Rate of Uninsured Children	The percentage of uninsured patients under age 19 will decrease.	Expansion of health care coverage to eligible low income adults	4.2.1 Number and Percentage of Uninsured Patients under Age 19 (Denominator: Total Patients under Age 19 Served by Enrolled Providers)	• Baseline: Enrolled PCASG providers • Demonstration: DHH/MVA Provider Sustainability Plans • Comparison: N/A

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
	The percentage of patients under age 19 enrolled in Medicaid or CHIP will increase.	Expansion of health care coverage to eligible low income adults	4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP (Denominator: Total Patients under Age 19 Served by Enrolled Providers)	• Baseline: Enrolled PCASG providers • Demonstration: DHH/MVA Provider Sustainability Plans • Comparison: N/A
5. Assess Behavioral Health Care Needs of Enrollee Sub-Populations				
5.1 Assess Service Utilization and Cost by Parent Population	The average number of behavioral health care encounters per enrollee with a child in the home will be less than that of childless enrollees.	Expansion of health care coverage to eligible low income adults	5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee With a Child in the Home (Numerator: Number of Behavioral Health Care Encounters (Basic and SMI); Denominator: Total Enrollment)	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A
	The average payment for behavioral health care per enrollee with a child in the home will be less than that for enrollees without a child in the home.	Expansion of health care coverage to eligible low income adults	5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A

Attachment B: Evaluation Design

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
5.2 Assess Service Utilization and Cost by Childless Population	The average number of behavioral health care encounters per enrollee without a child in the home will be greater than that of enrollees with a child in the home.	Expansion of health care coverage to eligible low income adults	5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A
	The average payment for behavioral health care per enrollee without a child in the home will be greater than that for enrollees with a child in the home.	Expansion of health care coverage to eligible low income adults	5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A
5.3 Assess Service Utilization and Cost by Medicaid Expansion Population	The average number of behavioral health care encounters per enrollee with income below 133% FPL will be greater than that of enrollees with income above 133% FPL.	Expansion of health care coverage to eligible low income adults	5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A
	The average payment for behavioral health care per enrollee with income below 133% FPL will be greater than that of enrollees with income above 133% FPL.	Expansion of health care coverage to eligible low income adults	5.3.3 Average Payment for Behavioral Health Care Per Enrollee with Income 0-133% FPL	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A

Attachment B: Evaluation Design

GOAL(S), OBJECTIVE(S)	HYPOTHESES	KEY INTERVENTION	MEASURE(S)	DATA SOURCE(S)
5.4 Assess Service Utilization and Cost by Exchange Population	The average number of behavioral health care encounters per enrollee with income above 133% FPL will be less than that of enrollees with income below 133% FPL.	Expansion of health care coverage to eligible low income adults	5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 133-200% FPL	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A
	The average payment for behavioral health care per enrollee with income above 133% FPL will be less than that of enrollees with income below 133% FPL.	Expansion of health care coverage to eligible low income adults	5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 133-200% FPL	• Baseline: N/A • Demonstration: DHH/MVA MEDS and MMIS • Comparison: N/A

Attachment B: Evaluation Design

GOAL 1: PRESERVE PRIMARY AND BEHAVIORAL HEALTH CARE ACCESS

The Demonstration provides for an expansion of health care coverage to eligible low income adult populations in the Greater New Orleans area. Eligible Primary Care Access and Stabilization Grant (PCASG)-funded providers may enroll as GNOCHC providers. The Demonstration provides enrollees with a limited benefit package, which includes primary and behavioral health care among other services; and, it provides a means for the State to reimburse enrolled providers for covered services to enrollees.

Over the course of the waiver, the State will collect and analyze data to determine *how successful the Demonstration has been in preserving access to primary and behavioral health care.* The State will seek answers to the following evaluation questions, and use the following measures to quantify the Demonstration's effects.

Baseline population data will be provided by the Louisiana Public Health Institute (LPHI), administrator of the Primary Care Access and Stabilization Grant (PCASG). Specifically, LPHI will provide data on PCASG awardees, including provider organization and sites, unduplicated counts for uninsured, non-elderly adults served, and primary care and behavioral health care encounter counts for this pre-Demonstration comparison population for the grant year ending September 30, 2010.

Comparison population data will be provided by the Louisiana State University Health Care Services Division (LSU HCSD). Specifically, LSU HCSD will provide data on uninsured, non-elderly adults served by the Interim Public LSU Hospital (located in New Orleans) and eligible for its Free Care Program but not enrolled in the Demonstration, including unduplicated patient counts, primary care encounter counts, and behavioral health care encounter counts for each Demonstration year during the waiver period (October 1, 2010 through December 31, 2013). (See Attachment A for the LSU HCSD Free Care policy and a comparison to Demonstration eligibility criteria.)

Evaluation Questions:

1. Will access to care for populations eligible for the Demonstration be preserved?

1.1 Will organizations eligible to provide covered services to eligible individuals enroll in the Demonstration?

1.2 Will sites eligible to provide covered services to eligible individuals enroll in the Demonstration?

1.3 Will the rate of primary care access be preserved?

1.4 Will the rate of behavioral health care access be preserved?

Measures:

1.1 Number and Percentage of Eligible Provider Organizations Enrolled (Denominator: Eligible Provider Organizations)

1.2 Number and Percentage of Eligible Provider Sites Enrolled (Denominator: Eligible Provider Sites)

1.3 Rate of Primary Care Access (Numerator: Number of Primary Care Encounters; Denominator: Total Enrollment)

1.4 Rate of Behavioral Health Care Access (Numerator: Number of Behavioral Health Care Encounters; Denominator: Total Enrollment)

GOAL 2: SUSTAIN AND ADVANCE THE MEDICAL HOME MODEL

The Demonstration provides for incentive payments to enrolled providers for National Committee for Quality Assurance Patient Centered Medical Home recognition. It also anticipates the linkage of enrollees to a medical home and provides for payments to providers for care coordination services (covered by the primary care encounter rate prior to enrollee linkage to a PCMH and paid separately on a per member per month basis once an enrollee is linked).

Over the course of the waiver, the State will collect and analyze data to determine *how successful the Demonstration has been in sustaining and advancing a community-based, medical home model of health care delivery.* The State will seek answers to the following evaluation questions, and use the following measures to quantify the Demonstration's effects.

Objectives:

2.1 Attain National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Recognition

2.2 Provide Enrollees with a Medical Home

2.3 Provide Care Coordination Services

2.4 Integrate Primary and Behavioral Health Care Services

Evaluation Questions:

2.1 Will the percentage of enrolled provider sites applying for NCQA PCMH recognition increase?

2.1 Will the percentage of enrolled provider sites with NCQA PCMH recognition increase?

2.2 Will enrollees have a medical home?

2.2 Will enrollees utilize their medical home as their usual source of care?

2.3 Will enrollees be provided with care coordination services?

2.4 Will primary care and behavioral health services be integrated?

Measures:

2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition (Denominator: Total Provider Organization Enrollment)

2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Denominator: Total Provider Site Enrollment)

2.1.2.1 Number and Percentage of Enrolled Provider Sites with Level 1 NCQA PCMH Recognition (Denominator: Total Provider Site Enrollment)

2.1.2.2 Number and Percentage of Enrolled Provider Sites with Level 2 NCQA PCMH Recognition (Denominator: Total Provider Site Enrollment)

2.1.2.3 Number and Percentage of Enrolled Provider Sites with Level 3 NCQA PCMH Recognition (Denominator: Total Provider Site Enrollment)

2.2.1 Number and Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012 (Denominator: Total Enrollment)

2.2.2 Number and Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH Linkage (Denominator: Total Primary Care Encounter Claims Submitted by Enrolled Providers)

2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed (Denominator: Total Primary Care Encounter Claims)

2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters (Denominator: Total Enrollment)

2.4.2 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters on the Same Date of Service (Denominator: Number of Enrollees with Both Primary Care and Behavioral Health Encounters)

GOAL 3: EVOLVE GRANT-FUNDED MODEL TO FINANCIAL SUSTAINABILITY THROUGH DIVERSE MEANS OF FINANCING

The Demonstration provides a means of financing for payments to enrolled providers for covered services provided to Demonstration enrollees. Provider payments under Phase 1 of the Demonstration focus on the transition from Primary Care Access and Stabilization Grant to the waiver. Under Phase 2 of the Demonstration, provider payments focus on the transition from the waiver to Medicaid and the Federal Health Benefits Exchange, as populations eligible for coverage under the Demonstration through December 31, 2013 will become eligible for coverage under the Medicaid expansion or the Federal Health Benefits Exchange on January 1, 2014 as required by the Affordable Care Act.

To qualify for payments under the Demonstration, enrolled providers must comply with a series of measures intended to increase their capacity to become self-sustaining organizational entities independent of Demonstration funding sources by December 31, 2013. Under Phase 1, it requires:

- Enrollment with the State Medicaid program as a Demonstration provider;
- Certification as a Medicaid Application Center;
- Encounter data reporting directly to the program's Fiscal Intermediary in CMS-1500 format by October 1, 2011;
- Development, implementation and evaluation of a strategic plan to become a sustainable entity capable of permanently providing primary or behavioral health care to residents in the Greater New Orleans region; and,
- Semi-annual progress reports on the sustainability plan.

The Demonstration also imposes penalties on providers for failure to comply with such requirements. For example, providers that do not meet sustainability plan reporting requirements are ineligible for federal financial participation; and, the Department may refuse payment to providers that achieve less than a 90 percent encounter submittal rate for primary and behavioral health care services.

Over the course of the waiver, the State will collect and analyze data to determine *how successful the Demonstration has been in evolving primary and behavioral health care access restored by PCASG and preserved by the Demonstration to facilitate financial sustainability through diverse means of financing.* The State will seek answers to the following evaluation questions, and use the following measures to quantify the Demonstration's effects.

Evaluation Questions:

3. Will the rate of uninsurance in the population eligible for the Demonstration decrease?

3. 1 Will enrolled provider sites (exclusive of mobile sites) become Certified Medicaid Application Centers?

3. 2 Will the percentage of patients enrolled in the Demonstration increase?

3. 3 Will the percentage of uninsured, non-elderly adult patients decrease?

3.4 Will the percentage of paid claims for services provided to enrollees increase?

Measures:

3.1 Number and Percentage of Enrolled Provider Sites (exclusive of mobile sites) Certified as Medicaid Application Center (Denominator: Total Provider Site Enrollment, exclusive of mobile sites)

3.2 Number of and Percentage of Patients Enrolled in the Demonstration (Denominator: Total Patient Population of Enrolled Provider Organizations)

3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients (Denominator: Total Patient Population of Enrolled Provider Organizations)

3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees (Denominator: Total Claims Submitted for Services Provided to Enrollees by Enrolled Providers)

GOAL 4: INCREASE ACCESS TO HEALTH CARE COVERAGE

The waiver provides for an expansion of health care coverage to populations eligible

Over the course of the waiver, the State will collect and analyze data to determine *how successful the Demonstration has been in increasing access to health care coverage for Demonstration, Medicaid, and CHIP eligible individuals.* The State will seek answers to the following evaluation questions, and use the following measures to quantify the Demonstration's effects.

Objectives:

4. Increase access to health care coverage

4.1 Increase access to health care coverage to populations eligible for the Demonstration

4.2 Reduce Rate of Uninsured Children Eligible for Medicaid or CHIP

Evaluation Questions:

4.1.1 Will the number of Demonstration enrollees increase?

4.1.2 Will a majority of Demonstration enrollees have income below 133% FPL?

4.1.3 Will a minority of Demonstration enrollees have income above 133% FPL?

4.2.1 Will the percentage of uninsured patients under age 19 decrease?

4.2.2 Will the percentage of patients under age 19 enrolled in Medicaid or CHIP increase?

Measures:

4.1.1 Total Enrollment

4.1.2 Number and Percentage of Enrollment in Medicaid Eligibility Group (MEG) 1 (0-133% FPL) (Denominator: Total Enrollment)

4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL) (Denominator: Total Enrollment)

4.2.1 Number and Percentage of Uninsured Patients under Age 19 (Denominator: Total Patients under Age 19 Served by Enrolled Providers)

4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP (Denominator: Total Patients under Age 19 Served by Enrolled Providers)

GOAL 5: ASSESS BEHAVIORAL HEALTH CARE NEEDS OF ENROLLEE SUB-POPULATIONS

Over the course of the waiver, the State will collect and analyze data to determine *what lessons the State has learned from the Demonstration regarding the behavioral health care needs of the low-income adult population to be eligible for enrollment in Medicaid or the State's Health Benefit Exchange in 2014.* The State will seek answers to the following evaluation questions, and use the following measures to quantify the Demonstration's effects.

Objectives:

5. Assess Behavioral Health Care Needs of Enrollee Sub-Populations

5.1 Assess Service Utilization and Cost by Parent Population

5.2 Assess Service Utilization and Cost by Childless Adult Population

5.3 Assess Service Utilization and Cost by Medicaid Expansion Population

5.4 Assess Service Utilization and Cost by Exchange Population

Evaluation Questions:

5. Do behavioral health care needs of enrollees differ by sub-population?

5.1.1 Will the average number of behavioral health care encounters per enrollee with a child in the home (parents) be less than that of enrollees without a child in the home (childless couples and single adults)?

5.1.2 Will the average payment for behavioral health care per enrollee with a child in the home be less than that for enrollees without a child in the home?

5.2.1 Will the average number of behavioral health care encounters per enrollee without a child in the home be greater than that of enrollees with a child in the home?

5.2.2 Will the average payment for behavioral health care per enrollee without a child in the home be greater than that for enrollees with a child in the home?

5.3.1 Will the average number of behavioral health care encounters per enrollee with income below 133% FPL be greater than that of enrollees with income above 133%?

5.3.2 Will the average payment for behavioral health care per enrollee with income below 133% FPL be greater than that of enrollees with income above 133% FPL?

5.4.1 Will the average number of behavioral health care encounters per enrollee with income above 133% FPL be less than that of enrollees with income below 133% FPL?

5.4.2 Will the average payment for behavioral health care per enrollee with income above 133% FPL will be less than that of enrollees with income below 133% FPL?

Measures:

5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee with a Child in the Home

5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home

5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home

5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home

5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL

5.3.2 Average Payment for Behavioral Health Care Per Enrollee with Income 0-133% FPL

5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 133-200% FPL

5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 133-200% FPL

V. TIMELINE FOR IMPLEMENTATION

The State will begin implementation of the evaluation design upon CMS approval of the design. Analysis of enrollment and encounter data will coincide with the schedule of State deliverables milestones under the Demonstration as defined in the STCs. For example, eligibility system implementation is deliverable by March 1, 2010 and encounter data reporting is deliverable by October 1, 2011.

The State will comply with the schedule of State deliverables on the evaluation during the Demonstration is as follows.

DELIVERABLE	DATE
Quarterly Progress Report	No later than 60 days after the end of each quarter or 60 days after the date of CMS approval of the Evaluation design
Annual Progress Report	No later than 60 days after the end of each operational year or 60 days after the date of CMS approval of the Evaluation design
Draft Evaluation Report	No later than 120 days after expiration of the Demonstration
Final Evaluation Report	No later than 60 days after receipt of CMS comments

Attachment C

Introduction

This Funding and Reimbursement Protocol fulfills STC requirement number 21 and also details the means through which the State will meet the requirements of STC number 25 (GNOCHC Program Encounter Data) and STC number 26 (Submission of Encounter Data). It explains the process the State will use to determine reimbursement methodologies for expenditures by eligible providers under the Demonstration. Eligible providers include mental health clinics, certain physicians, certain Federally Qualified Health Centers, and certain other licensed practitioners. See Exhibit 11for a list of eligible providers.

By July 1, 2011, the State will submit to CMS an Evolution Plan for implementation during Phase 2 of the Demonstration. Should the Evolution Plan envision a change to the funding protocol approved by CMS, the State will include with the Evolution Plan submission a revised funding and reimbursement protocol that will explain the process the State proposes to use to determine reimbursement methodologies for expenditures under the Demonstration during Phase 2.

I. Description of sources of funding for the non-Federal share of expenditures

The source of funding for the non-Federal share of expenditures under the Demonstration will be a U.S. Department of Housing and Urban Development (HUD) Community Development Block Grant (CDBG) award (Number ILOC-00032) to the State of Louisiana, Department of Health and Hospitals, Bureau of Health Services Financing by the State of Louisiana, Division of Administration (DOA), Office of Community Development (OCD), which administers the State's CDBG disaster recovery program through the Louisiana Local Government Emergency Infrastructure program.

A "Cooperative Endeavor Agreement" between DHH and DOA implementing the grant award. affirms HUD's permitted use of CDBG funds as the matching non-Federal share of funds for the Demonstration, and it confirms that such use allows for the determination of reimbursement methodologies for expenditures under the waiver shall be governed by the framework of the CMS award, rather than the statutes, regulations, policies and procedures governing the CDBG program taking precedence.

Receipt of the grant funds by DHH will be accomplished by an Interagency Transfer (IAT) from DOA. Authority for expenditure of the IAT funds was granted to DHH by the Joint Legislative Committee on the Budget on September 17, 2010.

The State will not use Certified Public Expenditures (CPE), Intergovernmental Transfers (IGT) or similar processes to address the provision of Demonstration eligible medical services under the GNOCHC program at this time.

II. Reimbursement Methodologies

A. Purpose

This protocol proposes the use of four reimbursement methodologies under the Demonstration and includes:

1. Interim payments	
2. Encounter rates	
a. Primary care	
b. Behavioral health care	
i. Basic	
ii. Serious Mental Illness	Not to exceed 10 percent of total computable expenditures
3. Targeted payments	
a. Infrastructure investments	Not to exceed 10 percent
b. Community care coordination	Not to exceed 10 percent
4. Incentive payments	
a. National Committee on Quality Assurance Patient Centered Medical Home recognition	Not to exceed 10 percent

Together, the set of reimbursement methods proposed for use under the Demonstration provide the necessary safeguards for the development of a new coverage opportunity and a sound community-based delivery system, with the requisite mechanisms for accountability to CMS for expenditures under the Demonstration.

B. Adjustments

1. Demonstration Year End

For each Demonstration Year, the State will subtract the sum of all payments made under the Demonstration for the year, including payments for State administrative costs and targeted payments, incentive payments and primary care, basic behavioral health and Serious Mental Illness behavioral health care encounter rate payments for dates of service during the year to eligible providers, from the limit of total computable expenditures allowed under the Demonstration as per STC 22. If the sum of all payments made under the Demonstration for the year is less than the limit of total computable expenditures allowed under the Demonstration for the year, the State will divide the remainder of total computable expenditures allowed under the Demonstration for the year by the total number of primary care and behavioral health care (basic and SMI) encounters for enrollees with dates of service during the year as reported by all eligible providers; and, the quotient will be considered a supplement to the primary care and behavioral health care encounter rates. A supplemental payment will be made to each eligible provider, and the payment amount will be the product of the supplemental rate and the number of primary care and behavioral health care encounters for enrollees with dates of service during the year as reported by the

provider. Supplemental payments, if any, will be made to providers during the quarter following the end of the Demonstration Year.

2. Reporting Deadline for Encounters

In order to be considered within the adjustment described in Section II. B. 1., eligible providers must submit encounter reports for dates for service applicable to the Demonstration Year no later than 45 days following the end of the Demonstration Year regardless if the encounter is reported in Excel format to the Department or on the CMS 1500 to the fiscal agent as described in Exhibit 11.

3. Formula for Encounter Payment Adjustments

The formulas for these payments are as follows:

RTC = LTCdy – SP

Q = RTC / Ea

ESP = Q * Ep

Definitions

- LTCdy = Limit of total computable expenditures allowed under the Demonstration for the year
- SP = Sum of all payments made under the Demonstration for the year
- RTC = Remainder of total computable expenditures allowed under the Demonstration for the year
- Ea = Primary care, basic behavioral health care, and SMI behavioral health care encounters by enrollees with dates of service during the Demonstration Year as reported by all eligible providers
- Q = Supplement to the primary care, basic behavioral health care, and SMI behavioral health care encounter rates
- ESP = Encounter supplemental payment to an eligible provider for the Demonstration Year
- Ep = Primary care, basic behavioral health care, and SMI behavioral health care encounters by enrollees with dates of service during the year as reported by the eligible provider

4. Other

Rates and payments may be adjusted as necessary to continue providing access to services while maintaining expenditures within budget neutrality limitations, or in conjunction with the various other payment mechanisms within the waiver. Such adjustments may be necessary if enrollment volume warrants a prioritization and/or limitation of services. If annual expenditures, based on actual or projected enrollment and payments, are projected to

exceed the annual limit as authorized in the waiver, DHH will impose enrollment caps, encounter rate reductions and/or modifications to other payments to manage expenditures within budget neutrality limitations.

C. Reimbursement Methodologies

1. Interim payments

Interim payments may be made to eligible providers as described below.

For the period October 1, 2010 through December 31, 2010, an eligible provider's interim payment will be a quarterly urgent sustainability payment equal to 25 percent of the provider's average annual historical grant award received under PCASG amount as described in STC 23.

For the period January 1, 2011 through September 30, 2011, an eligible provider's interim payment will be monthly up to one third of the quarterly urgent sustainability payment.

Interim payments may be reduced by DHH at the request of the provider and after consideration of limitations to ensure budget neutrality and promote sustainability.

The amount of interim payments, including urgent sustainability payments, made to providers in the period of October 1, 2010 through September 30, 2011 will be reconciled against the actual payments that would have been made to the providers to reimburse waiver related costs through targeted payments, incentive payments, and encounter rate payments for dates of service during the period. The reconciliation shall occur simultaneously with the adjustment described in Section II. B. 1. for Demonstration Year 1. After supplemental payments calculated in Section II. B. 1., any overpayments may be offset against a provider's payment in the quarter following the reconciliation. Any underpayments may be made in the quarter following the reconciliation, subject to any limitations necessary to maintain budget neutrality and promote sustainability. This reconciliation will be completed and a document detailing the reconciliations and any over or under payments identified will be submitted to CMS by December 31, 2011.

2. Encounter rates

a. Primary care encounter rate for enrolled eligible individuals

Payments to eligible providers for covered services defined as primary care services in Exhibit 1 will be made on a per visit/encounter basis. This primary care encounter rate will be a fixed amount for all providers and all sites. It will not be provider specific or vary by patient acuity or service intensity.

The primary care encounter rate will be established considering as a first step historical claims data of the existing Medicaid eligible adult population. Medicaid claims history reflects historical utilization patterns and payment rates for Medicaid eligible adults, providing a basis for the development of encounter rates. Historical payment information will be trended to the midpoint of Phase 1 to incorporate changes in utilization and payment rates since the historical claims history base period. Although claims data for non-elderly adults in non-disabled categories will be the starting point, the encounter rate may be adjusted using assumptions pertaining to the uninsured adult population, particularly childless adults, covered by the waiver. Such assumptions may be based upon review of literature for Medicaid expansion populations and/or additional claims experience specific to Louisiana that are appropriate for this population and may include utilization adjustments reflecting potentially higher utilization by individuals lacking consistent care, and adjustments to the mix of historic services considering the possibly higher acuity/intensity of the enrollment.

The primary care encounter rate will cover primary care services, including primary care, care coordination/case management, preventive care, specialty care, , immunizations and influenza vaccines not covered by the vaccines for children program and laboratory (excluding clinical diagnostic laboratory) and radiology (including the professional and technical components) services that are routinely available in a primary care setting or through contracted services (e.g., physician office or Federally Qualified Health Center) (See Exhibit 1). A separate fee for service payment will be made for vaccine administration up to the charge limit specified for Louisiana. Clinical diagnostic laboratory services will be reimbursed separately in an amount equal to the current Medicare rate for each test. The primary care encounter rate will not include behavioral health care services as defined in Exhibits 5 and 6, but may include screenings for mental health disorders as a component of the primary care visit.

A primary care encounter is defined as a visit to an eligible provider during which the enrollee receives primary care services as defined by the following procedure codes or successor codes from a licensed practitioner or a person working under the supervision of a licensed practitioner including but not limited to physicians, clinical nurse specialists, nurse practitioners and physician assistants. Only one primary care visit may be billed per day.

T1016	CASE MANG WAIVER SERV 15 MINUTE UVS
98966	TELEPHONE ASSESSMENT AND MANAGEMENT

Attachment C

98968	TELEPHONE ASSESSMENT AND MANAGEMENT
99202	OFFICE, NEW PT, EXPANDED STRAIGHT FOWD
99203	OFFICE, NEW PT, DETAILED, LOW COMPLEX
99204	OFFICE/OUTPATIENT, NEW MOD COMPLEXITY
99205	OFFICE, NEW PT, COMPREHEN, HIGH COMPX
99211	OFFICE EST PT, MINIMAL PROBLEMS
99212	OFFICE, EST PT, PROBLEM, STRAITFORWD
99213	OFFICE, EST PT, EXPANDED, LOW COMPLEX
99214	OFFICE, EST PT, DETAILED, MOD COMPLX
99215	OFFICE, EST PT, COMPREHEN, HIGH COMPLX
99241 – 99245	OFFICE CONSULTING
99354 – 99356	PROLONGED MD FACE TO FACE
99357 – 99359	PROLONGED MD NO FACE TO FACE
99366 – 99368	INTERDISCIPLINARY CONFERENCES
99385 – 99386	INIT COMP PREV MED 18 – 39 YRS, 40 – 64 YRS
99395 – 99396	PERIODIC COMP PREV MED 18 – 39 YRS, 40 – 64 YRS
99401 – 99404	COUNSELING AND/OR RISK FACTOR REDUCTION
99406	SMOKING AND TOBACCO USE CESSATION CO
99407	BEHAV CHNG SMOKING > 10 MIN
99408 – 99409	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO)
99411 – 99412	COUNSELING AND/OR RISK FACTOR REDUCT
99420	ADMINIS & INTERP HLTH RSK ASSMT INST
99429	UNLISTED PREVENTATIVE MEDICINE SERVICE
99441 – 99444	TELEPHONE/ONLINE EVALUATION AND MANAGEMENT

The primary care encounter rate will be all inclusive; Medicaid will not pay for any primary care medical services separate from the primary care encounter rate for enrollees. The sum total of payments for specialty care shall not exceed 15 percent of the total computable expenditures under the Demonstration.

The formula to be used in the development of the rate is as follows:

Primary Care Encounter Rate = {[(D1/E1 * Weight * T2) + (D2/E2 * (1-Weight))] * Uadj * SMadj * T * P * FA * aDHH} + CM

Definitions:

- D1 = SFY1 AFDC Similar Adult Expenditures for Primary and Specialty Care Covered Services
- D2 = SFY2 AFDC Similar Adult Expenditures for Primary and Specialty Care Covered Services

- Weight = Weight factor for first year of rate data
- T2 = Trend Factor to Mid-Point of SFY2
- Uadj = Uninsured Utilization Adjustment
- SMadj = Uninsured Service Mix Adjustment
- T = Trend Factor to Mid-Point of Payment Period
- P = Program Adjustment Factor
- FA = Funding Adjustment Factor
- E1 = SFY1 AFDC Similar Adult Encounters for Primary Care Visits
- E2 = SFY2 AFDC Similar Adult Encounters for Primary Care Visits
- CM = Per Encounter Case Management/Care Coordination Fee
- aDHH = Eligible provider specific adjustment based on documented specialty care utilization and the cost of such services as determined by DHH based upon specialty care encounter data for enrolled individuals (default of 1.00 unless revised by DHH specific calculation)

T2 and T factors are factors to trend historic information to later or projected periods.
P factors are to adjust historical claims experience for utilization and unit cost changes implemented by the State since the historic period but effective for the payment period.
FA adjustment factor to be used to maintain payments within the limitations defined in Section II Reimbursement Methodologies.
Uadj and SMadj factors to be used to adjust AFDC Similar expenditures for utilization and mix differences between the historic Medicaid claims experience and that anticipated for the waiver population.

b. Behavioral health care encounter rates for enrolled eligible individuals

Payments to eligible providers for covered services defined as behavioral health care services in Exhibits 5 and 6 will be made on a per visit/encounter basis. Two encounter rates, distinguished by patient acuity, are proposed for behavioral health:

i. **A basic behavioral health encounter rate** for services provided to enrollees who meet the American Society of Addictive Medicine (ASAM) criteria for substance abuse and/or have a major mental health disorder as defined by Medicaid but do not meet the federal definition of serious mental illness (SMI) (See Exhibit 5). All eligible providers are eligible for the basic behavioral health encounter rate.

ii. **A Serious Mental Illness (SMI) behavioral health encounter rate** for services provided to enrollees who meet the federal definition of serious mental illness, including those who also have a co-occurring addictive disorder (See Exhibit 6). Only two providers are eligible for the SMI behavioral health care encounter rate: Jefferson Parish Human Services Authority (JPHSA) and Metropolitan Human Services District (MHSD).

To distinguish the basic and SMI behavioral health encounter rates, DHH will use HCPCS code T1015 with one modifier (TF) that points to the basic behavioral health care encounter rate and a second modifier (TG) that points to the SMI behavioral health care

encounter rate. JPHSA and MHSD will identify individuals meeting the federal SMI definition and apply the appropriate modifier subject to audit. If at an eligible provider other than JPHSA and MHSD identifies an enrollee suspected to meet the SMI definition, the provider will refer the enrollee to JPHSA or MHSD for SMI behavioral health care services.

If both a primary care encounter and a separate behavioral health care encounter occur on the same day, both the primary care encounter and the basic behavioral health care or the SMI behavioral health care encounter rate may be billed. Medication management for behavioral health pharmacy that occurs during a primary care encounter is not considered a separate basic or SMI behavioral health encounter and may not be billed.

i. Basic behavioral health care encounter rate for enrolled eligible individuals

Payments to eligible providers for covered services defined in Exhibit 5 as basic behavioral health care will be made on a per visit/encounter basis.

The basic behavioral health care encounter rate will be a fixed amount for all providers. It will not be provider specific or vary by patient acuity or service intensity.

The basic behavioral health care rate will be established considering as a first step historical claims data of the existing Medicaid eligible adult population. Medicaid claims history reflects historical utilization patterns and payment rates for Medicaid eligible adults, providing a basis for the development of encounter rates. Historical payment information will be trended to the midpoint of Phase 1 to incorporate changes in utilization and payment rates since the historical claims history base period. Although claims data for non-elderly adults in non-disabled categories will be the starting point, the encounter rate may be adjusted using assumptions pertaining to the uninsured adult population, particularly childless adults, covered by the waiver. Such assumptions may be based upon review of literature for Medicaid expansion populations and/or additional claims experience specific to Louisiana that are appropriate for this population, and may include utilization adjustments reflecting potentially higher utilization by individuals lacking consistent care, and adjustments to the mix of historic services considering the possibly higher acuity/intensity of the enrollment.

A basic behavioral health care encounter is defined as a visit to an eligible provider during which the enrollee receives covered mental health and/or substance abuse services from a licensed practitioner and or other practitioner authorized under Medicaid Mental Health Clinic policies to provide services directly or under supervision to the extent permitted by the practitioner's scope of State licensure. Only one behavioral health care visit may be billed per day.

Rates will be designed to cover behavioral health care services provided to enrollees who do not meet the federal definition of Serious Mental Illness but do meet the American Society of Addictive Medicine (ASAM) criteria and/or have a major mental health disorder as defined by Medicaid or previously had a major mental health disorder and are in need of maintenance services. Behavioral health care services include mental

health and/or substance abuse screening, assessment, counseling, medication management, laboratory and follow-up services for conditions treatable or manageable in primary care settings, but will not include primary care services. Services in residential, inpatient hospital and outpatient hospital settings are not covered.

The basic behavioral health encounter rate is distinct from the primary care encounter rate and compensates providers for a different package of services. The basic behavioral health encounter rate and the primary care encounter rate may be billed on the same day if the enrollee with receives both types of services.

The basic behavioral health care encounter rate will be all-inclusive; Medicaid will not pay for any behavioral health care services separate from the encounter rate for enrollees.

The formula to be used in the development of the rate is as follows:

Basic Behavioral Health Care Encounter Rate = [(BhD2008/BhE2008 * BhWeight * BhT2009) + (BhD2009/BhE2009 * (1-BhWeight))] * BhUadj x BhSMadj * BhT * BhP * BhFA

Definitions

- BhD2008 = SFY2008 AFDC Similar Adult Expenditures for Basic Behavioral Health Covered Services
- BhD2009 = SFY2009 AFDC Similar Adult Expenditures for Basic Behavioral Health Covered Services
- BhWeight = Weight factor for first year of rate data
- BhT2009 = Trend Factor to Mid-Point of SFY2009
- BhUadj = Basic Behavioral Health Uninsured Utilization Adjustment
- BhSMadj = Basic Behavioral Health Uninsured Service Mix Adjustment
- BhT = Basic Behavioral Health Trend Adjustment Factor
- BhP = Basic Behavioral Health Program Adjustment Factor
- BhFA = Basic Behavioral Health Funding Adjustment Factor
- BhE2008 = SFY2008 AFDC Similar Adult Encounters for Basic Behavioral Health Care Covered Services
- BhE2009 = SFY2009 AFDC Similar Adult Encounters for Basic Behavioral Health Care Covered Services

BhT2009 and BhT factors are factors to trend historic information to later or projected periods.

BhP factors are to adjust historical claims experience for utilization and unit cost changes implemented by the State since the historic period but effective for the payment period.

BhFA adjustment factor to be used to maintain payments within the limitations defined in Section II Reimbursement Methodologies.

BhUadj and BhSMadj factors to be used to adjust AFDC Similar expenditures for utilization and mix differences between the historic Medicaid claims experience and that anticipated for the waiver population.

Note: Unit costs to include cost settlements for public providers for prior years.

ii. Serious Mental Illness (SMI) behavioral health care encounter rate for enrolled eligible individuals

Payments to Jefferson Parish Human Services Authority (JPHSA) and Metropolitan Human Services District (MHSD) for covered services defined in Exhibit 6 as SMI behavioral health care services will be made on a per visit/encounter basis distinct from the basic behavioral health care encounter rate. The SMI behavioral health care encounter rate will be a fixed amount for both JPHSA and MHSD.

The SMI behavioral health care encounter rate will be established considering as a first step historical claims data of the existing Medicaid eligible adult population that meets the federal SMI definition, including those who also have a co-occurring addictive disorder. Medicaid claims history reflects historical utilization patterns and payment rates for Medicaid eligible adults who meet the federal SMI definition, providing a basis for the development of encounter rates. Historical payment information may be trended to the midpoint of Phase 1 to incorporate changes in utilization and payment rates since the historical claims history base period. Trend factors to be based upon utilization and unit cost increases/decreases as indicated by the historical claims and projected health cost inflation. A program adjustment may also be included based upon changes to the State's utilization and unit cost policies (e.g. rate reductions) effective since the historic claims period. The SMI behavioral health care encounter rate may also examine available information on the utilization and cost of covered mental health and substance abuse services for uninsured individuals (non-Title XIX eligible) served by all Office of Behavioral Health providers, including but not limited to by JPHSA and MHSD.

An SMI behavioral health care encounter is defined as a visit to JPHSA or MHSD during which the enrollee who meets the federal SMI definition, including those who also have a co-occurring addictive disorder, receives covered mental health and/or substance abuse services from a licensed practitioner and or other practitioner authorized under Medicaid Mental Health Clinic policies to provide services directly or under supervision to the extent permitted by the practitioner's scope of State licensure.

Rates will be designed to cover behavioral health care services provided to enrollees who meet the federal definition of Serious Mental Illness, including those who also have a co-occurring addictive disorder and those who were previously identified as SMI and are in need of maintenance services. SMI behavioral health care services include mental health and/or substance abuse screening, assessment, counseling, medication management, follow-up and community support services. Services in residential, inpatient hospital and outpatient hospital settings are not covered. Only one SMI behavioral health care visit may be billed per day.

The SMI behavioral health encounter rate is distinct from the primary care encounter rate and the basic behavioral health care encounter rate and compensates providers for a different pattern of services typically provided to those with SMI. If unable to provide primary care services directly, JPHSA and MHSD will be required to coordinate with other eligible providers for the provision of primary care services to the enrollee. The SMI behavioral health care encounter rate and the primary care encounter rate may be billed on the same day if the enrollee receives both types of services.

The SMI behavioral health care encounter rate will be all inclusive; Medicaid will not pay for any behavioral health care services separate from the encounter rate.

The sum total of payments for behavioral health care services for Serious Mental Illness shall not exceed 10 percent of the total computable expenditures under the Demonstration.

The formula to be used in the development of the rate is as follows:

Serious Mental Illness Behavioral Health Care Encounter Rate = [(smiD2008/smiE2008 * smiWeight * smiT2009) + (smiD2009/smiE2009 * (1-smiWeight)] * smiUadj * smiSMadj * smiT * smiP * smiFA

Definitions

- smiD2008 = SFY2008 SMI Adult Expenditures for SMI Behavioral Health Covered Services for SMI providers
- smiD2009 = SFY2009 SMI Adult Expenditures for SMI Behavioral Health Covered Services for SMI providers
- smiWeight = Weight factor for first year of rate data
- smiT2009 = Trend Factor to Mid-Point of SFY2009
- smiUadj = SMI Behavioral Health Uninsured Utilization Adjustment
- smiSMadj = SMI Behavioral Health Uninsured Service Mix Adjustment
- smiT = SMI Behavioral Health Trend Adjustment Factor
- smiP = SMI Behavioral Health Program Adjustment Factor
- smiFA = SMI Behavioral Health Funding Adjustment Factor
- smiE2008 = SFY2008 SMI Adult Encounters for SMI Behavioral Health Care Covered Services for SMI providers
- smiE2009 = SFY2009 SMI Adult Encounters for SMI Behavioral Health Care Covered Services for SMI providers

smiT2009 and smiT factors are factors to trend historic information to later or projected periods.

smiP factors are to adjust historical claims experience for utilization and unit cost changes implemented by the State since the historic period but effective for the payment period.

smiFA adjustment factor to be used to maintain payments within the limitations defined in

Section II Reimbursement Methodologies and overall budget neutrality limitations.

smiUadj and smiSMadj factors to be used to adjust AFDC Similar expenditures for utilization and mix differences between the historic Medicaid claims experience and that anticipated for the waiver population.

Note: SMI providers are defined as Jefferson Parish Human Services Authority (JPHSA) and Metropolitan Human Services District (MHSD).

SMI encounters are those identified as SMI based upon claim modifiers/identifiers and practitioner specialty, and may include both AFDC and SSI eligibility groups as proxy populations.

Unit costs to include cost settlements for public providers for prior years.

3. Targeted payments

a. Infrastructure investments

Payments to eligible providers for infrastructure costs related to the provision of heath care services, as defined in STC 21.c. and the expenditure authority approved by CMS for the Demonstration, will be made based on proposals from participating providers and the State's assessment of the extent to which a provider's proposal meets designated criteria for targeted infrastructure investment, as defined in Exhibit 8. Payments will vary by provider.

The five targets for funding under the Infrastructure Investment Initiative will be in priority order:

i. To acquire, install and train staff to operate practice management, billing, financial and data collection systems required for payment, encounter reporting and accountability

ii. To enhance care management capacity through the acquisition of care/case management systems, development of comprehensive care management protocols and in depth staff training

iii. To acquire technical assistance to gain NCQA PCMH recognition and to cover the costs of the NCQA PCMH application process

iv. To develop, acquire and install data collection/reporting systems required to participate in quality/ performance improvement incentive programs

v. To acquire and install equipment required for telemedicine consults and/or mobile service capacity

Payments for infrastructure investments will cover expenditures to support the providers' delivery of services, billing for services, financial accountability, and encounter/quality reporting. Infrastructure payments will not cover any costs for the acquisition, construction or renovation of bricks and mortar.

Consistent with the expenditure authority approved by CMS for the Demonstration, the sum total of payments for infrastructure investments shall not exceed 10 percent of the total computable expenditures under the Demonstration.

Eligible providers will be required to report quarterly on the use of infrastructure investment payments as defined in Section III Reporting Requirements. Effective October 1, 2011, a provider may not receive infrastructure investment payments until it has submitted the required reports.

b. Community care coordination

Payments to participating providers for community care coordination, as defined in Exhibit 9, will be based on limited allocations.

DHH will determine a total amount available for payments for community care coordination. Using the number of uninsured adult encounters reported for the most recent twelve month period available from all participating providers, DHH will allocate and pay the total amount available for payments for community care coordination among providers based on each provider's annual number of uninsured adult encounters as a proportion of the total number of uninsured adult encounters for all participating providers.

Payments for community care coordination will be made to eligible providers in Demonstration Year 1 only. Any community care coordination funds not expended by September 30, 2011 shall be reallocated as described in Section II. B. 1..

Eligible providers will be required to report quarterly on the use of community care coordination payments as defined in Section III Reporting Requirements.

The sum total of payments for community care coordination shall not exceed 10 percent of the total computable expenditures under the Demonstration during Demonstration Year 1.

The formula to be used in the development of the rate is as follows:

Community Care Coordination = CC * E1/SumE

Definitions

- CC = Annual fixed amount determined by DHH for Community Care Coordination
- E1 = Uninsured adult encounters for a provider during historic Year 1
- SumE = Sum of all uninsured adult encounters for all providers during Year 1

4. Incentive payments

a. National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Recognition

Incentive payments to eligible providers for NCQA PCMH recognition, as described in

Exhibit 10, will be made on a quarterly basis.

Payment methods will differ for the pre- and post-June 30, 2011 periods.

For the period October 1, 2010 through June 30, 2011, the amount of a provider's payment will be the product of the fixed rate assigned to the level of NCQA PCMH recognition documented for the provider on the first day of the preceding quarter and the provider's quarterly number of uninsured adult encounters for the preceding quarter.

Rates for NCQA PCMH recognition levels 1, 2, and 3 will be fixed amounts for all providers (See Exhibit 10), and will be determined on an encounter basis. Payments will be made quarterly.

The formula for these payments is as follows:

PCMH1 = NCQAe * EupQ * PCMHFA

Definitions:

- PCMH1 = PCMH quarterly payment 10/1/10 – 6/30/11
- NCQAe = Encounter rate for one of three NCQA PCMH recognition levels based on NCQA PCMH recognition for the prior quarter
- EupQ = Encounters by uninsured adults for covered services for the prior quarter
- PCMHFA = PCMH funding adjustment factor

PCMHFA adjustment factor to be used to maintain payments within the limitations defined in Section II Reimbursement Methodologies.

Effective July 1, 2011, the amount of a provider's payment will be the product of the fixed rate assigned to the level of NCQA PCMH recognition documented for the provider on the first day of the preceding quarter and the provider's quarterly number of enrollee encounters for the preceding quarter.

Rates for NCQA PCMH recognition levels 1, 2, and 3 will be fixed amounts for all providers (See Exhibit 10), and will be determined on an encounter basis. Payments will be made quarterly.

The formula for these payments is as follows:

PCMH2 = NCQAe * EepQ * PCMHFA

Definitions

- PCMH2 = PCMH quarterly payment effective 7/1/11
- NCQAe = Encounter rate for one of three NCQA PCMH recognition levels based on NCQA PCMH recognition for the prior quarter
- EepQ = Encounters by enrollees for covered services for the prior quarter

- PCMHFA = PCMH funding adjustment factor

PCMHFA adjustment factor to be used to maintain payments within the limitations defined in Section II Reimbursement Methodologies. The sum total of payments for NCQA incentive payments shall not exceed 10 percent of the total computable expenditures under the Demonstration.

Eligible providers will be required to document quarterly the level of NCQA PCMH recognition for the provider on the first day of the preceding quarter. A provider may not receive NCQA PCMH payments until it has submitted the required documentation.

III. Reporting Requirements

Providers will be required to complete the following reports quarterly:

A. Infrastructure investment schedule

Providers are required to report quarterly on infrastructure investments, including but not limited to the following information:

- Reporting period
- Provider name
- Provider number
- Date of investment (expenditure)
- Description of investment
- Amount spent for investment

Quarterly infrastructure investment reports will be due thirty days after the end of the reporting period or sixty days after CMS approval of the funding protocol.

B. Community care coordination schedule

Providers are required to report quarterly on community care coordination, including but not limited to the following information:

- Reporting period
- Provider name
- Provider number
- Date of service
- Description of service
- Amount spent for service
- Number of individuals served

Quarterly community care coordination reports will be due thirty days after the end of the reporting period or sixty days after CMS approval of the funding protocol.

C. Encounter data reporting

Providers are required to report encounter data for covered services, as defined in Exhibit 11, including but not limited to the following information:

- Reporting period
- Provider name
- Provider number
- Enrollee name
- Enrollee number
- Date of birth
- Social Security number
- Date of service
- Type of service
- Units of service
- Procedure code(s)
- Diagnosis code(s)

IV. Covered Services Definitions

For detailed definitions of services covered under the Demonstration, including provider qualifications, service limitations and prior authorization, applicable HCPCS and CPT coding, and service exclusions (See Exhibits 1 through 7). Covered services under the Demonstration fall into two broad categories: core and specialty (or "add-on" services, as described in STC 17).

A brief summary of covered services definitions follows.

A. Core services are those medically necessary services coverable under section 1905(a) of the Social Security Act which each participating provider is expected to provide or purchase on behalf of enrollees. Core services include both primary care and behavioral health care services.

1. **Primary care services** include primary care, preventive care, immunizations and influenza vaccines, laboratory and radiology, and care coordination. Primary care services are provided by licensed practitioners, including physicians, nurse specialists, nurse practitioners and physician assistants (See Exhibits 1 through 3).

   The primary care encounter rate also includes specialty care including medically necessary referral to and treatment by physicians with a designated specialty or subspecialty and specialty laboratory and radiology testing as defined in Exhibit 4 are covered. Specialty care is not covered without a referral from the eligible primary care provider and compliance with the provider's prior authorization requirements in effect.

2. **Behavioral health care services** include mental health and/or substance abuse screening, assessment, counseling, treatment, medication management, laboratory,

follow-up, and support services provided to enrollees (See Exhibits 5 and 6). Behavioral health care services are provided by licensed practitioners including psychiatrists, physicians, psychologists, social workers, and psychiatric nurse practitioners or are provided by other practitioners (e.g. behavior and addiction specialists) authorized to provide services directly or under supervision in authorized under Medicaid Mental Health Clinic policies to provide services directly or under supervision to the extent permitted by the practitioner's scope of State licensure.

Payments for behavioral health care services are differentiated based on whether or not the enrollee provided with the service meets the federal definition of Serious Mental Illness (SMI), including those who also have a co-occurring addictive disorder. All participating providers may provide behavioral health care services to enrollees who do not meet the federal definition of SMI but do meet the American Society of Addictive Medicine (ASAM) criteria and/or have a major mental health disorder as defined by Medicaid. Only two providers, JPHSA and MHSD, may provide behavioral health care services to enrollees who meet the federal definition of SMI, including those who also have a co-occurring addictive disorder.

B. Definitions. In developing definitions for covered services under the Demonstration, the State examined multiple data sources, including but not limited to:

- Louisiana Medicaid State Plan and Waiver covered services definitions
- CMS definitions available for some services
- Draft service definitions for Coordinated Care Network (CCN) implementation planned for the State Medicaid program in 2012
- Draft mental health and substance abuse definitions for the Comprehensive System of Care (CSoCCSoC) planned to modernize the State's provision of behavioral health care services for Serious Mental Illness by State Plan Amendment in 2011
- Survey responses from GNOCHC-participating providers detailing the services they provide directly and services they refer to other providers but pay for
- Primary and preventive care definitions and coding included in the Affordable Care Act (ACA)

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
Care Coordination	The primary care encounter core services includes care coordination services delivered by health providers (or teams) in the individual's health care home: ▪ Engage individuals in preventing disease and maintaining their own health ▪ Assist in navigation of the health care system, including assistance with navigating Pharmacy Assistance Programs, State and local government funded programs, and privately funded sources for prescription medications. ▪ Provider health education and coaching ▪ Coordinate with other providers ▪ Support the individual with the social determinants of health such as access to healthy food,	▪ Primary Care Physicians ▪ Nurse Practitioners ▪ Physician Assistants ▪ Clinical Nurse Specialists ▪ Licensed Social Workers ▪ Registered Nurses or Bachelors Level health related degree and/or five years case management experience in health related setting	None	T1016* 99366 - 99368 99441 - 99444 98966 98968 Or successor codes	CASE MANAGEMENT INTERDISCIPLINARY CONFERENCES TELEPHONE AND ONLINE CONSULTATION TELEPHONE ASSESSMENT AND MANAG. NON MD

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding
	smoking cessation and exercise			

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
Primary Care	Health care services that maintain wellness and are not in the nature of specialty care. Primary care is the ongoing source of care for each individual and the access point for referral to specialized services	▪ Licensed physicians in family medicine, internal medicine, general practice, and pediatrics (only for individuals ages 19-21) ▪ Physician assistants, clinical nurse specialists and nurse practitioners operating within the scope of their licensure in the State of Louisiana	None	T1016*	CASE MANG WAIVER SERV 15 MINUTE UVS
				98966	TELEPHONE ASSESSMENT AND MANAGEMENT
				98968	TELEPHONE ASSESSMENT AND MANAGEMENT
				99202	OFFICE, NEW PT, EXPANDED STRAIGHT FOWD
				99203	OFFICE, NEW PT, DETAILED, LOW COMPLEX
				99204	OFFICE/OUTPATIENT, NEW MOD COMPLEXITY
				99205	OFFICE, NEW PT, COMPREHEN, HIGH COMPX
				99211	OFFICE EST PT, MINIMAL PROBLEMS
				99212	OFFICE, EST PT, PROBLEM, STRAITFORWD
				99213	OFFICE, EST PT, EXPANDED, LOW COMPLEX
				99214	OFFICE, EST PT, DETAILED, MOD COMPLX
				99215	OFFICE, EST PT, COMPREHEN, HIGH COMPLX
				99241 – 99245	OFFICE CONSULTING
				99354 – 99356	PROLONGED MD FACE TO FACE
				99357 – 99359	PROLONGED MD NO FACE TO FACE
				99366 – 99368	INTERDISCIPLINARY CONFERENCES
				99385 – 99386	INIT COMP PREV MED 18 – 39 YRS, 40 – 64 YRS
				99395 – 99396	PERIODIC COMP PREV MED 18 – 39 YRS, 40 – 64 YRS

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
				99401 – 99404	COUNSELING AND/OR RISK FACTOR REDUCTION
				99406	SMOKING AND TOBACCO USE CESSATION CO
				99407	BEHAV CHNG SMOKING > 10 MIN
				99408 – 99409	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO)
				99411 – 99412	COUNSELING AND/OR RISK FACTOR REDUCT
				99420	ADMINIS & INTERP HLTH RSK ASSMT INST
				99429	UNLISTED PREVENTATIVE MEDICINE SERVICE
				99441 – 99444	TELEPHONE/ONLINE EVALUATION AND MANAGEMENT
				90471*	IMMUNIZATION ADMIN
				99474*	MDW/OUT CONSULTING
				90862*	MEDICATION ADMIN
				G0108*	DIABETES TRAINING INDIV.
				G0109*	DIABETES TRAINING GRP.
				*Insufficient to justify an encounter payment Or successor codes The use of a telemedicine communications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management	

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
Preventive Care	Preventive services include: ▪ Immunizations (see next section of this table) ▪ Screening for - Diabetes - Tuberculosis - Cardiovascular Disease - Blood Pressure - Cholesterol - Cancer (within the guidelines for age and frequency adopted by Medicare for breast, cervical, uterine, and colorectal) - HIV - Hearing loss - Bone density - Depression - Mental Health and Substance Abuse conditions (alcohol misuse) - Chlamydia Infection - Gonorrhea	▪ Licensed physicians in family medicine, internal medicine, general practice, and pediatrics (only for individuals ages 19-21) ▪ Physician assistants, clinical nurse specialists and nurse practitioners operating within the scope of their licensure in the State of Louisiana	None	99385 – 99386	INIT COMP PREV MED 18 – 39 YRS, 40 – 64 YRS
				99395 – 99396	PERIODIC COMP PREV MED 18 – 39 YRS, 40 – 64 YRS
				99401 – 99404	COUNSELING AND/OR RISK FACTOR REDUCTION
				99406	SMOKING AND TOBACCO USE CESSATION CO
				99407	BEHAV CHNG SMOKING > 10 MIN
				99408 – 99409	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO)
				99411 – 99412	COUNSELING AND/OR RISK FACTOR REDUCT
				99420	ADMINIS & INTERP HLTH RSK ASSMT INST
				99429	UNLISTED PREVENTATIVE MEDICINE SERVICE
				99441 – 99444	TELEPHONE/ONLINE EVALUATION AND MANAGEMENT
				90471*	INJECTIONS WITHOUT CONSULTING
				90474*	INJECTIONS WITHOUT CONSULTING
				*Insufficient to justify an encounter payment Or successor codes	

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding
	- Hepatitis - Obesity - Osteoporosis ▪ Pap Smears ▪ Tobacco cessation ▪ Diet, lifestyle, and exercise programs ▪ Well woman exams ▪ STD Counseling ▪ Self examination teaching programs ▪ Remote testing ▪ Behavior modification			

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
Immunizations and Influenza Vaccines	Immunizations are covered services for the vaccine (not covered by vaccines for children) and administration of the vaccine provided that there is no other source of funding for the vaccine and subject to the payment limitation for vaccine administration for Louisiana: ▪ Influenza ▪ Pneumococcal ▪ HPV ▪ Hepatitis A ▪ Hepatitis B ▪ HBV ▪ MMR ▪ Tetanus booster Varicella ▪ Meningococcal	▪ RN/LPN administered	Ordered by Primary Care Provider	90281 - 90399*	IMMUNE GLOBULINS
				90470*	H1N1
				90471 - 90474*	INJECTIONS WITHOUT PHYSICIAN CONSULTING
				90649 - 090650*	HPV
				90655, 90656, 90658 - 90664, 90666, 90667, 90668*	INFLUENZA
				90632*	HEPATITIS A
				90669 - 90670*	PNEUMOCOCCAL
				90707*	MMR
				90716*	VARICELLA
				90718*	TETANUS BOOSTER
				90733 - 90734*	MENINGCOCCAL
				90736*	SHINGLES
				90746*	HEPATITIS B
				*Insufficient to justify an encounter payment Or successor codes	
Lab	Laboratory testing routinely available in a	▪ Furnished by a laboratory that meets	Primary care provider	See Exhibit 2	

Exhibit 1
Core Primary Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding
	clinic or physician office setting. Laboratory services meeting this criteria (see code set) are covered services whether provided by the GNOCHC provider or sent to an independent lab Clinical diagnostic laboratory services are paid outside the encounter rate according to Medicaid fee-for-service	the requirements of 42 CFR 493	ordered	
Radiology	Radiology services routinely available in a clinic or physician office setting. Radiology services meeting this criteria (see code set) are covered services whether provided by the GNOCHC provider or sent to an outside entity	▪ Licensed radiologists ▪ Certified registered radiologist technicians	Ordered by the primary care provider	See Exhibit 3

Exhibit 2
Core Laboratory Services

80047-8	Basic Metabolic Panel Calcium Total
80050	General Health Panel
80051	Electrolyte Panel
80053	Compre Metab Panel
80061	Lipid Panel
80069	Renal Function Panel
80074	Acute Hepatitis Panel
80076	Hepatc Funcj Panel
80100	Drug Scr Qual Mlt Drug Classes Chrom Ea Px *See Lab CPT Codes for Behavioral Health in Exhibits 5 and 6 for the 801XX series
80162	Digoxin
80178	Lithium
80198	Theophylline
81000	Urnls Dip Stick/Tablet Rgnt Non-Auto Mic
81001	Urnls Dip Stick/Tablet Rgnt Auto Mic
81003	Urnls Dip Stick/Tablet Rgnt Auto W/O Mic
81025	Urine Pregnancy Tst Vis Color Cmprsn Meths
82040	Albumin Serum Plasma/Whole Blood
82075	Alcohol Brth
82150	Amylase
82247	Bilirubin Total
82248	Bilirubin Direct
82270	Bld Oclt Proxidase Actv Qual Feces 1 Deter
82310	Assay Calcium In Blood
82383	Assay Blood Catecholamines
82465	Assay Serum Cholesterol
82550	Creatine Kinase Tot
82553	Creatine Kinase Mb Fxj Only
82565	Creatinine Bld
82728	Ferritin, Specify Method
82746	Folic Acid Serum
82747	Folic Acid Rbc
82947	Gluc Quan Bld
82951	Glucose Tolerance Test (Gtt)
82952	Gtt-Added Samples
82962	Gluc Bld Gluc Mntr Dev Cleared Fda Spec Home Use
82977	Glutamyltrase Gamma
82985	Glycoprotein Electrophoresis
83036	Hgb Glycosylated
83540	Assay Serum Iron
83550	Serum Iron Binding Test
83615	Uv-Assay Blood Ldh Enzyme
83690	Lipase
83718	Blood Lipoprotein Assay

Exhibit 2
Core Laboratory Services

83721	Lipoprotein, Direct Measurement
83735	Magnesium
83874	Myoglobin
83880	Natriuretic Peptide
84075	Assay Alkaline Phosphatase
84100	Phosphorus Inorganic
84152	Prst8 Spec Ag
84153	Prst8 Spec Ag Tot
84154	Prst8 Spec Ag
84155	Assay Serum Protein
84425	Thiamine
84436	Thyroxine, True, Ria
84443	Thyr Stimulating Horm
84450	Uv-Assay Transaminase (Sgot)
84460	Transferase Alanine Amino
84478	Assay Blood Triglycerides
84479	Triiodothyronine, Resin Uptake
84484	Troponin Quan
84512	Troponin, Qual
84520	Urea N Quan
84550	Uric Acid Bld
84702	Gonadotropin,Chorionic;Quantitative
84703	Gonad Chornc Qual
85025	Bld# Compl Auto Hhrwp&Auto Diffial
85027	Blood Count including HGB, HCT, RBC, WBC, and Platelet Count
85610	Prothrombin Tm
86308	Htrophl Antibodies Scr
86403	Part Aggluj Scr Ea Antb
86406	Part Aggluj Titer Ea Antb
86580	Skn Tst Tuberculosis Id
86677	Antb Helicobacter Pylori
86708	Hep Antb Haab Tot
86709	Hep Antb Haab Igm Antb
86710	Antb Inf Virus
86803	Hep C Antb
87210	Smr Prim Src Wet Mount Nfct Agt
87340	Iaad Eia Hep B Surf Ag
87390	Hiv-1 Ag, Eia
87804	Iaadiadoo Inf
87880	Iaadiadoo Streptococcus Grp
88150	Cytopathology, Pap Smear

Laboratory services identified for basic and SMI behavioral health services in Exhibits 5 and 6 are also covered services. Core laboratory services include all successor codes for the laboratory procedures defined above and will be updated annually.

Exhibit 3
Core Radiology Services

Radiology	
Code	**Description**
70030	X-Ray Eye; Detect Foreign Body
70110	Radex Mndbl Compl Minimum 4 Views
70150	Radex Facial B1S Compl Minimum 3 Views
70160	Radex Nsl B1S Compl Minimum 3 Views
70200	Radex Orbits Compl Minimum 4 Views
70210	Radex Sinuses Paransl < 3 Views
70220	Radex Sinuses Paransl Compl Minimum 3 Views
70250	Radex Skl < 4 Views
70260	X-Ray Skull; Complete
70360	Radex Nck Soft Tiss
71010	Radex Ch 1 View Frnt
71020	Radex Ch 2 Views Frnt&Lat
71022	X-Ray Chest; Oblique Projections
71035	Chest X-Ray
71101	Radex Ribs Uni W/Posteroant Ch Minimum 3 Views
71111	X-Ray Ribs,Bilat;Posteroanteri Chest
71120	X-Ray Exam Of Breastbone
72020	Radex Spi 1 View Spec Lvl
72040	Radex Spi Crv 2/3 Views
72050	Radex Spi Crv Minimum 4 Views
72052	X-Ray Exam Of Neck Spine
72070	X-Ray Exam Of Thorax Spine
72074	Radex Spi Thrc Minimum 4 Views
72090	X-Ray Exam Of Trunk Spine
72100	Radex Spi Lumbosac 2/3 Views
72110	L-Spine 4 Views
72114	X-Ray Exam Of Lower Spine
72120	X-Ray Exam Of Lower Spine
72170	Radex Pelvis 1/2 Views
72200	Radex Si Jts < 3 Views
72220	X-Ray Exam Of Tailbone
73000	Radex Clav Compl
73010	X-Ray Exam Of Shoulder Blade
73030	Radex Sho Compl Minimum 2 Views
73050	X-Ray Exam Of Shoulders
73060	Radex Hum Minimum 2 Views
73070	Radex Elbw 2 Views
73080	Radex Elbw Compl Minimum 3 Views
73090	Radex F/Arm 2 Views
73110	Radex Wrst Compl Minimum 3 Views
73130	Radex Hand Minimum 3 Views
73140	Radex Fngr Minimum 2 Views
73510	Radex Hip Uni Compl Minimum 2 Views

Exhibit 3
Core Radiology Services

73520	X-Ray Exam Of Hips
73550	Radex Femur 2 Views
73560	Radex Kne 1/2 Views
73562	X-Ray Knee A/P.Obliques,3+Views
73564	Radex Kne Compl 4/More Views
73590	Radex Tibfib 2 Views
73610	Radex Ankle Compl Minimum 3 Views
73630	Radex Foot Compl Minimum 3 Views
73650	X-Ray Exam Of Heel
73660	Radex Toe Minimum 2 Views
74000	Radex Abd 1 Anteropost View
74020	Radex Abd Compl W/Dcbts&/Erc Views
74022	Radex Abd Compl Aqt Abd W/S/E/D Views 1 View Ch
77072	Bone Age Studies
77074	Radiologic Examination, Osseous Surv

Covered radiology services include all successor codes for the defined procedures and will be updated annually.

Exhibit 5
Basic Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations/Prior Authorization	Applicable HCPCS and CPT Coding
Specialty Care	Specialist physician services referred by the primary care provider or provided directly by the GNOCHC provider	▪ Licensed physicians with a specialty or subspecialty designation ▪ Other licensed practitioners as allowed under Medicaid policy and procedures	These services are subject to dollars available to the provider for specialty care Ordered by the GNOCHC provider Complies with the authorization requirements in force at the GNOCHC provider	CPT coding Cosmetic procedures, pain management, and fertility treatments are not covered Ophthalmology services may be provided for treatment of trauma, infection, cataracts and congenital eye defects. Routine eye exams and eye glasses are not covered.
Specialty Laboratory	Specialty laboratory services not included in core services Clinical diagnostic laboratory testing is paid outside the encounter rate according to the Medicaid fee-for-service schedule	▪ Furnished by a laboratory that meets the requirements of 42 CFR 493	Ordered by a physician Subject to dollars available to the provider for specialty care	Laboratory 8XXX CPT codes not included in core services covered by Louisiana Medicaid
Specialty Radiology	Specialty radiology procedures not included in core services ▪ Magnetic Resonance (MRI) ▪ Computed Tomography (CT) ▪ Nuclear Cardiac imaging ▪ Ultrasound ▪ Positron Emission Tomography (PET)	▪ Licensed radiologists ▪ Certified registered radiologist technicians	Ordered by a physician Subject to dollars available to the provider for specialty care. Each provider must have in place a process for prior authorization of each procedure. Clinic may contract with the Radiology Utilization Management entity used by Medicaid.	Radiology 7XXX CPT codes not included in core services covered by Louisiana Medicaid

Exhibit 5
Basic Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
Basic Behavioral Health Care Services	Mental health and/or substance abuse screening, assessment, counseling, medication management, treatment, and follow-up for conditions treatable or manageable in primary care settings. Individuals who meet the ASAM criteria for substance abuse and/or who have a major mental health disorder as defined by Medicaid or previously had a major mental health disorder and are in need of maintenance services are eligible to receive basic behavioral health care services.	▪ Practitioners authorized to provide services directly or under supervision by Medicaid MH Clinic policies ▪ Licensed Psychiatrists, Licensed physicians, Psychologists, Social Workers, Psychiatric Nurse Practitioners, MA Level, Behavior and Addition Specialists, and BH licensed practitioners	Residential, Inpatient Hospital and Outpatient Hospital mental health and substance abuse services are not covered.	H0004	ALCOHOL AND/OR DRUG SERVICES
				H0031	MENTAL HEALTH ASSESSMENT
				H0049	ALCOHOL AND/OR DRUG SCREENING
				H2011	CRISIS INTERVENTION PER QTR HR
				H2014	SKILLED TRAINING & DEVELOPMENT
				H2015	COMPREHENSIVE COMMUNITY SUPPORTS/15
				H2017	PSYCHOSOCIAL REHAB SERVICES
				H2021	COMMUNITY BASED WRAP AROUND SERVICES
				T1016	CASE MANG WAIVER SERV 15 MINUTE UVS
				90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW
				90802	INTERACTIVE PSYCHIATRIC DX INTERVIEW
				90804	INDIV PSYCHOTH INSIGHT ORIE 20-30MIN
				90805	PSYCHOTH INSIGHT ORIE 20-30MIN W/E&M
				90806	INDIV PSYCHOTH INSIGHT ORIE 45-50 MIN
				90807	PSYCHOTH INSIGHT ORIE 45-50 MIN W/E&M
				90808	INDIV PSYCHOTH INSIGHT ORIE 75-80MIN
				90809	PSYCHOTH INSIGHT ORIE 75-80MIN W/E&M
				90810	INDIV PSYCHOTH INTERACTIVE 20-30 MIN
				90811	PSYCHOTH INTERACTIVE 20-30 MIN W/E&M
				90812	INDIV PSYCHOTH INTERACTIVE 45-50 MIN
				90813	PSYCHOTH INTERACTIVE 45-50 MIN W/E&M
				90814	INDIV PSYCHOTH INTERACTIVE 75-80 MIN
				90815	PSYCHOTH INTERACTIVE 75-80 MIN W/E&M
				90846	FAMILY MEDICAL PSYCHOTHERAPY (WITHOU

Exhibit 5
Basic Behavioral Health Care Services

				90849	MULTIPLE FAMILY GROUP PSYCHOTHER
				90853	GROUP PSYCHOTHERAPY Y
				90855	INTERACTIVE INDIVIDUAL MEDICAL PSYCH
				90857	INTERACTIVE GROUP MEDICAL PSYCHOTHER
				90887	CONSULTATION WITH FAMILY
				96101	PSYCHOLOGICAL TESTING PER HOUR
				96102	PSYCHO TESTING BY TECHNICIAN
				96115	NEUROBEHAVIOR STATUS EXAM
				96116	NEUROBEHAVIORAL STATUS EXAM
				96117	NEUROPSYCH TEST BATTERY
				96118	NEUROPSYCH TST BY PSYCH/PHYS
				96119	NEUROPSYCH TESTING BY TECH
				96120	NEUROPSYCH TST ADMIN W/COMP
				96125	STANDARDIZED COGNITIVE PERFORMANCE T
				96150	ASSESS HLTH/BEHAVE, INIT
				96151	ASSESS HLTH/BEHAVE, SUBSEQ
				96152	INTERVENE HLTH/BEHAVE, INDIV
				96153	INTERVENE HLTH/BEHAVE, GROUP
				96154	INTERV HLTH/BEHAV, FAM W/PT
				96372	THERAPEUTIC, PROPHYLACTIC, OR DIAGNO
				99202	OFFICE,NEW PT,EXPANDED,STRAIGHTFOWD
				99203	OFFICE,NEW PT, DETAILED, LOW COMPLEX
				99204	OFFICE/OUTPATIENT,NEW MOD COMPLEXITY
				99205	OFFICE,NEW PT, COMPREHEN, HIGH COMPX
				99211	OFFICE,EST PT, MINIMAL PROBLEMS
				99212	OFFICE,EST PT, PROBLEM,STRAITFORWD
				99213	OFFICE,EST PT, EXPANDED, LOW COMPLEX

Exhibit 5
Basic Behavioral Health Care Services

				99214	OFFICE,EST PT, DETAILED, MOD COMPLX
				99215	OFFICE,EST PT, COMPREHEN,HIGH COMPLX
				99241	OFF CONSULT,NRE PT,PRBLM,STRTFWD
				99242	OFF CONSLT,NRE PT,XPND PBLM, STRTFWD
				99243	OFF CNSLT,NRE PT,DTLD, LO CMPLXY
				99244	OFF CNSLT,NRE PT,CMPHSV,MOD CMPLXY
				99245	OFF CNSLT,NRE PT,CMPHSV,HI CMPLXY
				99354	PROLONGED PHYSICIAN SERVICE IN THE O
				99356	PROLONGED PHYSICIAN SERVICE IN THE I
				99357	PROLONGED PHYSICIAN SERVICE IN THE I
				99358	PROLONGED EVALUATION AND MANAGEMENT
				99359	PROLONGED EVALUATION AND MANAGEMENT
				99366	MEDICAL TEAM CONFERENCE WITH INTERDI
				99367	MEDICAL TEAM CONFERENCE WITH INTERDI
				99368	MEDICAL TEAM CONFERENCE WITH INTERDI
				99385	INIT COMP PREV MED 18-39 YRS
				99386	INIT COMP PREV MED 40-64 YRS
				99395	PERIODIC COMP PREV MED 18-39 YRS
				99396	PERIODIC COMP PREV MED 40-64 YRS
				99403	COUNSELING AND/OR RISK FACTOR REDUCT
				99404	COUNSELING AND/OR RISK FACTOR REDUCT
				99406	SMOKING AND TOBACCO USE CESSATION CO
				99407	BEHAV CHNG SMOKING > 10 MIN
				99408	ALCOHOL AND/OR SUBSTANCE (OTHER THAN
				99409	ALCOHOL AND/OR SUBSTANCE (OTHER

Exhibit 5
Basic Behavioral Health Care Services

					THAN
				99411	COUNSELING AND/OR RISK FACTOR REDUCT
				99412	COUNSELING AND/OR RISK FACTOR REDUCT
				99420	ADMINIS & INTERP HLTH RSK ASSMT INST
				99429	UNLISTED PREVENTIVE MEDICINE SERVICE
				99441	TELEPHONE EVALUATION AND MANAGEMENT
				99442	TELEPHONE EVALUATION AND MANAGEMENT
				99443	TELEPHONE EVALUATION AND MANAGEMENT
				99444	ONLINE EVALUATION AND MANAGEMENT SER
				H0033*	MEDICATION ADMIN.
				90862	PHARMACOLOGIC MGMT ER VISIT)
				*Insufficient to justify an encounter payment Or successor codes	
Lab	Laboratory testing routinely available in a clinic or physician office setting. Laboratory services meeting this criteria (see code set) are covered services whether provided by the GNOCHC provider or sent to an independent lab Clinical diagnostic laboratory testing is paid outside the encounter rate according to the Medicaid	▪ Furnished by a laboratory that meets the requirements of 42 CFR 493	Behavioral health care provider ordered	80100*	DRUG SCREENING QUAL MLT DRUG CLASSES CHROM EA PX
				80101*	DRUG SCREEN
				80152*	AMITRIPTYLINE (ANTIDEPRESSANT)
				80154*	BENZODIAZEPINES
				80156*	CARBAMAZEPINE (MOOD STABILIZERS)
				80160*	DESIPRAMINE (ANTIDEPRESSANT)
				80162*	DOXEPIN
				80164*	VALPROIC ACID LEVEL
				80178*	LITHIUM
				80173*	HALOPERIDOL (ANTIPSYCHOTIC)
				80174*	IMIPRAMINE
				80182*	NORTRIPTYLINE

Exhibit 5
Basic Behavioral Health Care Services

	fee-for-service schedule			80184*	PHENOBARITOL
				82075*	ALCOHOL BREATHING
				82383*	ASSAY BLOOD CATECHOLAMINE (STRESS)
				83840*	METHADONE
				84260*	SERATONIN
				85025*	CBC
				86592*	RPR
				*Insufficient to justify an encounter payment Or successor codes	

Exhibit 6
Serious Mental Illness Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
Serious Mental Illness Behavioral Health Care Services	Mental health and/or substance abuse screening, assessment, counseling, medication management, treatment, follow-up, and community support services. Individuals who meet the federal definition of SMI, including those who also have a co-occurring addictive disorder and those who previously were identified as SMI and are in need of maintenance services, are eligible to receive SMI behavioral health care services.	▪ Jefferson Parish Human Services Authority and Metropolitan Human Services District only ▪ Practitioners authorized to provide services directly or under supervision by Medicaid MH Clinic policies ▪ Licensed Psychiatrists, Licensed physicians, Psychologists, Social Workers, Psychiatric Nurse Practitioners, MA Level, Behavior and Addition Specialists, and BH licensed practitioners	Residential, Inpatient Hospital and Outpatient Hospital mental health and substance abuse services are not covered. Total dollars expended shall not exceed 10 percent of the total computable expenditures under the Demonstration.	H0004	ALCOHOL AND/OR DRUG SERVICES
				H0031	MENTAL HEALTH ASSESSMENT
				H0049	ALCOHOL AND/OR DRUG SCREENING
				H2011	CRISIS INTERVENTION PER QTR HR
				H2014	SKILLED TRAINING & DEVELOPMENT
				H2015	COMPREHENSIVE COMMUNITY SUPPORTS/15
				H2017	PSYCHOSOCIAL REHAB SERVICES
				H2021	COMMUNITY BASED WRAP AROUND SERVICES
				T1016	CASE MANG WAIVER SERV 15 MINUTE UVS
				90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW
				90802	INTERACTIVE PSYCHIATRIC DX INTERVIEW
				90804	INDIV PSYCHOTH INSIGHT ORIE 20-30MIN
				90805	PSYCHOTH INSIGHT ORIE 20-30MIN W/E&M
				90806	INDIV PSYCHOTH INSIGHT ORIE 45-50 MIN
				90807	PSYCHOTH INSIGHT ORIE 45-50 MIN W/E&M
				90808	INDIV PSYCHOTH INSIGHT ORIE 75-80MIN
				90809	PSYCHOTH INSIGHT ORIE 75-80MIN W/E&M
				90810	INDIV PSYCHOTH INTERACTIVE 20-30 MIN
				90811	PSYCHOTH INTERACTIVE 20-30 MIN

Exhibit 6
Serious Mental Illness Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
					W/E&M
				90812	INDIV PSYCHOTH INTERACTIVE 45-50 MIN
				90813	PSYCHOTH INTERACTIVE 45-50 MIN W/E&M
				90814	INDIV PSYCHOTH INTERACTIVE 75-80 MIN
				90815	PSYCHOTH INTERACTIVE 75-80 MIN W/E&M
				90846	FAMILY MEDICAL PSYCHOTHERAPY (WITHOU
				90849	MULTIPLE FAMILY GROUP PSYCHOTHER
				90853	GROUP PSYCHOTHERAPY Y
				90855	INTERACTIVE INDIVIDUAL MEDICAL PSYCH
				90857	INTERACTIVE GROUP MEDICAL PSYCHOTHER
				90887	CONSULTATION WITH FAMILY
				96101	PSYCHOLOGICAL TESTING PER HOUR
				96102	PSYCHO TESTING BY TECHNICIAN
				96115	NEUROBEHAVIOR STATUS EXAM
				96116	NEUROBEHAVIORAL STATUS EXAM
				96117	NEUROPSYCH TEST BATTERY
				96118	NEUROPSYCH TST BY PSYCH/PHYS
				96119	NEUROPSYCH TESTING BY TECH
				96120	NEUROPSYCH TST ADMIN W/COMP
				96125	STANDARDIZED COGNITIVE PERFORMANCE T
				96150	ASSESS HLTH/BEHAVE, INIT

Exhibit 6
Serious Mental Illness Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
				96151	ASSESS HLTH/BEHAVE, SUBSEQ
				96152	INTERVENE HLTH/BEHAVE, INDIV
				96153	INTERVENE HLTH/BEHAVE, GROUP
				96154	INTERV HLTH/BEHAV, FAM W/PT
				96372	THERAPEUTIC, PROPHYLACTIC, OR DIAGNO
				99202	OFFICE,NEW PT,EXPANDED,STRAIGHTFOWD
				99203	OFFICE,NEW PT, DETAILED, LOW COMPLEX
				99204	OFFICE/OUTPATIENT,NEW MOD COMPLEXITY
				99205	OFFICE,NEW PT, COMPREHEN, HIGH COMPX
				99211	OFFICE,EST PT, MINIMAL PROBLEMS
				99212	OFFICE,EST PT, PROBLEM,STRAITFORWD
				99213	OFFICE,EST PT, EXPANDED, LOW COMPLEX
				99214	OFFICE,EST PT, DETAILED, MOD COMPLX
				99215	OFFICE,EST PT, COMPREHEN,HIGH COMPLX
				99241	OFF CONSULT,NRE PT,PRBLM,STRTFWD
				99242	OFF CONSLT,NRE PT,XPND PBLM, STRTFWD
				99243	OFF CNSLT,NRE PT,DTLD, LO CMPLXY
				99244	OFF CNSLT,NRE PT,CMPHSV,MOD CMPLXY
				99245	OFF CNSLT,NRE PT,CMPHSV,HI

Exhibit 6
Serious Mental Illness Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
					CMPLXY
				99354	PROLONGED PHYSICIAN SERVICE
				99356	PROLONGED PHYSICIAN SERVICE
				99357	PROLONGED PHYSICIAN SERVICE
				99358	PROLONGED EVALUATION AND MANAGEMENT
				99359	PROLONGED EVALUATION AND MANAGEMENT
				99366	MEDICAL TEAM CONFERENCE WITH INTERDI
				99367	MEDICAL TEAM CONFERENCE WITH INTERDI
				99368	MEDICAL TEAM CONFERENCE WITH INTERDI
				99385	INIT COMP PREV MED 18-39 YRS
				99386	INIT COMP PREV MED 40-64 YRS
				99395	PERIODIC COMP PREV MED 18-39 YRS
				99396	PERIODIC COMP PREV MED 40-64 YRS
				99403	COUNSELING AND/OR RISK FACTOR REDUCT
				99404	COUNSELING AND/OR RISK FACTOR REDUCT
				99406	SMOKING AND TOBACCO USE CESSATION CO
				99407	BEHAV CHNG SMOKING > 10 MIN
				99408	ALCOHOL AND/OR SUBSTANCE (OTHER THAN
				99409	ALCOHOL AND/OR SUBSTANCE (OTHER THAN
				99411	COUNSELING AND/OR RISK FACTOR

Exhibit 6
Serious Mental Illness Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
					REDUCT
				99412	COUNSELING AND/OR RISK FACTOR REDUCT
				99420	ADMINIS & INTERP HLTH RSK ASSMT INST
				99429	UNLISTED PREVENTIVE MEDICINE SERVICE
				99441	TELEPHONE EVALUATION AND MANAGEMENT
				99442	TELEPHONE EVALUATION AND MANAGEMENT
				99443	TELEPHONE EVALUATION AND MANAGEMENT
				99444	ONLINE EVALUATION AND MANAGEMENT SER
				H0033*	MEDICATION ADMIN.
				90862	PHARMACOLOGIC MGMT ER VISIT)
				*Insufficient to justify an encounter visit Or successor codes	
Lab	Laboratory testing routinely available in a clinic or physician office setting. Laboratory services meeting this criteria (see code set) are covered services whether provided by the GNOCHC provider or sent to an independent lab	▪ Furnished by a laboratory that meets the requirements of 42 CFR 493	Behavioral health care provider ordered	80100*	DRUG SCREENING QUAL MLT DRUG CLASSES CHROM EA PX
				80101*	DRUG SCREEN
				80152*	AMITRIPTYLINE (ANTIDEPRESSANT)
				80154*	BENZODIAZEPINES
				80156*	CARBAMAZEPINE (MOOD STABILIZERS)
				80160*	DESIPRAMINE (ANTIDEPRESSANT)
				80162*	DOXEPIN
				80164*	VALPROIC ACID LEVEL
				80178*	LITHIUM

Exhibit 6
Serious Mental Illness Behavioral Health Care Services

Service	Definition	Provider Qualifications	Service Limitations and Prior Authorization	Applicable HCPCS and CPT Coding	
	Clinical diagnostic laboratory testing is paid outside the encounter rate according to the Medicaid fee-for-service schedule			80173*	HALOPERIDOL (ANTIPSYCHOTIC)
				80174*	IMIPRAMINE
				80182*	NORTRIPTYLINE
				80184*	PHENOBARITOL
				82075*	ALCOHOL BREATHING
				82383*	ASSAY BLOOD CATECHOLAMINE (STRESS)
				83840*	METHADONE
				84260*	SERATONIN
				85025*	CBC
				86592*	RPR
				*Insufficient to justify an encounter payment Or successor codes	

Service	Definition	Provider Qualifications	Service Limitations	Applicable Coding
		•		

Exhibit 7
Infrastructure Investment

Payments for infrastructure costs will cover expenditures to support eligible providers' delivery of services, billing for services, financial accountability, and encounter and quality reporting. Infrastructure payments will not cover any costs for the acquisition, construction, alteration or renovation of bricks and mortar. Payments will vary by provider based on proposals submitted by participating providers and the State's assessment of the extent to which the proposal targets the following five areas of infrastructure investments critical to provider readiness for Phase 2 of the Demonstration and listed in order of priority to the State:

1. To acquire, install and train staff to operate practice management, billing, financial and data collection systems required for payment, encounter reporting and accountability
2. To enhance care management capacity through the acquisition of care/case management systems, development of comprehensive care management protocols and in depth staff training
3. To acquire technical assistance to gain NCQA PCMH recognition and to cover the costs of the NCQA PCMH application process
4. To develop, acquire, install data collection/reporting systems required to participate in quality and performance improvement incentive programs
5. To acquire and install equipment required for telemedicine consults and/or mobile service capacity

Proposals will be rated on both the extent to which they target infrastructure investments in priority order and:

- Detailed the work plan for the project and an achievable timeline
- Demonstrate provider capacity to manage the infrastructure project
- Demonstrate cost effectiveness of the proposal (e.g., joint ventures that reduce design, development and implementation costs or projects that build on infrastructure in place among participating providers)
- Identify the level and source of other funds available to support or partially support the investment (e.g. Foundation or federal funds such as HIT)
- Provide detailed documentation and a reasonable basis for cost estimates included in the proposal (including a description of all other alternatives considered and the relative cost of those alternatives)
- Demonstrate that the provider can account for expenditures of infrastructure funds as distinct from the ongoing costs of operations
- Build community partnerships (e.g. hospitals, insurers) which contribute to the long term sustainability of the provider (e.g. regional HIE participation)

The State will issue a Request for Proposals for infrastructure investments by participating providers upon CMS approval of this Funding and Reimbursement protocol. Proposals will be reviewed by a team selected by the State and comprised of Demonstration managers, health care billing and practice management professionals, and information technology experts.
Consistent with the expenditure authority approved by CMS for the Demonstration, the sum total of payments for infrastructure investments shall not exceed 10 percent of the total computable expenditures under the Demonstration.

Exhibit 8
Care Coordination

STC number 17 defines Care Coordination, as follows:

> *"Care coordination includes services delivered by health provider teams to empower patients in their health and health care and improve the efficiency and effectiveness the health sector. These services may include health education and coaching, navigation of the medical home services and the health care system at large, coordination of care with other providers including diagnostics and hospital services, support with the social determinants of health such as access to healthy food and exercise. Care coordination also requires health care team activities focused on the patient and communities' health including outreach, quality improvement and panel management."*

In this definition, DHH has identified two different types of Care Coordination:

1. Enrollee Care Coordination
2. Community Care Coordination

Reimbursement for enrollee care coordination is included in the primary care encounter rate until PCMH choice and assignment processes are established. Once PCMH choice and assignment processes are established, a care coordination fee will be paid separately based on a Per Member Per Encounter rate to the enrollee's designated PCMH.

Reimbursement for community care coordination will be through targeted payments and will cover provider initiatives to improve the health of the communities they serve, including but not limited to:

- Community health promotion
- Events to increase health awareness by providing health screenings, activities, materials, Demonstrations, and information
- Education to increase awareness of local, state, and national health services and resources and assist with navigation of the health care system at large
- Health and wellness education
- Disease prevention education
- Teaching "self-care" practices that lead to improved health status
- Education on chronic disease self-management
- Efforts to improve access to no-cost or low-cost healthy food and exercise
- Events to motivate participants to make positive health behavior changes
- Peer education and peer support/counseling to enhance culturally competent care
- Programs that identify and respond to high-prevalence health problems in the community

Exhibit 9
National Committee for Quality Assurance Patient Centered Medical Home

The National Committee for Quality Assurance's (NCQA) Patient Centered Medical Home (PCMH) recognition process focuses a series of standards and measures of performance in a primary care practice, built on the following key elements:

- Personal physician. Each patient has an ongoing relationship with a personal physician who is trained to provide first contact, continuous and comprehensive care.
- Physician-directed medical practice. The personal physician leads a team of individuals at the practice level who collectively take responsibility for ongoing patient care.
- Whole-person orientation. The personal physician is responsible for providing all of the patient's health care needs or for arranging care with other qualified professionals.
- Care is coordinated and integrated across all elements of the complex health care system and the patient's community.
- Quality and safety are hallmarks of the medical home.
- Enhanced access to care is available through open scheduling, expanded hours and other innovative options for communication between patients, their personal physician and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.

NCQA recognition is based on meeting specific elements included in nine standard categories:

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Patient Self-Management and Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communication.

Included in the NCQA PCC-PCMH standards are 10 "must-pass" elements.

1. PPC-1A: Written standards for patient access and patient communication
2. PPC-1B: Use of data to show standards for patient access and communication are met
3. PPC-2D: Use of paper or electronic charting tools to organize clinical information
4. PPC-2E: Use of data to identify important diagnoses and conditions in practice
5. PPC-3A: Adoption and implementation of evidence-based guidelines for three chronic or important conditions
6. PPC-4B: Active support of patient self-management
7. PPC-6A: Systematic tracking of tests and follow up on test results
8. PPC-7A: Systematic tracking of critical referrals
9. PPC-8A: Measurement of clinical and/or service performance
10. PPC-8C: Performance reporting by physician or across the practice

NCQA's review and recognition process recognizes three levels of PCMH, which recognize the

evolution of practices over time from basic compliance (Level-1) to full compliance with these10 essential characteristics (Level 3).

- To achieve Level 1 Recognition, practices must successfully comply with at least 5 of the "must-pass" elements.

- Achieving Level 2 or Level 3 Recognition depends on overall scoring and requires compliance with all 10 "must pass" elements

Each of the three levels of PCMH recognition will be assigned a different rate for payment rate. Consistent with the numeric scale of NCQA recognition compliance with its PCMH standards, the payment rate for Level 1, recognizing basic compliance, will be lowest, and the rate for Level 3, recognizing full compliance the highest. The rate for Level 2 will be a midpoint between the rates for Levels 1 and 3.

Exhibit 10
Encounter Data Requirements

Requirements for reporting encounter data for covered services will differ for the pre- and post-September 30, 2011 periods.

For the period October 1, 2010 through September 30, 2011, providers may report encounter data for enrollees in one of two formats specified by DHH:

1. CMS 1500 format to the State's fiscal intermediary (See Exhibit 11)
2. Excel spreadsheet format to DHH

The Excel spreadsheet format will require providers to report on encounter data elements, including but not limited to the following:

- Reporting period
- Provider name
- Provider number
- Enrollee name
- Enrollee number
- Date of birth
- Social Security number
- Date of service
- Type of service
- Units of service
- Procedure code(s)
- Diagnosis code(s)

Encounter data reported in Excel format will be due quarterly thirty days after the end of the reporting period or sixty days after CMS approval of the funding protocol, whichever is later.

Effective September 30, 2011, providers will report encounter data for enrollees directly to the State's fiscal intermediary in paper or electronic CMS 1500 format as specified by DHH. The 1500 format specified for GNOCHC is based on the format used by the State Medicaid program for Federally Qualified Health Centers and Rural Health Centers, which provides for data reporting at both the encounter and service detail level.

The GNOCHC 1500 format will use CPT and HCPCS codes.

The table below describes the required primary and behavioral health care encounter data elements and edits to be applied leading to acceptance or rejection of the encounter.

Primary and behavioral health care encounter submittals may be rejected at three levels: the entire file, the encounter level, or the detail level. GNOCHC providers must correct and resubmit denied primary and behavioral health care encounters on the encounter submittal for the following month.

Data validation under GNOCHC will mimic data validation proposed for the CCN program to be implemented in 2012. DHH will randomly sample medical records for services provided directly or provided indirectly and paid for by eligible providers. The encounter record will be evaluated

on its completeness and consistency with the medical record.

DHH reserves the right to refuse payment for primary and behavioral health care encounters to eligible providers that achieve less than a 90% encounter submittal rate for primary and behavioral health care.

Exhibit 10
Encounter Data Requirements

CMS-1500 Billing Instructions For
Greater New Orleans Community Health Connection (GNOCHC)

Alerts below indicate when claims will be rejected back to the provider without entry into the system if the information is missing or incorrect. With the exception of those fields with Alerts, claims will deny through the claims processing system if the necessary information is not present on the claim.

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	**Required** -- Enter an "X" in the box marked Medicaid (Medicaid #).	**GNOCHC providers should mark the Medicaid indicator.**
1a	Insured's I.D. Number	**Required** – Enter the recipient's 13 digit GNOCHC ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS. **NOTE:** The recipients' 13-digit ID number must be used to bill claims. The CCN number from the plastic ID card is **NOT** acceptable. The ID number must match the recipient's name in Block 2.	**The 13-digit GNOCHC number and the 13-digit Medicaid number are the same number.**
2	Patient's Name	**Required** – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date Sex	**Optional** – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	**Leave Blank**	
5	Patient's Address	**Leave Blank**	
6	Patient Relationship to Insured	**Leave Blank**	
7	Insured's Address	**Leave Blank**	
8	Patient Status	**Leave Blank**	
9	Other Insured's Name	**Leave Blank**	
9a	Other Insured's Policy or Group Number	**Leave Blank**	
9b	Other Insured's Date of Birth Sex	**Leave Blank**	
9c	Employer's Name or School Name	**Leave Blank**	

Exhibit 10
Encounter Data Requirements

Locator #	Description	Instructions	Alerts
9d	Insurance Plan Name or Program Name	**Leave Blank**	
10 a. b. c.	Is Patient's Condition Related To: Employment Auto Accident Other Accident	**Situational** – Complete if the services are related to the patient's employment, an auto accident or another type of accident.	
11	Insured's Policy Group or FECA Number	**Leave Blank**	
11a	Insured's Date of Birth Sex	**Leave Blank**	
11b	Employer's Name or School Name	**Leave Blank**	
11c	Insurance Plan Name or Program Name	**Leave Blank**	
11d	Is There Another Health Benefit Plan?	**Leave Blank**	
12	Patient's or Authorized Person's Signature (Release of Records)	**Leave Blank**	
13	Patient's or Authorized Person's Signature (Payment)	**Leave Blank**	
14	Date of Current Illness / Injury / Pregnancy	**Leave Blank**	
15	If Patient Has Had Same or Similar Illness Give First Date	**Leave Blank**	
16	Dates Patient Unable to Work in Current Occupation	**Leave Blank**	
17	Name of Referring Provider or Other Source	**Leave Blank**	
17a	Unlabelled	**Leave Blank**	
17b	NPI	**Leave Blank**	

Exhibit 10
Encounter Data Requirements

Locator #	Description	Instructions	Alerts
18	Hospitalization Dates Related to Current Services	**Situational** – Complete if appropriate or leave blank	
19	Reserved for Local Use	Reserved for future use. Do not use.	**Usage to be determined.**
20	Outside Lab?	**Leave Blank**	
21	Diagnosis or Nature of Illness or Injury	**Required** -- Enter the most current ICD-9 numeric diagnosis code and, if desired, narrative description.	**The most current and specific diagnosis code(s) must be entered.**
22	Medicaid Resubmission Code	**Situational.** If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field. Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field. Appropriate reason codes follow: Adjustments 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only -Recovery 99 = Other Voids 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other	**To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different Internal Control Number (ICN).**
23	Prior Authorization Number	**Leave Blank**	
24	Supplemental Information	**Situational** – Applies to the detail lines for drugs and biologicals only. In addition to the procedure code, **the National Drug Code (NDC)** is **required** by the Deficit Reduction Act of 2005 for **physician-administered drugs** and **shall be entered** in the **shaded** section of 24A through 24G. **Claims for these drugs shall include the NDC from the label of the product**	**GNOCHC providers who administer drugs and biologicals must enter this drug-related information in the SHADED section of 24A – 24G of**

Exhibit 10
Encounter Data Requirements

<table>
<tr><th>Locator #</th><th>Description</th><th>Instructions</th><th>Alerts</th></tr>
<tr><td>24 (cont'd)</td><td></td><td><u>administered.</u>

To report additional information related to HCPCS codes billed in 24D, physicians and other providers who administer drugs and biologicals must enter the Qualifier N4 followed by the NDC. Do not enter a space between the qualifier and the NDC. Do not enter hyphens or spaces within the NDC.

Providers should then leave one space then enter the appropriate Unit Qualifier (see below) and the actual units administered. Leave three spaces and then enter the brand name as the written description of the drug administered in the remaining space.

The following qualifiers are to be used when reporting NDC units:

F2 International Unit
ML Milliliter
GR Gram
UN Unit</td><td>the appropriate detail line(s) for the drug or biological – not the encounter line.

This information must be entered in addition to the procedure code(s).</td></tr>
<tr><td>24A</td><td>Date(s) of Service</td><td>Required -- Enter the date of service for each procedure.

Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</td><td>Six-digit or 8-digit dates can be used on paper claims.

Only 8-digit dates can be used for electronic (EDI) claims.</td></tr>
<tr><td>24B</td><td>Place of Service</td><td>Required -- Enter the appropriate place of service code for the services rendered.
Acceptable Place of Service Codes are:

<table>
<tr><th>Code</th><th>Definition</th></tr>
<tr><td>04</td><td>Homeless Shelter</td></tr>
<tr><td>11</td><td>Office</td></tr>
<tr><td>12</td><td>Home</td></tr>
<tr><td>15</td><td>Mobile Unit</td></tr>
<tr><td>49</td><td>Independent Clinic</td></tr>
<tr><td>50</td><td>Federally Qualified Health Center</td></tr>
<tr><td>53</td><td>Community Mental Health Center</td></tr>
<tr><td>57</td><td>Non-Residential Substance Abuse Treatment Facility</td></tr>
<tr><td>71</td><td>State or Local Public Health Clinic</td></tr>
<tr><td>72</td><td>Rural Health Clinic</td></tr>
<tr><td>81</td><td>Independent Laboratory</td></tr>
</table></td><td></td></tr>
</table>

Exhibit 10
Encounter Data Requirements

Locator #	Description	Instructions	Alerts
24C	EMG	**Leave Blank**	
24D	Procedures, Services, or Supplies	**Required** -- Enter the procedure code(s) for services rendered. The appropriate modifier must be appended to the encounter code. The primary care encounter does not have a modifier. Use TF for the Basic Behavioral Health Encounter and TG for the SMI Behavioral Health Encounter. The primary care encounter and one behavioral health encounter may be billed on the same date of service if both types of visits occur. Enter the GNOCHC encounter procedure code on the first line. **Encounter Code = T1015** In addition to the encounter code, it is necessary to indicate on subsequent lines the specific services provided by entering the individual procedure code and description for each service rendered.	**The encounter code must be present on the claim, accompanied by at least 1 detail line for a covered service.** **All services should be included as detail lines.** **If the detail line is for drugs or biologicals, entering the appropriate information from Block 24 is required.**
24E	Diagnosis Pointer	**Required** – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number ("1", "2", etc.) in this block. More than one diagnosis/reference number may be related to a single procedure code.	
24F	$Charges	**Required** -- Enter usual and customary (U&C) charges or zero for detail lines.	
24G	Days or Units	**Required** -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	**Leave Blank**	
24I	I.D. Qual.	**Optional** - The I.D. Qualifier indicates what type of identifying provider number is being entered in 24J.	**This field can be left blank for GNOCHC.**
24J	Rendering Provider I.D. #	**Required** - Enter the Rendering Provider's GNOCHC Provider Number in the shaded portion of the block. Entering the Rendering Provider's NPI in the non-shaded portion of the block.	
25	Federal Tax I.D. Number	**Optional.**	
26	Patient's Account No.	**Situational** – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20	

Exhibit 10
Encounter Data Requirements

Locator #	Description	Instructions	Alerts
		characters.	
27	Accept Assignment?	**Leave Blank -** Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	**Required** – Enter the total of all charges listed on the claim.	
29	Amount Paid	**Leave Blank**	
30	Balance Due	**Leave Blank**	
31	Signature of Physician or Supplier Including Degrees or Credentials Date	**Required** -- The claim form **MUST** be signed. The practitioner or the practitioner's authorized representative must sign the form. Signature stamps or computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative. If this signature does not have original initials, the claim will be returned unprocessed. **Required** -- Enter the date of the signature.	**The claim will be rejected if an original signature or original initial (for stamped or computer generated signatures) is not present.**
32	Service Facility Location Information	**Leave Blank**	
32a	NPI	**Leave Blank**	
32b	Unlabelled	**Leave Blank**	
33	Billing Provider Info & Ph #	**Required** -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	**Required** – Enter the GNOCHC billing provider's NPI.	
33b	Unlabelled	**Required** – Enter the billing provider's 7-digit GNOCHC Provider Number.	**Claims will be rejected if this information is not present on the claim form.**

The following is a list of eligible providers under the Demonstration as of May 11, 2011. The State will notify CMS Regional Office of any changes to the list in a timely manner.

Jefferson Parish – Greater New Orleans Community Health Connection Sites				
Eligible Provider Name	**Eligible Provider Address**	**Eligible Provider Phone #**	**Type of Care**	**State Plan Provider Type**

Exhibit 10
Encounter Data Requirements

Daughters of Charity – Metairie	111 N Causeway Blvd. Metairie, LA 70001	(504)482-0084	Primary Care	FQHC
Jefferson Community Health Centers – Avondale	4028 US Hwy 90, Avondale, LA 70094	(504)436-2223	Primary Care	FQHC
Jefferson Community Health Centers – Grand Isle	108 Willow Ln, Grand Isle, LA 70358	(985)787-2066	Primary Care	Physician Services
Jefferson Community Health Centers – Marrero	1855 Ames Blvd, Marrero, LA 70072	(504)371-8958	Primary Care	FQHC
Jefferson Community Health Centers – River Ridge	11312 Jefferson Hwy, River Ridge, LA 70123	(504)463-3002	Primary Care	FQHC
JPHSA – East Bank	2400 Edenborn Ave, Metairie, LA 70001	(504)838-5257	Behavioral Health	Mental Health Clinic
JPHSA – West Bank	5001 Westbank Expwy, Marrero, LA 70072	(504)349-8708	Behavioral Health	Mental Health Clinic
Mercy Family Center	110 Veterans Memorial Blvd, Ste 425, Metairie, LA 70005	(888)950-0003	Behavioral Health	Physician Services
St. Charles Community Health Connection	200 W Esplanade Ave, Kenner, LA 70065	(504)712-7800	Primary Care	FQHC

Exhibit 10
Encounter Data Requirements

Orleans Parish – Greater New Orleans Community Health Connection Sites				
Eligible Provider Name	**Eligible Provider Address**	**Eligible Provider Phone #**	**Type of Care**	**State Plan Provider Type**
Algiers Community Health Clinic	1111 Newton St, New Orleans, LA 70114	(504)658-2550	Primary Care	FQHC
Algiers Community Health Connection	4422 Gen Meyer Ave, New Orleans, LA 70131	(504)361-6500	Behavioral Health	Mental Health Clinic
Central City Community Health	2221 Philip St, New Orleans, LA 70113	(504)568-6650	Behavioral Health	Mental Health Clinic
Chartres-Pontchartrain Community Health	719 Elysian Fields Ave, New Orleans, LA 70117	(504)942-8101	Behavioral Health	Mental Health Clinic
City of New Orleans Health Dept – Edna Pilsbury Health	2222 Simon Bolivar Ave, 2nd Fl, New Orleans, LA 70113	(504)658-2825	Primary Care	FQHC
City of New Orleans Health Dept – Care for the Homeless	2222 Simon Bolivar Ave, New Orleans, LA 70113	(504)658-2785	Primary Care	Physician Services
City of New Orleans Health Dept – New Orleans East	5640 Read Blvd, #540, New Orleans, LA 70127	(504)658-2750	Primary Care	Physician Service
Common Ground Health Clinic	1400 Teche St, New Orleans, LA 70114	(504)361-9800	Primary Care	Physician Services
Daughters of Charity – Carrollton	3201 S Carrollton Ave, New Orleans, LA 70118	(504)207-3060	Primary Care	FQHC
Daughters of Charity – St. Cecelia	1030 Lesseps St, New Orleans, LA 70117	(504)941-6041	Primary Care	FQHC
EXCELth Family Health Center	2050 Caton St, New Orleans, LA 70122	(504)524-1210	Primary Care	FQHC
Family Health Center	1501 Newton St, Ste C, New Orleans, LA 70114	(504)361-3777	Primary Care	Physician Services
Interim LSU Public Hospital – HIV OP Program	136 S Roman St, New Orleans, LA 70112	(504)903-6572	Primary Care	Physician Services
Interim LSU Public Hospital – L B Landry Community Clinic	1200 L B Landry, New Orleans, LA 70114	(504)308-3550	Primary Care	Physician Services
Interim LSU Public Hospital – Medical Home Care	1400 Poydras St, New Orleans, LA 70112	(504)903-2373	Primary Care	Physician Services
LSU Behavioral Science Ctr	3450 Chestnut St, New Orleans, LA 70115	(504)412-1580	Behavioral Health	Physician Services
MCLNO – Martin Behrman	725 Vallette St, New Orleans, LA 70114	(504)903-2373	Primary Care	Physician Services
New Orleans East Community Health	5552 Read Blvd, New Orleans, LA 70127	(504)243-7600	Behavioral Health	Mental Health

Exhibit 10
Encounter Data Requirements

Connection				Clinic
New Orleans Musicians' Clinic	2820 Napoleon Ave, Ste 890, New Orleans, LA 70115	(504)412-1366	Primary Care	Physician Services
NO/AIDS Task Force	2601 Tulane Ave, New Orleans, LA 70119	(504)821-2601	Primary Care	Physician Services
NOELA Community Health Center	4626 Alcee Fortier Blvd, Suite D, New Orleans, LA 70129	(504)255-8665	Primary Care	FQHC
Odyssey House	1125 N Tonti St, New Orleans, LA 70119	(504)378-7816	Primary Care	Physician Services
St. Thomas Community Health Ctr	1020 St. Andrew St, New Orleans, LA 70130	(504)529-5558	Primary Care	FQHC
Tulane Community Health	1430 Tulane Ave, SL16, New Orleans, LA 70112	(504)994-0054	Primary Care	Physician Services
Tulane Community Health Ctr at Covenant House	611 N Rampart St, New Orleans, LA 70112	(504)988-3000	Primary Care	Physician Services
Tulane Drop-In Center	1428 N Rampart St, New Orleans, LA 70112	(504)948-6701	Primary Care	Physician Services
Tulane Drop-In Clinic at Covenant House	611 N Rampart St, New Orleans, LA 70112	(504)584-1112	Primary Care	Physician Services
Tulane New Orleans Children's Health Project	1430 Tulane Ave, SL37, New Orleans, LA 70116	(504)988-0545	Primary Care	Physician Services
Walter L Cohen School Based Health Center	3520 Dryades St, New Orleans, LA 70115	(504)988-4180	Primary Care	Physician Services

St. Bernard Parish – Greater New Orleans Community Health Connection Sites				
Eligible Provider Name	**Eligible Provider Address**	**Eligible Provider Phone #**	**Type of Care**	**State Plan Provider Type**
St. Bernard Community Health Connection	7407 St. Bernard Ave, Ste A, Arabi, LA 70032	(504)278-7401	Behavioral Health	Mental Health Clinic
St. Bernard Health Ctr	7718 W Judge Perez Dr, Arabi, LA 70032	(504)281-2800	Primary Care	Physician Services

Attachment D – Administrative Protocol

Preface

In accordance with the Special Terms and Conditions (STCs) for the Greater New Orleans Community Health Connection (GNOCHC) waiver number 11-W-00252/6) demonstration, this document outlines the processes through which the State will satisfy the requirements of the STC paragraph 24, entitled "**Administrative Cost Claiming Protocol.**"

I. General Provisions

A. Applicability of Administrative Cost Claiming Protocol. This protocol is applicable to administrative costs incurred by the Louisiana Department of Health and Hospitals (LDHH) for administration of the program and includes expenses that are directly assigned to the Demonstration. This Protocol is not applicable to administrative costs incurred by GNOCHC providers or costs incurred prior to the Demonstration.

B. Office of Management and Budget (OMB) Circular A-87. All claims for federal financial participation (FFP) for administrative costs will be made in accordance with OMB Circular A-87 including direct charges of administrative costs to the Demonstration.

C. LDHH Cost Allocation Plan Administrative costs directly assigned to the Demonstration will be reflected in the LDHH's federally approved cost allocation plan.

D. Cooperative Endeavor Agreement (CEA). Administrative cost claims will also be in accordance with DHH's cooperative endeavor agreement with the Louisiana Division of Administration for the use of the Department of Housing and Urban Development's Community Development Block Grant funds. As required by the CEA, no funds authorized under this Demonstration will be used to cover any costs for the acquisition, construction, alteration, or renovation of "bricks and mortar."

E. Proper and Efficient Administration. Consistent with the requirements of 1903(a)(7) of the Social Security Act and 42.CFR.433.15(b)(7), administrative cost claims for FFP for the proper and efficient administration of the Demonstration will be at the 50 percent match rate. See Section II for a description of activities.

F. Reporting Category A new reporting category (4435) established for the Demonstration will account for LDHH directly assigned administrative expenses.

1. The reporting category will be used for administrative costs directly assigned to for the Demonstration only. No costs will be cost allocated to the Demonstration. This will allow for precise and complete accounting of Demonstration administrative costs reported on the CMS 64 9. Administrative costs will be reported on CMS 64.9 as waiver administrative costs not disproportionate share.

2. Payments to providers are not included in these reporting categories.

3. FFP will be claimed only for administrative costs directly assigned to this reporting category, preventing the comingling of funds.

4. Administrative costs associated with prior Demonstrations are not reflected in reporting category 4435.

G. Changes LDHH will submit all proposed changes to the Administrative Cost Claiming Protocol to CMS for review and approval.

H. Incorporation into the Accounting and Audit Protocol As required by the STC paragraph entitled, "Accounting and Audit Protocol," the Administrative Cost Claiming Protocol will be incorporated into the Accounting and Audit Protocol.

II. Allowable Administrative Costs

Administrative costs claimed under the Demonstration will be directly charged to the reporting category established for the program (4435).

Directly Assigned Administrative Costs

When any activity benefits the Demonstration specifically, the associated costs will be charged directly to the reporting category for the program. Directly assigned administrative costs under the Demonstration are limited to personnel and professional services. In accordance with OMB Circular A-87, "Costs of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the Federal Government."

A. *Personnel*

1. Documentation of LDHH Personnel Expense

Administrative costs for LDHH personnel (wages, benefits, travel and related operating expenses) performing Demonstration related activities will be directly assigned for those staff assigned 100% to the GNOCHC Demonstration. Directly assigned staff will provide an annual attestation utilizing **OMB Circular A-87, Attachment B, Item 8.h.(3)** as the basis for the annual attestation of full time assignment to GNOCHC functions. Directly assigned staff will be incorporated into the updated cost allocation plan.

2. Nature of Work Performed by Directly Assigned Personnel

Directly assigned personnel perform functions related to GNOCHC in three broad categories:

- Provider Relations

- Eligibility
- Program Administration

The functions performed in these three categories are detailed in Table 1.0 below.

Table 1.0 Functions of Directly Assigned DHH Personnel

Provider Relations ▪ Development and maintenance of provider enrollment processes for the Demonstration, including the provider enrollment criteria, application forms and processes, and coordination with fiscal intermediary on application review, approval and change processing; ▪ Development and maintenance of claims processing logic, including coordination with fiscal intermediary and Medicaid program operations staff; ▪ Development and maintenance of provider payment rates under the Demonstration, including management of a contract for actuarial services for encounter rate setting; ▪ Development and maintenance of a Provider Manual detailing all aspects of routine program operations, including but not limited to covered services definitions, reimbursement methods, reporting requirements; ▪ Communication with providers through the development and maintenance of a GNOCHC website to serve the informational needs of providers, including but not limited to Medicaid and Demonstration participating providers, weekly Remittance Advice statements, the bi-monthly Louisiana Medicaid Provider Update, periodic meetings and conference calls; ▪ Identification of training needs and provision of needed training, including coordination with fiscal intermediary; ▪ Development and management of Patient Centered Medical Home linkage processes; ▪ Development and management of provider reporting requirement processes, including forms and instructions and submission review; ▪ Development and issuance of a request for proposal for infrastructure investment, determination of allowable infrastructure investments, and monitoring of allowable infrastructure investment expenditures; ▪ Phone support for participating and non-participating providers providing general information about Demonstration, addressing billing concerns, and referrals for Demonstration enrollees; and ▪ Development and maintenance of eligibility verification through fiscal intermediary: swipe cards, online, and telephone.
Eligibility ▪ Development and maintenance of GNOCHC eligibility policy, procedure, and systems, including eligibility decision notices, online and application forms, medical eligibility cards, program flyers, etc.; ▪ Coordination with Eligibility Field Operations staff on outreach as appropriate; ▪ Coordination with Eligibility Supports staff to ensure that all participating GNOCHC providers are certified Medicaid Application Centers and remain incompliance;

- Coordinate with diverse internal and external partners to resolve individual enrollee issues and develop solutions to systemic problems as appropriate;
- Development and maintenance of a website to provide information about the Demonstration to the public, including covered services, network providers, and eligibility requirements;
- Monitor monthly third party liability reports and coordinate case maintenance with field staff ;
- Coordinate with Eligibility Field Operations staff on the development of training materials on GNOCHC eligibility policy and procedure, continuing guidance on GNOCHC relative to other Medicaid programs;
- Monitor program enrollment, including design and use of weekly and monthly reports by income and child-related status; and
- Field inquiries from participants and providers.

Program Administration

- Emergency and regular rulemaking, including coordination with the BHSF Policy Section on content development, fiscal impact statements, and public process;
- Development and management of the Cooperative Endeavor Agreement between DHH and the Division of Administration Disaster Recovery Unit to implement a Community Development Block Grant award to fund the State share of Demonstration expenditures, including routine invoicing and reporting;
- Administration of interim payments;
- Administration of the reconciliation of interim payments and actual payments;
- Administration of year end payment adjustments, including summary reporting to CMS;
- Development and management of contracts to support the development and implementation of the Demonstration, including but not limited to actuarial and enrollment broker services;
- Preparation of routine reports to CMS, including monthly progress reports and conference call materials, quarterly reports, annual reports;
- Development and monitoring of state budget relative to the Demonstration, including expenditure projections and budget adjustments;
- Represent the Demonstration in Medicaid Payment Error Rate Measurement program compliance efforts;
- Development and negotiation of Demonstration waiver documents subject to CMS approval, including but not limited to the special terms and conditions, expenditures authorities, and deliverables under the Demonstration, including attachments to the STCs such as the funding and reimbursement protocol, administrative cost claiming protocol, audit and accounting protocol, evaluation design, and evolution plan;
- Coordination of eligibility and benefits with other Medicaid programs, including behavioral health, family planning and coordinated care networks;
- Coordination with LDHH's birth outcomes initiative of which GNOCHC inter-pregnancy care coordination is one component; and
- Development and management of the Demonstration evaluation, including

internal data collection and analysis and oversight of any contract evaluators.

B. *Professional Services*

1. Documentation of Professional Services Expense

Professional services expenses will be directly assigned to the Demonstration according to contractor invoices detailing tasks, hours, and deliverables specific to the Demonstration. Invoices for professional services expenses specific to the Demonstration will be for a contract with a scope of work limited to the Demonstration as described in a. below.

a. Nature of Professional Services Activities

- Development of encounter data reporting requirements and mechanisms (STC 25 and 26);
- Planning for financial sustainability, including technical assistance to participating providers (STC 20);
- Development of the Evolution Plan (STC 53);
- Development of the Funding and Reimbursement Protocol (STC Attachment C);
- Implementation of the Funding and Reimbursement Protocol approved by CMS, including financial, rate and actuarial assistance;
- Development of the Administrative Cost Claiming Protocol (STC 24 and Attachment D);
- Development of the Accounting and Audit Protocol (STC 34 and Attachment E);
- Development of the Affordable Care Act Transition Plan (STC 37 and 53 e);
- Budget neutrality monitoring and reporting;
- Development and implementation of an Evaluation Design approved by CMS (STC 54 and 55); or
- Review of participating provider operations.
- .

C. *Notification*

1. The State will notify CMS and obtain CMS approval of all administrative changes which will impact the budget neutrality of the GNOCHC Demonstration.

III. Administrative Costs Incurred Prior to the Date of Approval of the Administrative Claiming Protocol

DHH will submit claims for Federal Financial Participation in the administrative costs of the

Attachment D – Administrative Protocol

Demonstration consistent with the approved Administrative Cost Claiming Protocol as prior period adjustments to the Form CMS-64.9 for GNOCHC waiver expenses beginning October 1, 2010 until the quarter subsequent to the approval date of this protocol.

Attachment E – Accounting and Audit Protocol (Due to CMS by March 1, 2011. See STC 34.)