DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

MAR 2 7 2014

Ruth Kennedy
Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 North 4th Street
Baton Rouge, LA 70802

Dear Ms. Kennedy:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your amendment request to the Louisiana's Greater New Orleans Community Health Connection (GNOCHC) section 1115 demonstration (Project No. 11-W-00252/6).

Per your February 2014 request, the amendment to the special terms and conditions (STCs) reflect an increase in the aggregate expenditure limit of the demonstration up to $105.6 million dollars due to the State's capacity to extend the non-federal share. This is an increase of $8.1 million to the available spending limit. The approval of the GNOCHC amendment is conditioned upon continued compliance with the enclosed STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Written acceptance should be sent to your project officer, Ms. Terri Fraser. Ms. Fraser's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard
Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5573
Email: Terri.Fraser@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Bill Brooks, Associate Regional Administrator in our Dallas Regional Office. Mr. Brook's contact information is as follows:

Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, TX 75202
Telephone: (214) 767-6495
Email: Bill.Brooks@cms.hhs.gov

If you have questions regarding this correspondence, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647. We look forward to continuing to work with you and your staff on the GNOCHC demonstration.

Sincerely,

Cindy Mann
Director

Enclosure

cc: Bill Brooks, Associate Regional Administrator, Region VI

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 the date of this approval through December 31, 2014, 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 three-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 effective through December 31, 2013. Effective January 1, 2014 with family income up to 100 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-eligible 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, 2014, capable of permanently providing primary care or behavioral health care services to residents in the Greater New Orleans region.

g. The state will provide 45-day 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, 2014, 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.** The maximum federal funding for the demonstration is the federal share of total computable expenditures of $105.6 million for DYs 1-5. Federal funding up the maximum available will be available for expenditures for payments for services furnished by GNOCHC providers based upon the applicable federal medical assistance percentage for the year in which the expenditures were incurred. An amendment will be required for any consideration of additional FFP above the $105.6 million limit. This limit also applies to expenditures for eligible administrative costs for the demonstration, as described in paragraph 24, for which federal funding will be at the rate of 50 percent.

23. No portion of the total award may be used for any expenditure other than the GNOCHC program. To the extent that the state maintains a consistent accounting system, 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.

24. **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.

25. **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.

26. **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.

27. **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.

28. **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.

29. **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.

30. **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.

31. **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

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

33. **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.

34. **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.

35. **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.

36. **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.

37. **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-eligible 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.

38. **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.

39. **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.

40. **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

41. **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).

42. **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.

43. **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 September 30, 2014.
   v. DY 5 (FFY) is defined as the period from October 1, 2014, through December 31, 2014.

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 2015 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, 2014, 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.

44. **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.

45. **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.

46. **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.

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

48. **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

49. **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.

50. **Risk.** The state shall be at risk for both the number of enrollees in the demonstration, as well as the aggregate cost for demonstration-eligible under this budget neutrality agreement.

51. **Budget Neutrality Expenditure Limit.** The budget neutrality expenditure limit must not exceed $105.6 million over the demonstration years 1 through 4 and the first quarter of FFY 2015.

52. **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.

53. **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

54. 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 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

55. **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?

56. **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.

57. **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.
04/01/2015	Submit draft final report	STC 39
07/01/2015	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