Greater New Orleans Community Health Connection
Section 1115 Demonstration Waiver

Renewal Application

Louisiana Department of Health and Hospitals

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DEPARTMENT OF HEALTH AND HOSPITALS

Louisiana Greater New Orleans Community Health Connection
Section 1115 Demonstration Renewal Application to the
Centers for Medicare & Medicaid Services

I. Background, Goals and Objectives

In the aftermath of Hurricanes Katrina and Rita, the Louisiana Department of Health and Hospitals (DHH) was awarded a $100 million Primary Care Access Stabilization Grant (PCASG) for July 2007 through September 2010 for the Greater New Orleans area to restore and expand access to primary care, mental health, and dental services without regard to a patient's ability to pay. In 2010, DHH submitted a proposal to CMS for a Medicaid section 1115 demonstration to continue funding of the PCASG provider organizations, propose a reduction in discretionary disproportionate share hospital (DSH) funding, and increase support for primary care medical homes (PCMH). CMS approved the Greater New Orleans Community Health Connection (GNOCHC) 1115 demonstration effective October 1, 2010 through December 31, 2013. In September 2013, CMS approved a 12-month extension of the program to December 31, 2014, changes to the eligibility criteria and reimbursement methodology, and on March 27, 2014, CMS approved an increase to the expenditures permitted under the budget neutrality limit for 2014.

The Greater New Orleans area comprised of Orleans, Jefferson, St. Bernard, and Plaquemines parishes is the largest population center in the state and is home to over 800,000 individuals, representing roughly 20 percent of the state's population. According to the 2012 U.S. Census Bureau's American Community Survey estimate for the GNOCHC service area, 16.5 percent of the residents aged 18-64 had incomes below poverty, nearly 20 percent of that age group who were employed were uninsured, 53 percent of the unemployed were uninsured, and 22.5 percent of those not in the labor force were uninsured. According to the Louisiana Health Insurance Survey, 124,904 individuals in the GNOCHC service area are under 100 percent of the Federal Poverty Level (FPL) and uninsured rates are highest for adults at this income level. Nine years since Hurricane Katrina, the Greater New Orleans area continues to be significantly impacted. As reiterated by commenters at the public hearings for the waiver renewal, the lives and health, both mental and physical, of residents are still overwhelmingly impacted by the devastation from the storms. Patients are still dealing with the trauma of losing their homes, jobs, and essentially the life they had prior to the storm. The GNOCHC program has been essential to not only restoring and building the primary care and behavioral health infrastructure in the community but also to building back lives. **The GNOCHC 1115 demonstration is a critical program for these residents to continue receiving primary care and mental health services in the community.**

DHH is requesting a three-year renewal of the GNOCHC 1115 demonstration waiver. An extension of this waiver program continues access to critical physical and behavioral health care in the Greater New Orleans area, avoiding the need for more costly care in an emergency setting, while permitting participating providers to continue on a path toward self-sustainability.

II. GNOCHC Successes To Date

The GNOCHC demonstration accomplished its Phase I goals that focused on access preservation and evolution planning by enrolling thousands of eligible, low-income, uninsured adults into basic health care coverage; transforming PCASG awardees into coverage model-driven health care providers with routine Medicaid enrollment and billing processes and encounter rate payments; and substantially completing program start up, paving the way for routine program operations and further evolution in Phase 2.

In Phase 2, DHH continued to enroll thousands of eligible adults into the GNOCHC demonstration; finalized the remaining key elements of the terms and conditions of the demonstration; and established and maintained routine operations to enable providers to move further toward the goal of self-sustainability into 2014. Below are examples of the GNOCHC demonstration's progress to date.

Preserving Primary and Behavioral Health Care Access

The demonstration has been successful in preserving access to primary and behavioral care, as the percentage of eligible, participating providers who participated in the PCASG and who continue to participate in GNOCHC has remained at over 80 percent (18 organizations). The number of enrolled sites remains at 42, but FFY14 will show an increase due to planned clinic expansions. Also of note:

- Clinics are working together to offer a greater array of services.
- Some GNOCHC clinics have contracted with other medical entities such as Louisiana State University to offer specialty care like mammography and endocrinology services.

Sustaining and Advancing the Medical Home Model

- The GNOCHC clinics continue to serve as the "medical home" and the provider of choice for area-underserved residents.
- Funding from GNOCHC has helped many providers attain and keep National Committee for Quality Assurance (NCQA) Primary Care Medical Home (PCMH) recognition. The percentage of participating provider sites with NCQA PCMH recognition is at 45.2 percent (19 sites). Thirteen of the sites are at Level 3, and six sites are at Level 2. One additional site is actively pursuing recognition.

Provider Financial Sustainability Through Diverse Means of Financing

GNOCHC providers were challenged to carefully evaluate their current GNOCHC utilization, and, based on a data-driven analysis of expenditures, future utilization, and estimated revenue projections through 2014, to develop realistic strategies for future financial sustainability and to provide a clear vision of an organization moving decisively toward self-sufficiency. Observations include:

- There remains significant variation among providers in their ability to perform and respond to this assessment.
- With the advent of Medicaid managed care in Louisiana Medicaid, most GNOCHC providers are enrolled providers with all five Bayou Health managed care plans, which increases their non-GNOCHC patient count and provides another source of revenue. Most have increased staff to allow for a rise in the number of patients.
- Most providers have made improvements/upgrades to billing/claims systems and have (or will) transitioned to a new Electronic Medical Record/billing system; GNOCHC funding has provided computer equipment, servers, and funds for training.
- Providers have engaged in outreach to diversify their patient base to include non-GNOCHC Medicaid patients and patients with private insurance.
- Most GNOCHC providers receive funding from federal and non-federal grants. Other sources of revenue are private contributions, payment from non-GNOCHC Medicaid recipient claims, funds raised through community events, enhanced reimbursement from Medicaid and Medicare as a result of Federally Qualified Health Center (FQHC) status, and private insurance. All continue to seek sources of additional funding; **however funding continues to be a concern, particularly for smaller clinics**.
- All are looking forward to the changes the Affordable Care Act will bring, such as more private insurance payments through the Exchange and more patients.

Increasing Access to Health Care Coverage

- From the inception of the GNOCHC demonstration in October 2010 to September 2013, the GNOCHC demonstration grew to serve approximately 63,000 individuals. With the new income limit of 100 percent of the FPL effective January 1, 2014 to align with availability of subsidized coverage in the Marketplace, the demonstration currently serves approximately 49,000 individuals.

Assessing Behavioral Health Care Needs of Enrollee Sub-Populations

DHH is gaining experience through the GNOCHC demonstration on behavioral health utilization and costs of the GNOCHC adult population. For example, evaluation measures that track utilization of behavioral health services by enrollee subpopulation indicate that the average payment for behavioral health care for childless enrollees is $147 per month, which is 12.2 percent higher than payment for enrollees with a child in the home, which average $131 per month. Also, the average payment per month for enrollees with incomes of 133 percent of the FPL or less was $145 per month, which is 9.8 percent higher than the average of $132 per month for enrollees earning 134 – 200 percent of the FPL.

The GNOCHC demonstration as of June 28, 2014 is serving approximately 49,000 individuals in the Greater New Orleans Area through the network of 18 GNOCHC clinics (42 sites) that provide access to primary and behavioral health services. These clinics are not without remaining challenges and funding continues to be a concern, particularly for some of the smaller clinics

that rely more heavily on GNOCHC and Medicaid and lack the resources to perform the same level of self-assessment and improvement as some of the larger clinics. The continued support from the GNOCHC demonstration remains critical to the provision of services to the GNOCHC adult population as well as to the clinics' ability to further evolve as 2014 brings the introduction of new, private payer sources as a result of the Federally Facilitated Marketplace.

III. Waiver Renewal Support

Attachment 1 contains seven letters from a variety of public and provider stakeholders demonstrating unanimous support for the renewal of the GNOCHC demonstration.

IV. Demonstration Renewal Request

The goal of the renewal is to preserve and further increase access to healthcare in the Greater New Orleans area, support providers in their efforts to transform and become self-sustainable, and reduce the need for more costly emergency care. **DHH is requesting to make incremental revisions to GNOCHC in this renewal request while planning for additional new initiatives that will benefit enrollees and providers over the next three years.**

Summary of Changes

DHH intends to discontinue the requirement that eligible individuals be uninsured for at least six months and modify provider reimbursement to transition provider incentive payments from incentives for NCQA PCMH status to incentives that more closely align with quality and outcomes. Details of these proposed changes follow.

V. Eligibility

For this renewal, DHH proposes to remove the requirement that eligible individuals be uninsured for at least six months. Removal of this enrollment barrier received strong support from commenters during our public notice period and is expected to help improve access and continuity of care. **All other eligibility requirements remain unchanged.** Individuals enrolled in GNOCHC must**:**

- Live in Jefferson, Orleans, St. Bernard or Plaquemines parish;
- Not be pregnant;
- Be uninsured;
- Have family income up to 100 percent of the FPL;
- Meet U.S. citizenship requirements under the Deficit Reduction Act of 2008 and the Children's Health Insurance Program Reauthorization Act of 2009;
- Be age 19 through 64 years old; and
- Not be eligible for Medicaid, CHIP or Medicare. Applicants will continue to be pre-screened to determine possible eligibility in a full benefit program prior to determining eligibility for GNOCHC, a limited benefit program. Applicants may still qualify for the Tuberculosis Infected Program or the TAKE CHARGE Family Planning Waiver or

succeeding State Plan Family Planning services. Coverage for retroactive eligibility is not available under GNOCHC.

Recipients will continue to undergo an eligibility redetermination at least annually. Each redetermination will include a review of the individual's eligibility for coverage in other Medicaid or CHIP programs.

VI. Services

DHH proposes no changes to covered services**.** The following services paid for and provided directly or indirectly by referral by a participating GNOCHC provider would continue to be covered:

- Care coordination;
- Immunizations and influenza vaccines;
- Laboratory and radiology;
- Behavioral health care;
- Primary health care;
- Preventive health care;
- Substance disorder treatment; and
- Specialty care (as provided by the GNOCHC provider or through referral agreement by the GNOCHC provider).

As a result of public comments, DHH is actively exploring the addition of a dental benefit for the GNOCHC enrollees under the demonstration and researching the connection between dental conditions and avoidable emergency room visits in GNOCHC enrollees. DHH anticipates this will be a future change requested during the renewal period.

Currently, DHH does not impose cost sharing for GNOCHC enrollees, but retains flexibility to do so under the approved demonstration. DHH is requesting the ability to preserve this option through the renewal period. If imposed, the enrollee's share of the cost would be restricted to a 5 percent aggregate limit per family.

VII. Participating Providers

Currently, there are 42 GNOCHC participating provider sites in the 4-parish area. Providers are disproportionately located in Orleans parish, while Plaquemines, St. Bernard, and to a lesser extent, Jefferson parish, are relatively underserved. **All participating requirements (as listed below) will remain unchanged.**

- Be a GNOCHC enrolled provider;
- Be an original Primary Care Access Stabilization Grant (PCASG)-participating provider, operational and serving GHOCHC demonstration participants on October 1, 2010;
- Be a public or private not-for-profit entity that meets the following conditions:
    - the entity must not be an individual practitioner in private solo or group practice;

    - the provider shall be currently licensed, if applicable;
    - either the provider or its licensed practitioners shall be currently enrolled in the Louisiana Medicaid Program; and
    - all health care practitioners affiliated with the provider that provide health care treatment, behavioral health counseling, or any other type of clinical health care services to patients shall hold a current, unrestricted license to practice in Louisiana within the scope of that licensure.
- Provide full disclosure of ownership and control, including but not limited to any relative contractual agreements, and partnerships;
- Have a statutory, regulatory or formally established policy commitment (*e.g.* through corporate bylaws) to serve all people, including patients without insurance, at every income level regardless of their ability to pay for services, and be willing to accept and serve new publicly insured and uninsured individuals;
- Maintain one or more health care access points or service delivery sites for the provision of health care services which may include medical care, behavioral health care and substance disorder treatment services, either directly on-site or through established contractual arrangements;
- Continue to collect all data on services rendered and maintain such data at the provider level; and
- Continue to submit required reports on patient population and revenue.

DHH proposed for public comment to remove the requirement that GNOCHC providers also have participated as PCASG providers prior to the 1115 demonstration. Due to limited budget resources for GNOCHC, DHH has decided to continue this requirement in the renewal. However, DHH will consider requests from additional provider organizations and, as necessary to comply with any CMS requirements, request revision in the waiver to include additional sites on the list of participating providers.

VIII. Quality Assurance

DHH prepares quarterly and annual GNOCHC reports that summarize the results of monitoring and quality assurance activities. Attachments 2.1, 2.2, and 2.3 contain the annual reports for demonstration Years 1 – 3. DHH initially focused on implementing the demonstration internally with system readiness, setting policy and procedures, and staff training and externally with providers and recipients to process claims and educate the public about the program. By year 2, routine program operations were in place, but the State continued to finalize the terms and conditions of the program and made changes to the funding protocol to assure providers were correctly reimbursed. Year 3 showed a continued enrollment of thousands of individuals as in years past and the providers working toward self-sustainability. The demonstration was extended for 12 months (to December 31, 2014) and changes were put into place to assure the continued availability of funding.

The quality of data collection by the providers has been an issue, but DHH continues to collaborate with them to improve data collection. Utilization is being monitored as well as application and renewal case processing as a result of delays caused by the implementation of the Affordable Care Act.

IX. Payment Methodology

GNOCHC providers currently receive encounter rates unique to the demonstration and DHH is proposing to continue those rates for the renewal period.

Providers also receive quarterly incentive payments for National Committee for Quality Assurance (NCQA) Patient Centered Medical Homes (PCMH) recognition. During the initial waiver period, achieving NCQA PCMH status was an important building block in building the clinic infrastructure and capacity. For the renewal, the goal is to now move to the next phase of practice transformation that help increase access to care and utilization within a primary care medical home. DHH is proposing to transition to incentive payments over the renewal period that are based on active and provider practice outcomes as measured by PCMH Core Elements. Initially, the payments will continue but we are working with the GNOCHC providers to determine that transition plan which will include potential availability of the incentive to all GNOCHC providers. When a plan is in place, we will request to CMS an update to the approved GNOCHC Funding and Reimbursement Protocol.

These incentives will be outcome based and shall be awarded to providers successfully meeting certain standards, *e.g.,* increase access to services:

- Extended business hours such as weekends, early morning, and evening hours; and
- Availability of same day appointments.

DHH is also proposing to continue the Louisiana Inter-Pregnancy Care (LA-IPC) Project payments that are currently authorized under the demonstration and approved in the Funding and Reimbursement Protocol.

X. Source of Non-Federal Share

The source of funding for the non-federal share of expenditures under the GNOCHC demonstration continues to be a U.S. Department of Housing and Urban Development (HUD) Community Development Block Grant (CDBG) award (Number ILOC-00032) with DHH as the sub-recipient of CDBG funds from the Office of Community Development (OCD) Disaster Recovery Unit (DRU) who administers the state's CDBG disaster recovery program through the Louisiana Local Government Emergency Infrastructure program.

A "Cooperative Endeavor Agreement (CEA)" 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. DHH and DOA executed an amendment to the CEA on November 12,

2013, to extend the term of the agreement through December 31, 2014 and an updated agreement for the waiver renewal period is under development.

Receipt of the grant funds by DHH will continue to be accomplished by an Interagency Transfer (IAT) from DOA. Authority for expenditure of the IAT funds was first granted to DHH by the Joint Legislative Committee on the Budget on September 17, 2010, and continues to be appropriated annually. Louisiana DHH received an appropriation from the Legislature. The initial appropriation for the waiver renewal was appropriated via HB 1 [1] (incorporated into Act 15). DHH does not have legislative appropriations for GNOCHC for the full three years, since we do budgets once a year. However, we do anticipate annual appropriations from the Legislature. DHH is requesting a three-year waiver renewal with annual updates (or more frequently, as needed) via the Funding and Reimbursement Protocol to CMS on the source of the non-federal share and the amount available to DHH.

XI. Budget Neutrality

DHH is requesting a maximum of approximately $49.2 million in federal funding for the demonstration renewal term. Total demonstration expenditures (including GNOCHC expenditures and DSH expenditures) will not exceed Louisiana's DSH allotment. Attached are updated budget neutrality spreadsheets in support of this request, Attachment 3.

DHH is requesting continued discretion to take measures to remain within the allotted budget. **DHH proposes to keep the following measures, which may be taken to manage eligibility** to ensure that expenditures do not exceed funding allocations. DHH may:

- Employ a first come, first served reservation list to manage the number of applications received;
- Limit the number of applications provided to potential recipients;
- Impose enrollment limits; or
- Reduce encounter rates and/or modify other payments.

As of June 28, 2014, enrollment totals 49,124, and is expected to grow at a rate of 2 percent per year under the renewal, consistent with 2013 enrollment growth for GNOCHC eligible individuals under 100 percent of the FPL. Annual expenditures for the most recent calendar year (2013) totaled $27,827,737. It is anticipated that total annual expenditures under the renewal would not exceed historic annual expenditures due to the income eligibility limit of 100 percent of the FPL effective January 1, 2014.

XII. Evaluation of Program (Updated July 25, 2014)

To date, the GNOCHC demonstration has successfully met its goal of preserving access to primary and behavioral health care. Data for the evaluation is obtained from semi-annual

[1] HB1 can be viewed on the Louisiana Legislative website at www.legis.la.gov/legis/ViewDocument.aspx?d=915624&n=HB1. Refer to page 125.

reports received from the GNOCHC providers and from the Louisiana Medicaid Database each quarter. From the database, DHH personnel retrieve the GNOCHC certifications by category (adult parent and childless adult) and type case along with the procedure codes for primary care, basic behavioral health, and SMI behavioral health to report payments, number of claims by procedure code, rate of access, and number of recipients receiving each type of service. The providers report revenue, patient demographics, and the number of insured and uninsured patients served. Using this data, DHH staff is able to analyze the program and develop the annual and quarterly reports for CMS. See Attachment 8.

Since the implementation of the demonstration, the number of GNOCHC sites remains at over 80 percent. All four parishes have an adequate number of sites to serve their residents, but access could be an issue for some enrollees. Many GNOCHC providers report financial stability continues to be an issue. The providers continue to look for alternative sources of funding. In addition to GNOCHC, the GNOCHC providers accept commercial insurance, Medicaid, and the uninsured. Most of the patients are adults (86.7 percent), but they do offer services for the entire family. Children under the age of 19 are served at the GNOCHC sites and the majority (12.1 percent of the 13.3 percent served) are Medicaid and CHIP patients. The Affordable Care Act has slowly brought another revenue stream from commercial insurance plans, but several sites say should the GNOCHC program end, they may have to reduce staff or as a drastic measure, close down. Overall, GNOCHC revenue accounts for 41 percent of total patient revenue, but 21 percent of providers report GNOCHC is more than 75 percent of their total patient revenue and 25 percent of their patient number. They report that nearly 28 percent of patients are uninsured adults and 30 percent are GNOCHC enrollees, illustrating the great impact GNOCHC is as a source of revenue.

GNOCHC enrollment has decreased because of the change in income requirements on January 1, 2014 and has remained relatively steady since that time.

Behavioral health usage is low as compared to primary care, 10.5 percent to 1.5 percent average per month, but the need continues due to the impact Hurricanes Katrina and Rita still have on the region. Behavioral health usage has always been slightly higher for childless adults, but that correlates to the number of childless enrollees far outweighing the number with children in the home. Integration of primary and behavioral health care services has been a goal of providers, which supports the medical home model and addresses the medical needs of the entire individual. The percentage of enrollees receiving both primary care and behavioral is slowly improving; and we are pleased to report that the number of enrollees receiving both a primary care and behavioral health service on the same day has increased this calendar year to 79 percent (previously 30 percent). This is a plus for patients with transportation issues.

The utilization rate for all GNOCHC services was 40 percent for 2013, meaning 40 percent of GNOCHC enrollees (or 31,431 of the 78,017 enrolled) received at least one GNOCHC service. DHH will be looking to increase this percentage for the renewal period. Discussions are now underway with providers determine the reason(s). As stated previously, even though it appears that there are a sufficient number of GNOCHC providers, there may be other issues for enrollees like transportation or simply not knowing where to go to receive GNOCHC services.

All GNOCHC provider sites are application centers. Before a patient is examined, they are screened to determine if they are uninsured. If they are uninsured, specially trained enrollment staff offers a Medicaid application. If the individual applies, the application is submitted to the Medicaid office for a review of all household family members for all Medicaid programs. On October 11, 2013, the State forwarded a list of enrollees with incomes above 100 percent of the FPL to all GNOCHC providers so that they could begin directly communicating with their patients about the income changes and assist them with next steps for continuing healthcare coverage, including an enrollment through the Federally Facilitated Marketplace. The Medicaid office submits renewal and application information to the Marketplace, electronically. Outreach by the providers does occur. Their websites are continually updated with the latest clinic news, contact information, and health related topics. They are involved in the community. They sponsor and participate in community events like health fairs and send out newsletters about activities at the clinics or happening in the community. They have staff to educate and enroll patients into the Marketplace.

As of July 7, 2014, twenty providers are recognized as NCQA Patient-Centered Medical Homes (PCMH). Fourteen sites are at the highest possible recognition level, Level 3, and six sites are at Level 2. An application is in progress for one site. NCQA PCMH incentive payments to the sites for the most recent quarter totaled $650,000. These funds are used to support the sites to cover the costs of uninsured patients and services not covered by GNOCHC.

The inter-pregnancy care coordination (IPC) component of the demonstration has not been successful. The objective was to provide care coordination in the form of medical and community resources to women who had a prior adverse pregnancy outcome in order to improve health outcomes. Data sharing took time to develop and provide to the contractor. By the time the data was received by the contractor, the individual may have already moved, thereby making the contact information on file, useless. Outreach challenges were not expected. For the renewal period, DHH is considering moving to a more focused approach, beginning the efforts with the GNOCHC provider rather than the contractor, City of New Orleans' Healthy Start agency. Healthy Start was unfamiliar to the recipients who were successfully contacted, so this may have been the cause in the difficulty convincing them to enroll and continuing IPC. It is expected that the GNOCHC providers would be able to continue to work with the IPC enrollee over time as the enrollee would be using this provider for other ongoing medical care, not specifically related to IPC.

As vocalized in the public hearings and in the letters DHH has received supporting the continuation of the demonstration, GNOCHC is vital to the health of area residents. Many attendees expressed that the GNOCHC provider clinic sites continue to be their reliable and sometimes only source of regular medical care. The providers not only provide GNOCHC services, but also provide or help to provide non-covered services like dental and medications. Provider organizations recognize the need for expansion, so they continue to plan to open additional GNOCHC sites. They strive to improve health outcomes by becoming patient centered medical homes, and partnering with other medical facilities to offer more services for their patients.

DHH is not proposing any changes to the evaluation design from what is currently approved. For the final evaluation report, DHH plans to work with GNOCHC providers to develop a survey for GNOCHC enrollees to determine the effect GNOCHC has had on their health and the establishment of a medical home. The survey would be conducted by an independent contractor. At the public hearings, DHH sought feedback from the public on other ways to demonstrate the impact that the program has had on providers and recipients. We received support for our proposal to work with a third party to calculate Healthcare Effectiveness Data and Information Set (HEDIS) measures. All evaluation data will be posted publicly to the DHH website.

XIII. Tribal Notice, Public Notice and Stakeholder Input

A copy of DHH's Tribal Notice is included in Attachment 4. No feedback was received. Providers and other stakeholders were notified using an email distribution list. Additionally, the renewal process and potential changes to the demonstration were discussed in regularly scheduled GNOCHC provider meetings with DHH.

DHH's draft application for public notice was published on DHH's website on May 21, 2014[2]. A copy of the draft application for public notice is included in Attachment 5.

Public notice was also published in 8 major Louisiana newspapers. A copy of the newspaper notice is included in Attachment 6. The public notice comment period ran from May 21, 2014 through June 21, 2014.

DHH held two public hearings in the Greater New Orleans Area, which were each broadcast via statewide webcast and teleconference. The Medicaid Director made a presentation at both hearings. The GNOCHC public hearing PowerPoint presentation is included as Attachment 7. The public were provided the opportunity to submit written comments online or by mail, and/or attend one of the hearings to leave comments and/or speak.

The first hearing was held on May 28, 2014 at 1:00 p.m., at LSU's School of Allied Health and Nursing Building, Tiger Room #138, 1900 Gravier Street, New Orleans, LA, 70112. There were 55 attendees and 17 of those spoke. The second hearing was held on June 2, 2014 at 7:00 p.m., at the Joseph S. Yenni Building, EB Council Chambers room, 1221 Elmwood Park Boulevard, Jefferson, LA, 70123. There were 67 attendees and 11 of those spoke. For those that orally commented at the hearings, many spoke for several minutes recounting their experiences with the GNOCHC program as patients, advocates, area residents, family of GNOCHC enrollees, and medical providers.

The deadline for receipt of all written comments closed on June 21, 2014 at 4:30pm.

[2] Draft application public notice may be viewed on the DHH website at http://www.dhh.louisiana.gov/index.cfm/newsroom/category/80 and http://new.dhh.louisiana.gov/index.cfm/page/679.

Summary of Public Comments and DHH Response:

As demonstrated by the robust attendance of patients, providers, and community members to the public hearings and legislative sessions, as well as the proceedings of the legislative sessions, many people strongly support the GNOCHC program that is vital to the Greater New Orleans area. At the public hearings, patients, GNOCHC providers and other medical providers, patient advocates, and community members provided verbal statements and personal examples that highlighted the effectiveness of this program which provides desperately needed primary care and behavioral health services to enrollees in the Greater New Orleans region. In addition to comments expressing support for the program and stating the need for the program to continue, below is a summary of comments made at the public hearings and received via public input grouped thematically about any requests for changes in the waiver.

1. **Dental Benefits**

   While patients were grateful for the high-quality primary care received, one issue for patients is access to dental services. Currently the waiver does not cover dental services for patients. Patients must pay out of pocket for dental care, and there is limited access to dental services at a reduced cost. For musicians, who make up the heart of New Orleans, this is particularly important because it affects their ability to play instruments and perform. Without dental care, they are unable to work. In addition, without access to dental care and few affordable options, patients present in the emergency room, which is something as a community we wish to avoid.

   DHH Response: As a result of public comments, DHH is actively exploring the addition of a dental benefit for the GNOCHC enrollees under the demonstration and researching the connection between dental conditions and avoidable emergency room visits in GNOCHC enrollees. DHH anticipates this will be a future change during the renewal period.

2. **Eligibility**

   Commenters expressed strong support for removing the requirement that patients be uninsured for 6 months before they can be enrolled in the program.

   DHH Response: We are proposing this change for this renewal request.

3. **Hurricane Katrina Still Affects New Orleans Area Residents**

   Several patients provided statements regarding how their lives and their health, both mental and physical, are still overwhelmingly impacted by the devastation of Katrina. Patients are still dealing with the trauma of losing their homes, jobs, and essentially lives they had prior to the storm. The GNOCHC program is a critical program for these patients to receive primary care and mental health services. A few commented that without the program, they would not be alive. The GNOCHC program has been essential to not only building the primary care and behavioral health infrastructure in the community but also to building back lives.

DHH Response: DHH appreciates the time that GNOCHC members have taken to participate in the public input process and demonstrate to DHH and CMS the importance of GNOCHC to the continued rebuilding in the Greater New Orleans Area. Hurricane Katrina was 9 years ago and the assumption may be that the area and its residents have fully recovered. Important feedback received through the public testimony is that this is clearly not the case.

4. Behavioral Health Services and Behavioral Health Integration

Several providers commented that without the program, access to important mental health and substance disorder treatment programs would be cut. In a community that is struggling to provide enough services to residents, cuts in this area would be devastating. In addition, the GNOCHC program supports clinics in their efforts to work towards integrating behavioral health in their workflows and practice. Commenters stressed that many factors such as the hurricanes, economy, and personal struggles, have led to the increased (and ongoing) need for behavioral health. Several said they were undiagnosed for years. DHH recognizes the need for more sites to offer or refer for behavioral health services.

DHH Response: We agree that GNOCHC plays a vital role in addressing longstanding unmet needs for behavioral health services.

5. High Quality Care, Care Coordination, and Access to Medications

Several attendees provided comments about the high-quality of care that they receive at the clinics. Providers also noted their ability to provide care coordination and assist patients with enrolling in patient assistance programs to receive needed medications. Without the GNOCHC program and additional financial support of patient centered medical homes, clinics would not be able to provide the same level of coordination and services to patients, including assistance in obtaining medication through manufacturers' pharmacy assistance programs. This would result in inefficiencies in the health care system and increase costs.

DHH Response: One of the goals of the renewal of the GNOCHC demonstration will be continued practice transformation and support of patient-centered medical homes.

6. Cost-Sharing

DHH received a comment in opposition to DHH's request to preserve the ability to introduce cost-sharing up to 5 percent of a recipient's aggregate family income. The commenter noted that GNOCHC is currently provided with no cost sharing and any future cost sharing could present a "significant hurdle" to accessing care.

DHH Response: Although DHH is requesting the ability we have today under the current demonstration to impose cost sharing in accordance with federal rules if determined appropriate, DHH has no plans to impose cost sharing on GNOCHC demonstration participants. Such a fee would require legislative approval by two-thirds vote of the Louisiana Legislature.

7. Changes in the Payment Methodology

In the draft application for public notice, DHH proposed to modify how GNOCHC providers are paid under the demonstration. Instead of the current encounter payment rates, DHH proposed to instead reimburse GNOCHC providers for GNOCHC covered services based on the Medicaid rate payable for the service according to the GNOCHC provider's Medicaid provider type (FQHC, physician group, or behavioral health clinic). Several commenters expressed concern that the reduction in payment rates would result in cuts to existing services available to patients. According to commenters, access to both primary care and behavioral health services available in the community would decrease. This would exacerbate the issue individuals currently are facing of insufficient behavioral health resources in the community leaving patients without care. In addition, commenters stated that it will be absolutely impossible for GNOCHC patients to receive the existing scope of services under the program with these additional proposed cuts, particularly in regards to care coordination, lab work, x-rays, diagnostics, any specialty care, assisting patients with enrolling in medication access programs, patient navigation, and maintaining PCMH activities.

DHH also proposed changes to the payments designed to incentivize quality under GNOCHC. Regarding the payment methodology for quality payments, providers discussed the need for working with DHH to ensure the restructuring of the payments is done in the most effective way possible to reach the goals of improving quality and increasing access to care. The restructuring needs to be done in a way that would not sacrifice steps already taken to achieve the goals of advancing and sustaining the medical home model and demonstrating financial sustainability. Providers proposed developing a small work group of GNOCHC providers and DHH staff to further explore this issue together to develop the details and determine the most effective way at reaching the mutual goals.

DHH Response: Upon further consideration of these proposed changes in response to the public input received, DHH is requesting authority from CMS to continue current encounter rate payments to GNOCHC providers. DHH is working with providers to develop a revised plan for incentive payments.

XIV. Statutory Waivers and Expenditure Authority Requests

Louisiana requests the following waiver and expenditure authorities for the GNOCHC demonstration renewal:

Expenditure Authority:

1. Effective January 1, 2015, expenditures for health care costs for individuals who are non-pregnant, adults ages 19 through 64 years with family incomes that do not exceed 100 percent of the federal poverty level (FPL), are not otherwise eligible under the Medicaid state plan, and who do not have other health insurance coverage and are residents of the Greater New Orleans region (which includes Orleans, St. Bernard, Plaquemines, and Jefferson parishes).

2. Expenditures for infrastructure costs related to providing healthcare services under the GNOCHC demonstration are not to exceed 10 percent of the budget limit. Allowable infrastructure costs will be defined in the funding and reimbursement protocol. These costs include expenditures to support actual provider practices to increase access and improve outcomes.

Requests for Title XIX Requirements Not Applicable to the Demonstration Population:

1. Reasonable Promptness Section 1902(a)(3) and 1902(a)(8)

To the extent necessary to enable Louisiana to implement a reservation list as a tool to manage enrollment for the demonstration-eligible population.

2. Amount, Duration, and Scope Section 1902(a)(10)(B)

To the extent necessary to enable Louisiana to offer a different benefit package to the demonstration-eligible population that varies in amount, duration, and scope from the benefits offered under the state plan.

3. Freedom of Choice Section 1902(a)(23)

To the extent necessary to enable Louisiana to restrict freedom-of-choice of provider for the demonstration-eligible population.

4. Retroactive Eligibility Section 1902(a)(34)

To the extent necessary to relieve Louisiana from the obligation to provide coverage for the demonstration-eligible population for any time prior to the date of enrollment into the GNOCHC.

5. Eligibility Standards Section 1902(a)(17)

To the extent necessary to enable Louisiana to apply different eligibility methodologies and standards to the demonstration-eligible population than are applied under the state plan.

6. Early and Periodic Screening, Diagnostic, and Treatment services Section 1902(a)(43)

To the extent necessary to relieve Louisiana from the obligation to provide coverage of early and periodic screening, diagnostic and treatment services to 19- and 20-year-old individuals in the demonstration-eligible population.

7. Statewideness/Uniformity Section 1902(a)(1)

To the extent necessary to enable Louisiana to operate the demonstration only in the Greater New Orleans region.

8. Comparability Section 1902(a)(10)(B) and 1902(a)(17)

To the extent necessary to enable Louisiana to provide different benefits to the demonstration-eligible population receiving services at GNOCHC clinics.

9. Methods of Administration: Transportation Section 1902(a)(4), insofar as it incorporates 42 CFR 431.53

To the extent necessary to relieve Louisiana from the obligation to assure transportation to and from GNOCHC providers for the demonstration-eligible population.

Attachments (described above):

1. Letters of Support
2. GNOCHC Annual Reports for Demonstration Years 1 – 3 (attachments 2.1, 2.2, 2.3)
3. Budget Neutrality
4. Tribal Notice
5. Draft Application for Public Notice
6. Public Notice from Newspaper (2 examples)
7. GNOCHC DHH Public Hearing Presentation
8. Evaluation Data

State Contact:

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Date Submitted to CMS: July 1, 2014

Update Submitted to CMS: July 25 2014

GOAL 1: Preserve Primary and Behavioral Health Care Access

	FFY12 Q1			FFY12 Q2		
	Number	Percentage		Number	Percentage	
1.1 Number and Percentage of Eligible Provider Organizations Enrolled	19	86.4%	as of Dec. 31, 2011	18	81.8%	as of Mar. 31, 2012
1.2 Number and Percentage of Eligible Provider Sites Enrolled	39	62.9%	as of Dec. 31, 2011	39	62.9%	as of Mar. 31, 2012
1.3 Rate of Primary Care Access		11.9%	Avg rate per month in Q1		12.5%	Avg rate per month in Q2
1.4 Rate of Behavioral Health Care Access		2.3%	Avg rate per month in Q1		2.8%	Avg rate per month in Q2

Notes: 22 provider organizations participated in the Primary Care Access Stabilization Grant (PCASG), with 62 service locations throughout the New Orleans metro area. Performance measures 1.1 and 1.2 compare participation in PCASG and GNOCHC.

GOAL 2: Sustain and Advance Medical Home Model

2.1 Attain NCQA PCMH Recognition						
2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition	N/A	N/A	as of Dec. 31, 2011	7	17.9%	as of Mar. 31, 2012
2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Levels 1, 2, and 3)	24	61.5%	as of Dec. 31, 2011	7	17.9%	as of Mar. 31, 2012
2.1.3 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 1 Recognition	12	30.8%	as of Dec. 31, 2011	4	10.3%	as of Mar. 31, 2012
2.1.4 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 2 Recognition	1	2.6%	as of Dec. 31, 2011	1	2.6%	as of Mar. 31, 2012
2.1.5 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 3 Recognition	11	28.2%	as of Dec. 31, 2011	2	5.1%	as of Mar. 31, 2012
~~2.2 Provide Enrollees with a Medical Home~~						
~~2.2.1 Number and Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
~~2.2.2 Number and Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH Linkage~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
2.3 Provide Care Coordination Services						
2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed	0	0.0%		0	0.0%	
2.4 Integrate Primary and Behavioral Health Care Services						
2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters	740	0.7%		1,038	0.8%	
2.4.2 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters on the Same Date of Service	80	10.7%		174	16.6%	

GOAL 3: Evolve Grant-Funded Model to Financial Sustainability Through Diverse Means of Financing

3.1 Number and Percentage of Enrolled Provider Sites Certified as Medicaid Application Center	37	94.9%		37	94.9%	
3.2 Number and Percentage of Patients Enrolled in the Demonstration	6,147	22.0%		7,445	24.2%	
3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients	9,072	32.3%		8,959	29.2%	
3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees	$3,907,315	41.3%		$12,660,004	70.4%	Includes supplemental pymts.

Notes: This information is self-reported by providers in their semi-annual Sustainability Progress Reports. Performance measures 3.2, 3.3, and 3.4 provide information on GNOCHC enrollees as compared to the total population served by GNOCHC providers.

GOAL 4: Increase Access to Health Care Coverage

4.1 Increase Access to Health Care Coverage to Populations Eligible for the Demonstration						
4.1.1 Total Enrollment	38,413		as of Dec. 31, 2011	44,298		as of Mar. 31, 2012
4.1.2 Number and Percentage of Enrollment in MEG 1 (0-133% FPL)	33,142	86.3%	as of Dec. 31, 2011	37,957	85.7%	as of Mar. 31, 2012
4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL)	5,271	13.7%	as of Dec. 31, 2011	6,341	14.3%	as of Mar. 31, 2012

Notes: As of 1/11/14, income limit changed to under 100% FPL, therefore 4.1.3 no longer captured effective with DY4 Q2 report.

4.2 Reduce Rate of Uninsured Children						
4.2.1 Number and Percentage of Uninsured Patients Under Age 19	5,826	12.8%		4,792	7.8%	
4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP	11,559	25.1%		11,482	18.4%	

Notes: Data for performance measures 4.2.1 and 4.2.2 are self-reported by providers in their semi-annual Sustainability Progess Reports. Reporting was incomplete for some providers, some cannot readily track age-related information in their internal databases.

GOAL 5: Assess Behavioral Health Care Needs of Enrollee Sub-Populations

5.1 Assess Service Utilization and Cost by Parent Population					
5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee with a Child in the Home	1.5	Avg per recipient per month in Q1		1.3	Avg per recipient per month in Q2
5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home	$156.20	Avg per recipient per month in Q1		$131.12	Avg per recipient per month in Q2
5.2 Assess Service Utilization and Cost by Childless Population					
5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home	1.6	Avg per recipient per month in Q1		1.5	Avg per recipient per month in Q2
5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home	$162.42	Avg per recipient per month in Q1		$159.81	Avg per recipient per month in Q2
5.3 Assess Service Utilization and Cost by Medicaid Expansion Population					
5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	1.5	Avg per recipient per month in Q1		1.5	Avg per recipient per month in Q2
5.3.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	$159.43	Avg per recipient per month in Q1		$157.43	Avg per recipient per month in Q2
5.4 Assess Service Utilization and Cost by Exchange Population					
5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	1.3	Avg per recipient per month in Q1		1.4	Avg per recipient per month in Q2
5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	$136.70	Avg per recipient per month in Q1		$141.13	Avg per recipient per month in Q2

GOAL 1: Preserve Primary and Behavioral Health Care Access

	FFY12 Q3			FFY12 Q4		
	Number	Percentage		Number	Percentage	
1.1 Number and Percentage of Eligible Provider Organizations Enrolled	18	81.8%	as of June 30, 2012	18	81.8%	as of Sept. 30, 2012
1.2 Number and Percentage of Eligible Provider Sites Enrolled	41	66.1%	as of June 30, 2012	41	66.1%	as of Sept. 30, 2012
1.3 Rate of Primary Care Access		12.2%	Avg rate per month in Q3		9.5%	Avg rate per month in Q4
1.4 Rate of Behavioral Health Care Access		2.4%	Avg rate per month in Q3		1.7%	Avg rate per month in Q4

Notes: 22 provider organizations participated in the Primary Care Access Stabilization Grant (PCASG), with 62 service locations throughout the New Orleans metro area. Performance measures 1.1 and 1.2 compare participation in PCASG and GNOCHC.

GOAL 2: Sustain and Advance Medical Home Model

2.1 Attain NCQA PCMH Recognition						
2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition	N/A	N/A	as of June 30, 2012	10	24.4%	as of Sept. 30, 2012
2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Levels 1, 2, and 3)	10	24.4%	as of June 30, 2012	12	29.3%	as of Sept. 30, 2012
2.1.3 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 1 Recognition	4	9.8%	as of June 30, 2012	4	9.8%	as of Sept. 30, 2012
2.1.4 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 2 Recognition	2	4.9%	as of June 30, 2012	2	4.9%	as of Sept. 30, 2012
2.1.5 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 3 Recognition	4	9.8%	as of June 30, 2012	6	14.6%	as of Sept. 30, 2012
~~2.2 Provide Enrollees with a Medical Home~~						
~~2.2.1 Number and Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
~~2.2.2 Number and Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH Linkage~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
2.3 Provide Care Coordination Services						
2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed	0	0.0%		0	0.0%	
2.4 Integrate Primary and Behavioral Health Care Services						
2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters	1,114	0.7%		810	0.5%	
2.4.2 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters on the Same Date of Service	196	17.8%		144	17.8%	

GOAL 3: Evolve Grant-Funded Model to Financial Sustainability Through Diverse Means of Financing

3.1 Number and Percentage of Enrolled Provider Sites Certified as Medicaid Application Center	39	95.1%		39	95.1%
3.2 Number and Percentage of Patients Enrolled in the Demonstration	7,940	27.7%		7,577	27.7%
3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients	6,663	23.2%		5,927	21.6%
3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees	$4,217,866	41.2%		$4,102,283	45.8%

Notes: This information is self-reported by providers in their semi-annual Sustainability Progress Reports. Performance measures 3.2, 3.3, and 3.4 provide information on GNOCHC enrollees as compared to the total population served by GNOCHC providers.

GOAL 4: Increase Access to Health Care Coverage

4.1 Increase Access to Health Care Coverage to Populations Eligible for the Demonstration						
4.1.1 Total Enrollment	49,712		as of June 30, 2012	53,565		as of Sept. 30, 2012
4.1.2 Number and Percentage of Enrollment in MEG 1 (0-133% FPL)	42,348	85.2%	as of June 30, 2012	45,943	85.8%	as of Sept. 30, 2012
4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL)	7,364	14.8%	as of June 30, 2012	7,622	14.2%	as of Sept. 30, 2012

Notes: As of 1/11/14, income limit changed to under 100% FPL, therefore 4.1.3 no longer captured effective with DY4 Q2 report.

4.2 Reduce Rate of Uninsured Children					
4.2.1 Number and Percentage of Uninsured Patients Under Age 19	2,210	3.6%		1,866	3.3%
4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP	12,035	18.9%		12,542	21.7%

Notes: Data for performance measures 4.2.1 and 4.2.2 are self-reported by providers in their semi-annual Sustainability Progess Reports. Reporting was incomplete for some providers, some cannot readily track age-related information in their internal databases.

GOAL 5: Assess Behavioral Health Care Needs of Enrollee Sub-Populations

5.1 Assess Service Utilization and Cost by Parent Population					
5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee with a Child in the Home	1.3	Avg per recipient per month in Q3		1.2	Avg per recipient per month in Q4
5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home	$135.31	Avg per recipient per month in Q3		$129.76	Avg per recipient per month in Q4
5.2 Assess Service Utilization and Cost by Childless Population					
5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home	1.5	Avg per recipient per month in Q3		1.3	Avg per recipient per month in Q4
5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home	$158.43	Avg per recipient per month in Q3		$140.03	Avg per recipient per month in Q4
5.3 Assess Service Utilization and Cost by Medicaid Expansion Population					
5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	1.5	Avg per recipient per month in Q3		1.3	Avg per recipient per month in Q4
5.3.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	$157.59	Avg per recipient per month in Q3		$139.25	Avg per recipient per month in Q4
5.4 Assess Service Utilization and Cost by Exchange Population					
5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	1.3	Avg per recipient per month in Q3		1.3	Avg per recipient per month in Q4
5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	$134.24	Avg per recipient per month in Q3		$132.96	Avg per recipient per month in Q4

GOAL 1: Preserve Primary and Behavioral Health Care Access

	FFY13 Q1			FFY13 Q2		
	Number	Percentage		Number	Percentage	
1.1 Number and Percentage of Eligible Provider Organizations Enrolled	18	81.8%	as of Dec. 31, 2012	18	81.8%	as of Mar. 31, 2013
1.2 Number and Percentage of Eligible Provider Sites Enrolled	41	66.1%	as of Dec. 31, 2012	41	66.1%	as of Mar. 31, 2013
1.3 Rate of Primary Care Access		10.6%	Avg rate per month in Q1		10.8%	Avg rate per month in Q2
1.4 Rate of Behavioral Health Care Access		1.9%	Avg rate per month in Q1		1.7%	Avg rate per month in Q2

Notes: 22 provider organizations participated in the Primary Care Access Stabilization Grant (PCASG), with 62 service locations throughout the New Orleans metro area. Performance measures 1.1 and 1.2 compare participation in PCASG and GNOCHC.

GOAL 2: Sustain and Advance Medical Home Model

2.1 Attain NCQA PCMH Recognition						
2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition	6	14.6%	as of Dec. 31, 2012	5	12.2%	as of Mar. 31, 2013
2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Levels 1, 2, and 3)	14	34.1%	as of Dec. 31, 2012	14	34.1%	as of Mar. 31, 2013
2.1.3 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 1 Recognition	0	0.0%	as of Dec. 31, 2012	0	0.0%	as of Mar. 31, 2013
2.1.4 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 2 Recognition	3	7.3%	as of Dec. 31, 2012	2	4.9%	as of Mar. 31, 2013
2.1.5 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 3 Recognition	11	26.8%	as of Dec. 31, 2012	12	29.3%	as of Mar. 31, 2013
~~2.2 Provide Enrollees with a Medical Home~~						
~~2.2.1 Number and Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
~~2.2.2 Number and Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH Linkage~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
2.3 Provide Care Coordination Services						
2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed	0	0.0%		0	0.0%	
2.4 Integrate Primary and Behavioral Health Care Services						
2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters	1,088	0.6%		1,038	0.6%	
2.4.2 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters on the Same Date of Service	184	17.0%		156	15.3%	

GOAL 3: Evolve Grant-Funded Model to Financial Sustainability Through Diverse Means of Financing

3.1 Number and Percentage of Enrolled Provider Sites Certified as Medicaid Application Center	39	95.1%		39	95.1%	
3.2 Number and Percentage of Patients Enrolled in the Demonstration	8,129	26.9%		8,398	28.3%	
3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients	6,580	21.8%		6,306	21.2%	
3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees	$4,204,382	39.3%		$6,370,154	50.7%	Includes supplemental pymts.

Notes: This information is self-reported by providers in their semi-annual Sustainability Progress Reports. Performance measures 3.2, 3.3, and 3.4 provide information on GNOCHC enrollees as compared to the total population served by GNOCHC providers.

GOAL 4: Increase Access to Health Care Coverage

4.1 Increase Access to Health Care Coverage to Populations Eligible for the Demonstration						
4.1.1 Total Enrollment	57,028		as of Dec. 31, 2012	58,640		as of Mar. 31, 2013
4.1.2 Number and Percentage of Enrollment in MEG 1 (0-133% FPL)	48,999	85.9%	as of Dec. 31, 2012	50,639	86.4%	as of Mar. 31, 2013
4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL)	8,029	14.1%	as of Dec. 31, 2012	8,001	13.6%	as of Mar. 31, 2013

Notes: As of 1/11/14, income limit changed to under 100% FPL, therefore 4.1.3 no longer captured effective with DY4 Q2 report.

4.2 Reduce Rate of Uninsured Children						
4.2.1 Number and Percentage of Uninsured Patients Under Age 19	1,882	2.9%		2,343	3.8%	
4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP	13,023	20.0%		12,666	20.4%	

Notes: Data for performance measures 4.2.1 and 4.2.2 are self-reported by providers in their semi-annual Sustainability Progess Reports. Reporting was incomplete for some providers, some cannot readily track age-related information in their internal databases.

GOAL 5: Assess Behavioral Health Care Needs of Enrollee Sub-Populations

5.1 Assess Service Utilization and Cost by Parent Population						
5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee with a Child in the Home	1.3	Avg per recipient per month in Q1		1.3	Avg per recipient per month in Q2	
5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home	$133.40	Avg per recipient per month in Q1		$131.12	Avg per recipient per month in Q2	
5.2 Assess Service Utilization and Cost by Childless Population						
5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home	1.3	Avg per recipient per month in Q1		1.3	Avg per recipient per month in Q2	
5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home	$140.12	Avg per recipient per month in Q1		$137.31	Avg per recipient per month in Q2	
5.3 Assess Service Utilization and Cost by Medicaid Expansion Population						
5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	1.3	Avg per recipient per month in Q1		1.3	Avg per recipient per month in Q2	
5.3.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	$140.17	Avg per recipient per month in Q1		$136.72	Avg per recipient per month in Q2	
5.4 Assess Service Utilization and Cost by Exchange Population						
5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	1.2	Avg per recipient per month in Q1		1.3	Avg per recipient per month in Q2	
5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	$128.35	Avg per recipient per month in Q1		$133.58	Avg per recipient per month in Q2	

GOAL 1: Preserve Primary and Behavioral Health Care Access

	FFY13 Q3			FFY13 Q4		
	Number	Percentage		Number	Percentage	
1.1 Number and Percentage of Eligible Provider Organizations Enrolled	18	81.8%	as of June 30, 2013	18	81.8%	as of Sept.30, 2013
1.2 Number and Percentage of Eligible Provider Sites Enrolled	41	66.1%	as of June 30, 2013	41	66.1%	as of Sept.30, 2013
1.3 Rate of Primary Care Access		11.0%	Avg rate per month in Q3		9.7%	Avg rate per month in Q4
1.4 Rate of Behavioral Health Care Access		1.9%	Avg rate per month in Q3		1.4%	Avg rate per month in Q4

Notes: 22 provider organizations participated in the Primary Care Access Stabilization Grant (PCASG), with 62 service locations throughout the New Orleans metro area. Performance measures 1.1 and 1.2 compare participation in PCASG and GNOCHC.

GOAL 2: Sustain and Advance Medical Home Model

2.1 Attain NCQA PCMH Recognition						
2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition	5	12.2%	as of June 30, 2013	3	7.3%	as of Sept.30, 2013
2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Levels 1, 2, and 3)	14	34.1%	as of June 30, 2013	14	34.1%	as of Sept.30, 2013
2.1.3 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 1 Recognition	0	0.0%	as of June 30, 2013	0	0.0%	as of Sept.30, 2013
2.1.4 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 2 Recognition	2	4.9%	as of June 30, 2013	2	4.9%	as of Sept.30, 2013
2.1.5 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 3 Recognition	12	29.3%	as of June 30, 2013	12	29.3%	as of Sept.30, 2013
~~2.2 Provide Enrollees with a Medical Home~~						
~~2.2.1 Number and Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012~~	/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
~~2.2.2 Number and Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH Linkage~~	/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
2.3 Provide Care Coordination Services						
2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed	1	0.0%		0	0.0%	
2.4 Integrate Primary and Behavioral Health Care Services						
2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters	1,298	0.7%		828	0.4%	
2.4.2 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters on the Same Date of Service	258	21.3%		250	30.5%	

GOAL 3: Evolve Grant-Funded Model to Financial Sustainability Through Diverse Means of Financing

3.1 Number and Percentage of Enrolled Provider Sites Certified as Medicaid Application Center	39	95.1%		39	95.1%	
3.2 Number and Percentage of Patients Enrolled in the Demonstration	9,226	26.0%	Data incomplete for most providers.	9,215	31.7%	
3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients	10,275	28.9%	Data incomplete for most providers.	6,214	21.3%	
3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees	$5,140,851	26.4%	Data incomplete for most providers.	$5,470,489.16	35.1%	

Notes: This information is self-reported by providers in their semi-annual Sustainability Progress Reports. Performance measures 3.2, 3.3, and 3.4 provide information on GNOCHC enrollees as compared to the total population served by GNOCHC providers.

GOAL 4: Increase Access to Health Care Coverage

4.1 Increase Access to Health Care Coverage to Populations Eligible for the Demonstration						
4.1.1 Total Enrollment	60,819		as of June 30, 2013	62,656		as of Sept.30, 2013
4.1.2 Number and Percentage of Enrollment in MEG 1 (0-133% FPL)	52,682	86.6%	as of June 30, 2013	54,407	86.8%	as of Sept.30, 2013
4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL)	8,137	13.4%	as of June 30, 2013	8,249	13.2%	as of Sept.30, 2013

Notes: As of 1/11/14, income limit changed to under 100% FPL, therefore 4.1.3 no longer captured effective with DY4 Q2 report.

4.2 Reduce Rate of Uninsured Children						
4.2.1 Number and Percentage of Uninsured Patients Under Age 19	675	0.8%	Data incomplete for most providers.	633	1.0%	
4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP	9,073	10.4%	Data incomplete for most providers.	8,836	13.4%	

Notes: Data for performance measures 4.2.1 and 4.2.2 are self-reported by providers in their semi-annual Sustainability Progess Reports. Reporting was incomplete for some providers, some cannot readily track age-related information in their internal databases.

GOAL 5: Assess Behavioral Health Care Needs of Enrollee Sub-Populations

5.1 Assess Service Utilization and Cost by Parent Population						
5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee with a Child in the Home	1.3		Avg per recipient per month in Q3	1.2		Avg per recipient per month in Q4
5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home	$130.73		Avg per recipient per month in Q3	$129.61		Avg per recipient per month in Q4
5.2 Assess Service Utilization and Cost by Childless Population						
5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home	1.3		Avg per recipient per month in Q3	1.6		Avg per recipient per month in Q4
5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home	$138.26		Avg per recipient per month in Q3	$172.01		Avg per recipient per month in Q4
5.3 Assess Service Utilization and Cost by Medicaid Expansion Population						
5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	1.3		Avg per recipient per month in Q3	1.6		Avg per recipient per month in Q4
5.3.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	$137.40		Avg per recipient per month in Q3	$166.70		Avg per recipient per month in Q4
5.4 Assess Service Utilization and Cost by Exchange Population						
5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	1.3		Avg per recipient per month in Q3	1.2		Avg per recipient per month in Q4
5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	$135.47		Avg per recipient per month in Q3	$129.23		Avg per recipient per month in Q4

	FFY14 Q1			FFY14 Q2		
	Number	Percentage		Number	Percentage	
GOAL 1: Preserve Primary and Behavioral Health Care Access						
1.1 Number and Percentage of Eligible Provider Organizations Enrolled	18	81.8%	as of Dec 31, 2013	18	81.8%	as of Mar 31, 2014
1.2 Number and Percentage of Eligible Provider Sites Enrolled	41	66.1%	as of Dec 31, 2013	41	66.1%	as of Mar 31, 2014
1.3 Rate of Primary Care Access		10.7%	Avg rate per month in Q1		10.5%	Avg rate per month in Q2
1.4 Rate of Behavioral Health Care Access		1.9%	Avg rate per month in Q1		1.5%	Avg rate per month in Q2
Notes: 22 provider organizations participated in the Primary Care Access Stabilization Grant (PCASG), with 62 service locations throughout the New Orleans metro area. Performance measures 1.1 and 1.2 compare participation in PCASG and GNOCHC.						
GOAL 2: Sustain and Advance Medical Home Model						
2.1 Attain NCQA PCMH Recognition						
2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition	0	0.0%	as of Dec 31, 2013	0	0.0%	as of Mar 31, 2014
2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Levels 1, 2, and 3)	14	34.1%	as of Dec 31, 2013	15	36.6%	as of Mar 31, 2014
2.1.3 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 1 Recognition	0	0.0%	as of Dec 31, 2013	0	0.0%	as of Mar 31, 2014
2.1.4 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 2 Recognition	2	4.9%	as of Dec 31, 2013	3	7.3%	as of Mar 31, 2014
2.1.5 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 3 Recognition	12	29.3%	as of Dec 31, 2013	12	29.3%	as of Mar 31, 2014
~~2.2 Provide Enrollees with a Medical Home~~						
~~2.2.1 Number and Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
~~2.2.2 Number and Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH Linkage~~	N/A - No PCMH Linkages in GNOCHC			N/A - No PCMH Linkages in GNOCHC		
2.3 Provide Care Coordination Services						
2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed	0	0.0%		0	0.0%	
2.4 Integrate Primary and Behavioral Health Care Services						
2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters	1,204	0.6%		932	1.8%	
2.4.2 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters on the Same Date of Service	356	30.1%		244	79.0%	
GOAL 3: Evolve Grant-Funded Model to Financial Sustainability Through Diverse Means of Financing						
3.1 Number and Percentage of Enrolled Provider Sites Certified as Medicaid Application Center	39	95.1%		39	95.1%	
3.2 Number and Percentage of Patients Enrolled in the Demonstration	19,531	30.1%	4 out of 18 provider organizations did not provide	18,750	24.9%	4 out of 18 provider organizations did not provide
3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients	14,777	24.1%	6 out of 18 provider organizations did not provide	19,274	27.7%	5 out of 18 provider organizations did not provide
3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees	$4,406,102	41.0%	4 out of 18 provider organizations did not provide	$3,407,362	31.5%	4 out of 18 provider organizations did not provide
Notes: This information is self-reported by providers in their semi-annual Sustainability Progress Reports. Performance measures 3.2, 3.3, and 3.4 provide information on GNOCHC enrollees as compared to the total population served by GNOCHC providers.						
GOAL 4: Increase Access to Health Care Coverage						
4.1 Increase Access to Health Care Coverage to Populations Eligible for the Demonstration						
4.1.1 Total Enrollment	50,955		as of Dec 31, 2013	50,461		as of Mar 31, 2014
4.1.2 Number and Percentage of Enrollment in MEG 1 (0-133% FPL)	49,829	97.8%	as of Dec 31, 2013	50,461	100.0%	as of Mar 31, 2014
4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL)	1,126	2.2%	as of Dec 31, 2013	N/A	N/A	as of Mar 31, 2014
Notes: As of 1/11/14, income limit changed to under 100% FPL, therefore 4.1.3 no longer captured effective with DY4 Q2 report.						
4.2 Reduce Rate of Uninsured Children						
4.2.1 Number and Percentage of Uninsured Patients Under Age 19	563	0.9%	6 out of 18 provider organizations did not provide	819	1.2%	5 out of 18 provider organizations did not provide
4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP	7,123	11.6%	6 out of 18 provider organizations did not provide	8,395	12.1%	5 out of 18 provider organizations did not provide
Notes: Data for performance measures 4.2.1 and 4.2.2 are self-reported by providers in their semi-annual Sustainability Progess Reports. Reporting was incomplete for some providers, some cannot readily track age-related information in their internal databases.						
GOAL 5: Assess Behavioral Health Care Needs of Enrollee Sub-Populations						
5.1 Assess Service Utilization and Cost by Parent Population						
5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee with a Child in the Home	1.2	Avg per recipient per month in Q1		1.2	Avg per recipient per month in Q2	
5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home	$122.92	Avg per recipient per month in Q1		$121.47	Avg per recipient per month in Q2	
5.2 Assess Service Utilization and Cost by Childless Population						
5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home	1.8	Avg per recipient per month in Q1		1.4	Avg per recipient per month in Q2	
5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home	$181.68	Avg per recipient per month in Q1		$147.57	Avg per recipient per month in Q2	
5.3 Assess Service Utilization and Cost by Medicaid Expansion Population						
5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	1.7	Avg per recipient per month in Q1		1.5	Avg per recipient per month in Q2	
5.3.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	$178.70	Avg per recipient per month in Q1		$155.46	Avg per recipient per month in Q2	
5.4 Assess Service Utilization and Cost by Exchange Population						
5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	1.3	Avg per recipient per month in Q1		1.7	Avg per recipient per month in Q2	
5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	$129.57	Avg per recipient per month in Q1		$169.76	Avg per recipient per month in Q2	

DEPARTMENT OF HEALTH
CITY OF NEW ORLEANS

MITCHELL J. LANDRIEU
MAYOR

ANDREW D. KOPPLIN
FIRST DEPUTY MAYOR AND
CHIEF ADMINISTRATIVE OFFICER

CHARLOTTE M. PARENT, RN, MHCM
DIRECTOR OF HEALTH

April 21, 2014

Secretary Kathy Kliebert
Louisiana Department of Health and Hospitals
628 N. 4th Street
Baton Rouge, LA 70802

Dear Secretary Kliebert:

It has been our pleasure to partner with the State to rebuild the primary care health network devastated by Hurricane Katrina in the four parish region of Jefferson, Plaquemines, St. Bernard, and Orleans. That partnership, initially through the Primary Care Access to Stabilization Grant (PCASG) program and now through the Louisiana Section 1115a Medicaid Demonstration Waiver (Waiver), has allowed the four parish region to provide a broad array of primary care services at a low cost and with exceptional outcomes. Moreover, financial responsibility assessments by the U.S. Department of Health and Human Services (HHS), Office of Inspector General, have demonstrated a responsible use of funding made available by the Waiver.

The Waiver, known as the Greater New Orleans Community Health Connection (GNOCHC), is a critical program that provides access to primary care and mental health services to nearly 53,000 in the New Orleans region who do not qualify for traditional Medicaid. Although GNOCHC is expected to expire in August of this year, HHS has announced that it will consider an extension of the Waiver beyond 2014.

In 2013, the Legislature expressed its support for an extension of the Waiver through adoption of Senate Concurrent Resolution No. 108. I therefore respectfully request, on behalf of the network of providers and the patients benefiting from these essential primary care services, that you submit a letter seeking an extension of the Waiver for three additional years. Extending the program through December 2014 would require identifying $4 million by May 1, which would leverage an additional $6.5 million in federal funding. Continued support would require $10 million annually identified by June 30, 2014 to leverage $16.4 million in federal funding each year.

Nearly 53,000 GNOCHC enrollees will lose access to primary care and mental health services and will become uninsured if this program comes to an abrupt end at the close of 2014. The financial impact of this devastating cut to primary care and mental health coverage in the region is one that we simply cannot afford.

It is our intention, in collaboration with the business communities of the four parish region, local political leaders, and our state legislative delegation, to partner with your Administration to find and secure matching funds required to fund the services under the Waiver.

Sincerely,

Charlotte M. Parent, RN, MHCM
Director of Health, City of New Orleans

June 26, 2014

Secretary Kathy Kliebert
Louisiana Department of Health & Hospitals
P. O. Box 629
Baton Rouge, LA 70821-0629
Dear Secretary Kliebert:

Thank you for your leadership and support for the Greater New Orleans Community Health Connection (GNOCHC) Section 1115(a) Medicaid Demonstration Waiver. While the Waiver is currently set to expire on December 31, 2014, we understand the Louisiana Department of Health and Hospitals (DHH) is submitting a Waiver Renewal package to the Center for Medicare and Medicaid Services (CMS) to continue the Waiver for another three years. Daughters of Charity is in full support of this essential program and commend your actions to continue it.

We have directly heard from GNOCHC patients that they are extremely appreciative of this program that allows them to receive badly needed care in a high-quality setting. They have expressed their fear that if the program ends, they will not be able to pay for care that they desperately need, but cannot afford. This will only cause them to delay care, and present in a more complex state later to the emergency room.

If the program ends in December, it will have a substantial impact on the number of patient that receive quality care in the Greater New Orleans region. At some point organizations like us will have to make a decision regarding the quality of care that we can continue to provide, where we can provide it, and how feasible it is for us to continue to render care to as many uninsured patients as we have been serving. We anticipate seeing a significant population of patients begin to use the local emergency rooms if patients lose this valuable coverage.

The GNOCHC program should be renewed because it allows community health centers to continue to provide high quality care to patients and to keep them healthy and alive. It is also a cost saving mechanism to Louisiana tax payers by keeping patients out of emergency rooms. It is an important form of healthcare coverage that keeps people who are vulnerable, poor and unable to provide for themselves, from choosing between food and healthcare. Simply put, it keeps people alive.

Thank you for your support and efforts to continue this extremely important program.

Sincerely,

[redacted]

Mike Griffin
President/CEO

Mailing Address:
Daughters of Charity Health Centers ~ P O Box 13038 ~ New Orleans, LA 70178
(504)482-2080

504Healthnet.org

June 26, 2014

Secretary Kathy Kliebert
Louisiana Department of Health & Hospitals
P. O. Box 629
Baton Rouge, LA 70821-0629

Dear Secretary Kliebert:

Thank you for your leadership and support for the Greater New Orleans Community Health Connection (GNOCHC) Section 1115(a) Medicaid Demonstration Waiver. While Waiver is currently set to expire on December 31, 2014, we understand the Louisiana Department of Health and Hospitals (DHH) is submitting a Waiver Renewal package to CMS to continue the Waiver for another three years. Without the GNOCHC Waiver, our community will experience a devastating decrease in access to primary care and mental health services. We are in full support of this essential program and commend your actions to continue it.

As you know, GNOCHC is a vital program in our community providing primary care and mental health services to 53,000 individuals at or below 100% FPL in the New Orleans region. If it ends, tens of thousands of residents would lose access to primary care and mental health services and become uninsured. They would have little access to care except through the emergency rooms.

This program reinforces and financially supports the region's primary care and behavioral health safety net clinics allowing residents to obtain high-quality care in the appropriate setting, irrespective of ability to pay. Without it, the GNOCHC providers, majority of them who are 504HealthNet members, would face a crushing financial blow forcing them to decrease services and potentially driving some clinic sites to close.

Thank you for supporting GNOCHC, which is an example of government and community leaders working together to create an innovative program that works for Louisiana.

Sincerely,

2601 Tulane Ave., Suite 500, New Orleans, LA 70119
504.383.5524 · www.504healthnet.org

[redacted]

Access Health Louisiana
Mark Keiser

[redacted]

City of New Orleans Health Department
Charlotte Parent

[redacted]

Covenant House
James R. Kelly

[redacted]

Daughters of Charity Services of New Orleans
Michael G. Griffin

[redacted]

EXCELth, Inc.
Michael Andry

[redacted]

Jefferson Community Health Care Centers,
Shondra Williams

[redacted]

Interim LSU Hospital
Paolo Zambito

[redacted]

LSU Health Care Network
Cathi Fontenot

[redacted]

Mercy Family Center
Rex Menasco

[redacted]

Metropolitan Human Services District
Yolanda Webb

[redacted]

NO/AIDS Task Force
Seema Gai

[redacted]

NO/AIDS Task Force
Noel Twilbeck

[redacted]

PACE Greater NO
Stephanie Smith

[redacted]

St. Anna's Medical Mission
Diana Meyers

[redacted]

St. Thomas Community Health Center
Donald Erwin, CEO

[redacted]

St. Thomas Community Health Center
Mary Deynoodt, COO

[redacted]

Tulane Community Health Centers
Eboni Price-Haywood

ILH
Interim LSU Hospital

June 26, 2014

Secretary Kathy Kliebert
Louisiana Department of Health & Hospitals
P. O. Box 629
Baton Rouge, LA 70821-0629

Dear Secretary Kliebert:

Thank you for your leadership and support for the Greater New Orleans Community Health Connection (GNOCHC) Section 1115(a) Medicaid Demonstration Waiver. While the Waiver is currently set to expire on December 31, 2014, I understand the Louisiana Department of Health and Hospitals (DHH) is submitting a Waiver Renewal package to CMS to continue the Waiver for another three years. The Interim LSU Hospital (ILH) and the future University Medical Center is in full support of this essential program and commends your actions to continue it.

We have directly heard from GNOCHC patients that they are extremely appreciative of this program that allows them to receive much needed care in a high-quality setting. They have expressed their fear that if the program ends, they will not be able to pay for care that they desperately need, but cannot afford. This will only cause them to delay care, and present in a more complex state later to the emergency room or hospital.

If the program ends in December, it will have a substantial impact on the number of patients that receive high-quality care in the Greater New Orleans region. If patients lose this valuable coverage we anticipate seeing an increase in the use of the local emergency rooms and patients needing a higher level of care and therefore more costly. The GNOCHC program should be renewed because it allows community health centers to continue to provide high quality care to patients and to keep them healthy and alive. It is an important form of healthcare coverage that allows low-income people to receive the care they need.

Thank you for your support and efforts to continue this extremely important program.

Sincerely,

[redacted]

Paolo Zambito, RN
Senior VP of Operations, ILH

2021 Perdido Street
New Orleans, LA 70112
504-903-3000
www.umcno.org

LOUISIANA HOSPITAL ASSOCIATION

9521 BROOKLINE AVENUE ◆ BATON ROUGE, LOUISIANA 70809-1431
(225) 928-0026 ◆ FAX (225) 923-1004 ◆ www.lhaonline.org

April 10, 2014

Honorable Bobby Jindal
Governor, State of Louisiana
P.O. Box 94004
Baton Rouge, LA 70804-9004

Dear Governor Jindal:

As you know, Louisiana's Section 1115a Medicaid Demonstration Waiver, the Greater New Orleans Community Health Connection (GNOCHC), is a critical program that provides primary care and mental health services to nearly 53,000 individuals in the New Orleans region who do not qualify for traditional Medicaid.

GNOCHC is scheduled to expire in August 2014 and, if eliminated, the program's participants will lose access to primary care and mental health services and will become uninsured. The financial impact of this is a devastating cut to primary care and mental health services in the region that we simply cannot afford.

Your administration's leadership in applying for and administering GNOCHC has been commendable. Since it began in 2010, GNOCHC has become a national model that has been praised by the State and the Office of Inspector General as successful and fiscally responsible; it has also been supported by other independent organizations such as GNO, Inc. and the New Orleans Business Council.

GNOCHC is a great example of State, Parish, and community leaders working in concert to create an innovative program that works for Louisiana. We must continue to work together to ensure that our area's most vulnerable residents can gain access to high-quality, affordable health care. The LHA supports the extension of this important program.

Sincerely,

Paul A. Salles
President & CEO

Parish President's Office
Billy Nungesser

April 4, 2014

Honorable Bobby Jindal
Governor, State of Louisiana
P.O. Box 94004
Baton Rouge, LA 70804-9004

Dear Governor Jindal:

Louisiana's Section 1115a Medicaid Demonstration Waiver, the Greater New Orleans Community Health Connection (GNOCHC), is a critical program which provides primary care and mental health services to nearly 53,000 in the New Orleans region who do not qualify for traditional Medicaid. The funding for GNOCHC is expected to come to an end in August, 2014.

Extending the program through December 2014 would require identifying $4 million by May 1, 2014 which would leverage an additional $6.5 million in Federal funding. Continued support would require $10 million annually identified by June 30, 2014 to leverage $16.4 million in Federal funding for a program total of$26.4 million. Nearly 53,000 GNOCHC enrollees will lose access to primary care and mental health services and will become uninsured if this program comes to an abrupt end at the end of 2014. The financial impact of this is a devastating cut to primary care and mental health services in the region that we simply cannot afford.

GNOCHC is a national model that has been praised by the State, independent organizations, and the Office of Inspector General as successful and fiscally responsible. Through this program, residents who would otherwise be uninsured in Plaquemines Parish receive high-quality primary and preventive care in a network of community health centers that provide care to everyone irrespective of ability to pay. This network includes Plaquemines Primary Care and Access Health, who would be negatively affected by a discontinuation of GNOCHC. Without this program, the number of uninsured residents would increase by approximately 25 percent.

Senate Concurrent Resolution 108, passed unanimously by both the Louisiana House and Senate in 2013, urges you and the Department of Health and Hospitals to extend GNOCHC for three years, which is an option you have with the Centers for Medicare and Medicaid Services (CMS). It also requests that you identify a source of funding for the non-federal funds required under the extended Waiver. I am in strong support of S. Con. Res. 108.

GNOCHC is a perfect example of State, Parish leaders, and community providers working in concert to create an innovative program that works for Louisiana. I look forward to working with you to extend and fund this vital program.

Sincerely,

[redacted]

William "Billy" Nungesser
Parish President
Plaquemines Parish

cc: Kathy Kliebert, Secretary of the Department of Health and Hospitals

St. Bernard Parish Government

8201 West Judge Perez Drive
Phone (504) 278-4200

Chalmette, Louisiana 70043
Fax (504) 278-4330

David E. Peralta
Parish President

April 2, 2014

Honorable Bobby Jindal
Governor, State of Louisiana
P.O. Box 94004
Baton Rouge, LA 70804-9004

Dear Governor Jindal:

As you know, Louisiana's Section 1115a Medicaid Demonstration Waiver, the Greater New Orleans Community Health Connection (GNOCHC), is a critical program which provides primary care and mental health services to nearly 53,000 in the New Orleans region who do not qualify for traditional Medicaid. The funding for GNOCHC is expected to expire in August, 2014.

Nearly 53,000 GNOCHC enrollees will lose access to primary care and mental health services and will become uninsured if this program comes to an abrupt end at the end of 2014. The financial impact of this is a devastating cut to primary care and mental health services in the region that we simply cannot afford. Extending the program through December 2014 would require identifying $4 million by May 1, 2014 which would leverage an additional $6.5 million in Federal funding. Continued support would require $10 million annually identified by June 30, 2014 to leverage $16.4 million in Federal funding for a program total of $26.4 million.

Thank you for your Administration's leadership to apply for and administer GNOCHC since it began in 2010. GNOCHC is a national model that has been praised by the State, independent organizations, and the Office of Inspector General as successful and fiscally responsible. Through this program, St. Bernard Parish residents receive high-quality primary and preventive care in a network of community health centers that provide care to everyone irrespective of ability to pay. This network includes Access Health and Metropolitan Human Services District's St. Bernard locations. Without this program, our parish would see approximately a 35% increase in the number of uninsured residents.

Senate Concurrent Resolution 108, passed unanimously by both the Louisiana House and Senate in 2013, urges you and the Department of Health and Hospitals to extend GNOCHC for three years, which is an option you have with the Centers for Medicare and Medicaid Services (CMS). It also

requests that you identify a source of funding for the non-federal funds required under the extended Waiver. I am in strong support of S. Con. Res. 108.

GNOCHC is a perfect example of State, Parish leaders, and community providers working in concert to create an innovative program that works for Louisiana. I look forward to working with you to extend and fund this vital program.

Sincerely,

[redacted]

David Peralta
Parish President
St. Bernard Parish

GNOCHC Annual Report

FFY11

State of Louisiana Greater New Orleans
Community Health Connection Demonstration
11-W-00252/6

Submitted to CMS
January 25, 2012

INTRODUCTION

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00252/6, Section 1115(a) Demonstration, 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 Greater New Orleans Community Health Connection (GNOCHC) Annual Report for Demonstration Year 1 (October 1, 2010 through September 30, 2011). Due to be submitted to CMS by January 27, 2012 under the revised schedule established by CMS for deliverables during the Demonstration, this document satisfies the requirements of STC V. 38 – Annual Report.

This draft documents accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration during year 1. It also contains:

- 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;
- Data and findings of health status of the population served under the Demonstration;
- The number of persons served and the allocation of funds per GNOCHC provider under the Demonstration;
- Data and findings of cost of providing care to persons served under the Demonstration;
- Updates on the State's success in meeting the milestones listed in section VIII; and
- The progress and outcome of any GNOCHC program receiving FFP.

BACKGROUND

Through the Greater New Orleans Community Health Connection program, Louisiana will:

- Preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with Primary Care Access and Stabilization Grant (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. By Demonstration month 10 (July 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 State Health Benefits Exchange, and Demonstration phase-down.

YEAR IN REVIEW

MILESTONE SUCCESS

During Demonstration Year 1, the State successfully met the schedule established in the STCs by CMS for deliverables during the period. It:

- Submitted timely the outreach strategy described in STC VIII. 53. a.
- Implemented ahead of schedule the eligibility system described in VIII. 53. b.
- Executed with eligible entities provider agreements described in IV. 27.
- Made urgent sustainability payments to eligible providers described in IV. 23.
- Submitted timely the Funding and Reimbursement Protocol described in IV. 21.
- Submitted ahead of schedule encounter data requirements described in IV. STC 25.
- Submitted timely the Evolution Plan described in VIII. 53. c.
- Submitted timely the Accounting and Audit Protocol described in V. 34.
- Submitted timely the Administrative Cost Claiming Protocol described in VI. 24.
- Submitted the draft Evaluation Design described in IX. 54.
- Actively participated in the monthly calls described in V. 35.
- Submitted timely the quarterly reports described in V. 36, including the budget neutrality reporting described in VI. 42.
- Provided the quarterly expenditure reports described in VI. 40.
- Submitted a successful application for CDBG funds to serve as source of non-Federal share of expenditures under the Demonstration described in VI. 45.
- Executed a Cooperative Endeavor Agreement to implement the CDBG award.
- Ensured providers submitted the sustainability plans and progress reports described in IV. 20.
- Ensured providers submitted the quarterly community care coordination and infrastructure investment expenditure reports described in Attachment C – Funding and Reimbursement Protocol.
- Prepared for the submission of encounter data to MSIS described in IV. 26.

In addition, the State:

- Secured from CMS approval for the Funding and Reimbursement Protocol.
- Negotiated with CMS toward approval of the Accounting and Audit Protocol, Administrative Cost Claiming Protocol, Evaluation Design, and Evolution Plan.
- Submitted to and secured CMS approval for an amendment request described in IV. 6 and 7 to remove pharmacy from the table of standard benefits in the STCs.

ACCOMPLISHMENTS

Through these milestone successes, the State accomplished its Phase 1 goals, most notably:

- It enrolled tens of thousands of eligible, low-income uninsured adults into basic health care coverage.
- It transformed PCASG awardees into coverage model-driven health care providers with routine Medicaid enrollment and billing processes.
- It transitioned provider revenues from PCASG grant-like interim payments to Medicaid-like enrollee encounter rate payments while preserving health care access restored by and sustaining the medical home model begun under PCASG.
- Substantially completed program start up, paving the way for routine program operations in Demonstration year 2.

The following sections detail these accomplishments.

ENROLLMENT OF ELIGIBLE INDIVIDUALS

The STCs approved by CMS for the Demonstration required the State to implement by March 1, 2011 a 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.

Implementation required the completion of numerous tasks, including:

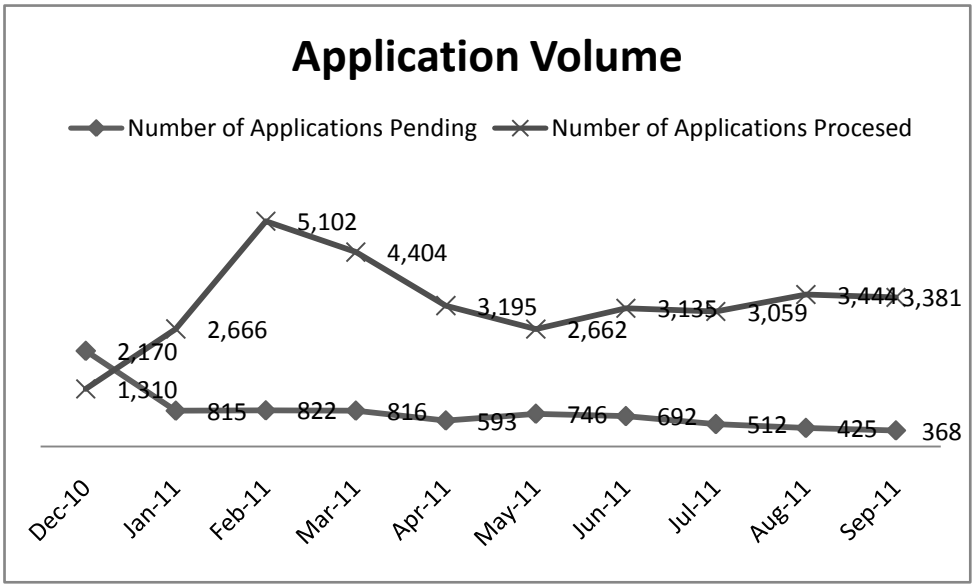
- Development and issuance of GNOCHC eligibility policy and procedures, and training of eligibility staff;
- Development of a flyer for purposes of enrollment outreach;
- Provider training on the Medicaid Application Center certification process and certification of GNOCHC providers;
- Edits to Medicaid Eligibility Data System (MEDS) to provide for GNOCHC eligibility determination;
- Edits to the Medicaid Management Information System (MMIS) to receive GNOCHC eligibility data; and,
- Updates to telephone and online systems for provider verification of enrollee eligibility.

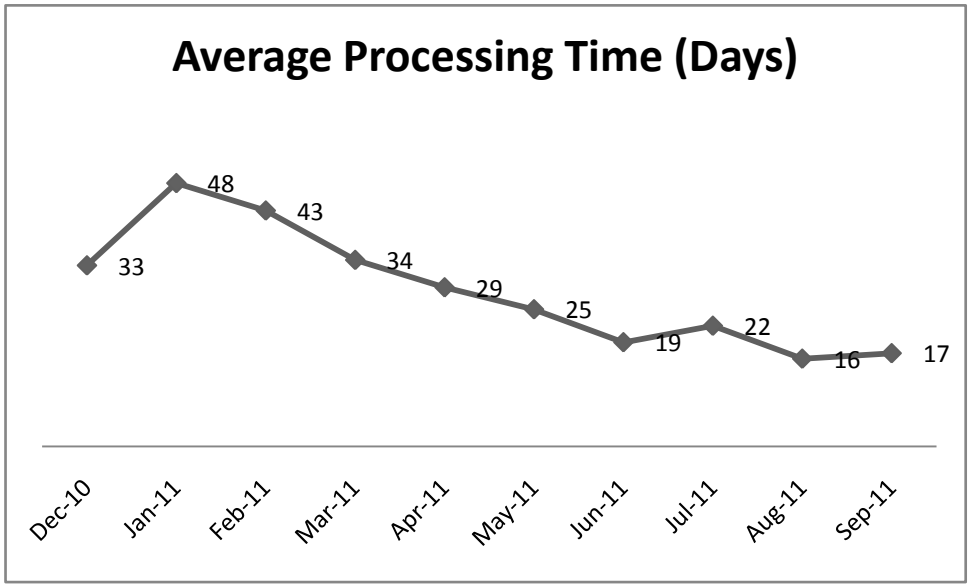
The State completed these tasks and began GNOCHC eligibility determination by mid-December 2010, by which time nearly three thousand GNOCHC applications had been received by the Medicaid agency. To ensure timely application processing, eligibility management temporarily tasked eligibility staff from other regions of the state to assist New Orleans area staff with GNOCHC start up volume. It also targeted resources to streamline the new enrollment system and eliminate application backlog, including:

- Site visits to a sample of GNOCHC participating providers to assess the enrollment process and identify opportunities for improvement;

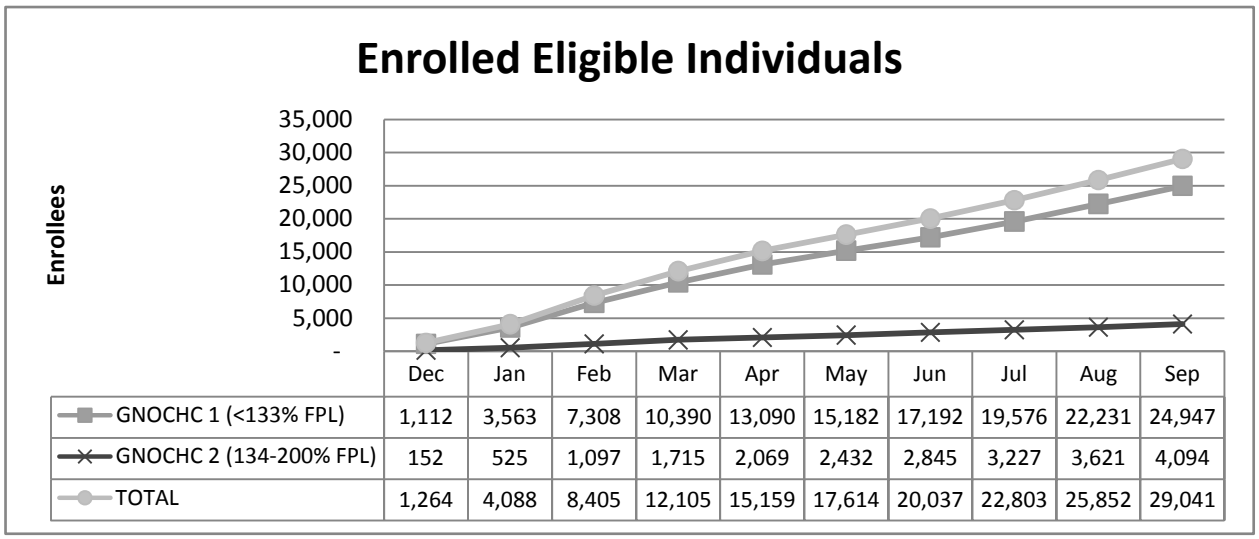
- Solicitation of improvement ideas and feedback on proposed changes from local eligibility staff and GNOCHC participating providers;
- Rerouting of digital fax receipts and web-based application processing queues;
- Revision of the GNOCHC application form;
- Development of GNOCHC application submission instructions; and,
- Training for GNOCHC participating providers on the revised GNOCHC application form and submission instructions.

Through these efforts, winter's application backlog was eliminated by spring, and by summer the enrollment process had normalized.





Monthly enrollment growth rates mirrored application processing trends. Winter's triple digit percentage increases settled into the teens by late spring, with enrollment ending at 29,041 for Demonstration year 1. Enrollment is biased heavily toward the low end of the income spectrum, with 86 percent of enrollees with income below 133 percent of the Federal Poverty Level (FPL).



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
GNOCHC 1 (<133% FPL)	1,112	3,563	7,308	10,390	13,090	15,182	17,192	19,576	22,231	24,947
GNOCHC 2 (134-200% FPL)	152	525	1,097	1,715	2,069	2,432	2,845	3,227	3,621	4,094
TOTAL	1,264	4,088	8,405	12,105	15,159	17,614	20,037	22,803	25,852	29,041

ENROLLMENT OF ELIGIBLE PROVIDERS

Concurrent with the enrollment of eligible individuals was the enrollment of eligible providers, which required:

- Education of eligible providers on the terms and conditions approved by CMS for the Demonstration, including provider requirements;
- Development of boilerplate GNOCHC provider agreement for CMS-approval;
- Issuance of CMS-approved provider enrollment packet (See Attachment 5);
- Education of eligible providers on the GNOCHC provider enrollment process; and,
- Enrollment of eligible provider organizations.

Most eligible organizations and sites enrolled as providers in the Demonstration. Eligible providers or sites that did not enroll as GNOCHC providers generally specialized in populations and/or services funded under PCASG but not under the Demonstration, such as children and elderly adults, immigrants not meeting citizenship requirements, or dental and ophthalmology services.

In all, 20 provider organizations, including 45 service sites were enrolled as Demonstration providers during Demonstration year 1.

GNOCHC Enrolled Providers

Organization	Service Site Name	Service Site Location
Administrators of the Tulane Educational Fund	Tulane Community Health On The Move	1430 Tulane Ave/SL16, New Orleans
	New Orleans Children's Health Project	1430 Tulane Ave SL37, New Orleans
	Drop In Center	1428 N Rampart St, New Orleans
	Walter L. Cohen School Based Health Clinic	3520 Dryades St, New Orleans
	Adolescent Drop-In Clinic	611 N Rampart St, New Orleans
	Tulane Community Health Center at Covenant House	611 N Rampart St, New Orleans
	Tulane Community Health Center New Orleans East	4626 Alcee Fortier Blvd/Ste D, New Orleans
City of New Orleans Health Department	New Orleans East	5640 Read St/Ste 540, New Orleans
	Edna Pilsbury	2222 Simon Blvd Ave, New Orleans
	Algiers Community Health Clinic	1111 Newton St, New Orleans
	Health Care for the Homeless	2222 Simon Boliver Ave Fl 2, New Orleans
Common Ground Health Clinic	Common Ground Health Clinic	1400 Teche St, New Orleans
Daughters of Charity Services of New Orleans	Carrolton	3201 S Carrollton, New Orleans
	Metairie	111 N Causeway, Metairie
	Gentilly	1030 Lesseps St, New Orleans
EXCELth, Incorporated	Gentilly	2050 Caton St, New Orleans
	Algiers	4422 General Meyer Ave/Ste 103, New Orleans
Jefferson Community Health Care	Avondale	4028 US Hwy 90, Avondale
	Marrero	1855 Ames Blvd, Marrero
	Grand Isle	108 Willow Ln, Grand Isle
	River Ridge	11312 Jefferson Hwy, River Ridge
Jefferson Parish Human Service Authority	West Jefferson	5001 Westbank Expy, Marrero
	East Jefferson	2400 Edenborn Ave, Metairie
Leading Edge Services International	Family Health Center	1501 Newton St/Ste C, New Orleans
Louisiana State University School of Medicine	LSU Healthcare Network Behavioral Health	3450 Chestnut St, New Orleans
Medical Center of Louisiana at New Orleans	Interim LSU Public Hospital	1200 L B Landry Ave, New Orleans
	MCLNO-Martin Behrman	725 Valette St, New Orleans
	Interim LSU Public Hospital	136 S Roman St, New Orleans
	Interim LSU Public Hospital	1400 Poydras St, New Orleans
	University Medical Office Building	2025 Gravier St, New Orleans

GNOCHC Enrolled Providers (continued)

Organization	Service Site Name	Service Site Location
Metropolitan Human Services District	Algiers	4422 Gen Meyer Ave/Ste 201, New Orleans
	St Bernard	7407 St Bernard Ave/Ste A, Arabi
	New Orleans East	5552 Read Blvd, New Orleans
	Central City	2221 Philip St, New Orleans
	Chartres-Ponchartrain	719 Elysian Fields Ave, New Orleans
Mary Queen of Vietnam Community Development Corporation	NOELA	4626 Alcee Fortier Blvd/Ste D, New Orleans
New Orleans Musicians Assistance Foundation	New Orleans Musicians Assistance Clinic	2820 Napoleon Ave #890, New Orleans
NO/AIDS Task Force	NO/AIDS Task Force	2601 Tulane Ave, New Orleans
Odyssey House Inc Louisiana	Odyssey House	1125 N Tonti St, New Orleans
Plaquemines Primary Care	Plaquemines Primary Care Inc	26851 Hwy 23/Ste A, Port Sulphur
Sisters of Mercy Ministries	Mercy Family Center	110 Veterans Mem Blvd/Ste 425, Metairie
St Bernard Community Health Center	St Bernard Community Health Center	7718 W Judge Perez Dr, Arabi
St Charles Community Health Center	St Charles Community Health Center	200 W Esplanade Ave, Kenner
St Thomas Community Health Center	St Thomas Community Health Center	1020 St Andrew St, New Orleans
	St Thomas Community Health Center	2405 Jackson Ave, New Orleans

PROVIDER ENROLLMENT CHANGES

Over the course of Demonstration year 1, three types of changes in provider enrollment occurred: site closures, site openings, and site ownership transfers.

SITE CLOSURES

- Jefferson Community Health Care closed its Grand Isle site in January.
- Leading Edge closed its sole site in March.
- The City of New Orleans phased out its direct delivery of primary care services, and closed three of its four sites:
    - Algiers Community Health Clinic closed in May;
    - Edna Pilsbury closed in June; and,
    - New Orleans East closed in August.
- Tulane closed its New Orleans East site in February.

SITE OPENINGS

- Mary Queen of Vietnam Community Development Corporation, with CMS approval of its participation as a provider under the Demonstration, assumed operations of the former Tulane New Orleans East site in March.
- EXCELth opened its Algiers site in May, returning it to its pre-Katrina location.
- Interim LSU Hospital / Medical Center of Louisiana at New Orleans opened its University Medical Office Building site in August.
- Plaquemines Primary Care opened its Port Sulphur site in April.

OWNERSHIP TRANSFERS

- St. Bernard Community Health Center was purchased by St. Charles Community Health Center effective March 1.
- Tulane transferred ownership of its New Orleans East service site to Mary Queen of Vietnam Community Development Corporation effective March 1, as noted above.

At year's end, 19 organizations, including 39 service sites, remained active participants in the GNOCHC program.

PROVIDER PAYMENTS

PAYMENT METHOD OVERVIEW

The following summary of Demonstration Year 1 provider payments considers both the interim payments made during the Demonstration Year 1 and the targeted, incentive, and encounter rate payments that would have been made for Demonstration Year 1 under the approved funding protocol as identified in the Preliminary Reconciliation Report submitted to CMS on December 30, 2011. For purposes of understanding this summary, an overview of the terms governing these payments, including the STCs approved for the Demonstration by CMS on September 22, 2010 and STC Attachment C - Funding and Reimbursement Protocol approved by CMS on June 27, 2011, is provided below.

STC IV. 23.

STC IV. 23. a. permitted the State to make urgent sustainability payments during the first quarter of Demonstration Year 1 to any eligible GNOCHC provider requiring financial support to maintain clinical operations while the State sought to obtain CMS approval for the Funding and Reimbursement Protocol.

STC IV. 23. b. through d. define the urgent sustainability payment in terms of a GNOCHC provider's historical grant award received under the Primary Care Access and Stabilization Grant (PCASG). A provider's urgent sustainability payment amount may equal up to one quarter of the provider's average annual PCASG grant award amount over the three-year PCASG grant period.

STC. 23. f. requires the State to reconcile the amount of the urgent sustainability payment paid to a provider against the actual payments that would have been made to the provider based on the approved Funding and Reimbursement Protocol, and submit to CMS a document detailing the reconciliations and any over or under payments identified. It also permits any overpayment to be offset against a provider's payments in the quarter following the reconciliation and any underpayment to be made in the quarter following the reconciliation.

FUNDING AND REIMBURSEMENT PROTOCOL

The Funding Protocol approved on June 28, 2011 provides for four reimbursement methodologies under the Demonstration: 1) interim payments, 2) targeted payments, 3) incentive payments, and 4) encounter rate payments.

1) Interim payments

The funding protocol permits interim payments for Demonstration Year 1 only, and defines interim payments to include urgent sustainability payments. In addition to the urgent sustainability payments, the funding protocol permits interim payments for the January through September 2011 period. The formula in the protocol for determining a provider's maximum interim payment amount is the essentially same as the formula in the STCS for determining a provider's maximum urgent sustainability amount. The only difference is the frequency, which does not change the maximum payment amount. The urgent sustainability payment is a single quarterly amount whereas the interim payment is a monthly amount up to the one third of the urgent sustainability payment amount. The protocol permits interim payment amounts less than the maximum.

2) Targeted payments

The protocol provides for two types of targeted payments: community care coordination payments and infrastructure investment payments.

COMMUNITY CARE COORDINATION PAYMENTS are permitted through September 30, 2011 only, not to exceed ten percent of total computable expenditures. Community care coordination is defined as provider initiatives to improve the health of the communities they serve; it is distinct from enrollee care coordination which is separately reimbursed in the primary care encounter rate. Payments will be based on limited allocations. The State will allocate and pay the total amount available for community care coordination among providers based on each provider's share of the total number of uninsured adult encounters reported by all participating providers for the most recent twelve month period. Any payments unspent by the end of Demonstration Year 1 will be reallocated in the yearend adjustment.

INFRASTRUCTURE INVESTMENT PAYMENTS are permitted throughout the Demonstration, not to exceed ten percent of total computable expenditures. Infrastructure investment payments cover expenditures to support the providers' delivery of services, billing for services, financial accountability, and encounter/quality reporting. Payments will be based on applications from participating providers and the State's assessment of the extent to which a provider's application meets designated criteria for targeted infrastructure investment. They will not cover any costs for the acquisition, construction or renovation of bricks and mortar.

3) Incentive payments

The protocol provides for quarterly **NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) PATIENT CENTERED MEDICAL HOME (PCMH) RECOGNITION INCENTIVE PAYMENTS**, not to exceed ten percent of total computable expenditures. The amount of a provider's quarterly 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 either through June 30, 2011, the provider's quarterly number of uninsured adult encounters for the prior quarter, or effective July 1, 2011, the number of enrollee encounters for the prior quarter.

4) Encounter rate payments

The protocol defines encounter rates as payments made on a per visit/encounter basis to eligible providers for covered services received by enrolled eligible individuals from qualified practitioners. Three types of encounters are payable under GNOCHC: primary care, basic behavioral health care, and Serious Mental Illness (SMI) behavioral health care. Each encounter type has its own rate which is fixed for all providers. All encounter rates cover a bundle of services.

The **PRIMARY CARE ENCOUNTER RATE** covers 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 and radiology services that are routinely available in a primary care setting or through contracted services.

The **BASIC BEHAVIORAL HEALTH CARE ENCOUNTER RATE** covers 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). Basic 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 do not include primary care services. All providers are eligible for the basic behavioral health care encounter rate.

The **SMI BEHAVIORAL HEALTH CARE ENCOUNTER RATE** covers services provided to enrollees who meet the federal SMI definition, including those who also have a co-occurring addictive disorder. SMI behavioral health care services include mental health and/or substance abuse screening, assessment, counseling, medication management, follow-up and community support services. Only two providers are eligible for the SMI behavioral health care encounter rate. SMI payments may not exceed ten percent of total computable expenditures.

The protocol also provides for a yearend adjustment consisting of **SUPPLEMENTAL ENCOUNTER RATE PAYMENTS**. For each Demonstration Year, the State will subtract the sum of all payments made under the Demonstration for that year, including payments for State administrative costs and targeted payments, incentive payments and encounter rate payments for dates of service during the year, from the limit of total computable expenditures allowed under the Demonstration.

If the sum of all payments made is less than the limit of total computable expenditures allowed 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 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. To be considered in the yearend adjustment, encounter reports for dates of service during Demonstration year must be submitted not later than 45 days after the end of the Demonstration year as specified in the GNOCHC Provider Manual.

For Demonstration Year 1 only, the yearend adjustment must occur simultaneously with the reconciliation of interim payments. The amount of interim payments, including urgent sustainability payments, made to providers must be reconciled against the 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 Demonstration Year 1.

After supplemental payments, 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. The protocol requires the State to complete the reconciliation and submit a document detailing the reconciliations and any over or under payments identified to CMS by December 31, 2011.

RECONCILIATION PROCESS

KEY INPUTS

Over or under payments identified in this report are the outcomes of a reconciliation process with many inputs. The text of the STCs and Funding Protocol summarized above are inputs. Equally so are the mechanisms through which that text was implemented. Every new program requires implementation planning. Ordinarily, implementation planning precedes operations. In the case of the GNOCHC Demonstration, program operation and implementation planning were concurrent activities. In many ways, the outcomes of the reconciliation are explained by this timing, as follows.

The $100 million PCASG program was intended to provide short-term financial relief to outpatient provider organizations in the wake of Hurricane Katrina. Like many hurricane relief programs, PCASG was designed as a temporary funding source – from July 23, 2007 through September 30, 2010. To be eligible for PCASG funds, a provider had to have the intent to be sustainable, that is, able to continue providing primary care after PCASG funding was no longer available. After being awarded PCASG funds, providers were required to plan and take action to increase their ability to

be sustainable and ensure that they did not rely primarily on PCASG funds for their continued operation.

By May 2010, however, PCASG still accounted for a large portion of many providers revenue; and, it was expected that providers would have to scale back capacity or close when PCASG funding ended in September. To preserve primary and behavioral health care access that was restored and expanded with PCASG funds, on August 6, 2010 the State of Louisiana submitted to CMS a proposal for a Demonstration to continue funding of various clinics currently funded by the PCASG program. To avoid a break in funding, CMS urgently approved the Demonstration on September 22, 2010 with an effective date of October 1, 2010.

The urgent approval resulted in a set of Special Terms and Conditions with key program details structured as deliverables under the Demonstration. The STCs provided only for a single urgent sustainability payment to be made during the October through December 2010 period based solely on a provider's historical PCASG award amounts. No additional federal financial participation would be forthcoming until CMS approval of the Funding and Reimbursement Protocol. The protocol was not due to CMS until January 1, 2011, and it was not approved by CMS until June 27, 2011.

In the approved funding protocol, payments for enrollee encounters are the primary source of provider payments; they are also the driver in the reconciliation of interim payments. This emphasis, while intentional to incent a coverage model, including enrollment and billing for covered services, is problematic in the first year of the Demonstration – and the only year in which interim payments can be made and must be reconciled – due to:

1. The timeline for enrollment of eligible individuals;
2. The process for enrollment of eligible individuals;
3. The timeline for infrastructure investment payments; and,
4. The timeline and process for filing claims for encounters by enrolled eligible individuals for dates of service during the Demonstration year.

Enrollment timeline

As described earlier in this report, GNOCHC eligibility determination began nearly three months after the Demonstration's effective date, and the GNOCHC enrollment system did not normalize until some months later. Despite high enrollment growth rates from January through September, this timeline resulted in low total enrollment for Demonstration year 1, particularly relative to the unduplicated count uninsured, non-elderly adult under PCASG in the year prior to GNOCHC.

The comparison to PCASG is meaningful for GNOCHC because interim payments to be reconciled against actual payments that would have been made under the approved funding protocol are based on PCASG award amounts and PCASG award amounts are based on PCASG patient counts. The fewer the GNOCHC enrollees, the fewer the GNOCHC enrollee encounters to substantiate interim payments. The greater the gap between the PCASG patient counts and GNOCHC enrollee encounters, the greater the risk of interim overpayment under GNOCHC.

Enrollment process

Mindful of the Demonstration's annual expenditure limit and its intent to continue funding to participating PCASG providers, the State initially implemented an approach to GNOCHC enrollment designed to target enrollment to eligible individuals who seek services from PCASG providers. It required a GNOCHC-specific paper application obtained from and submitted to Medicaid through a GNOCHC participating provider site.

This approach met with resistance internally and externally. Applicants took the application forms from GNOCHC provider sites, completed them elsewhere, and attempted to submit them by walk in to the local Medicaid office or by fax to a centralized customer service center. Policy and procedure prevented customer service center staff from processing a faxed application not submitted by a GNOCHC provider site. It also prevented the local Medicaid office from taking walk in applications. It put local Medicaid office staff in the position of redirecting applicants to a GNOCHC provider site for submission at a time when eligible PCASG providers had not yet completed the GNOCHC enrollment process and it was unclear where applicants could go. It proved equally difficult to manage for eligible PCASG providers who were not yet trained or staffed serve as Medicaid Applications Centers.

From a customer service standpoint, this approach conflicted with a culture of Medicaid eligibility process improvement in Louisiana. The policy and procedure products of this culture have been lauded nationally and served as a model for the administrative simplification principles for Medicaid and Health Benefit Exchange eligibility included in the Affordable Care Act. In light of this conflict and the resistance described above, the agency replaced this approach with an alternative consistent with existing customer service practices.

Under the alternative, any application (GNOCHC or any other program-specific application or a general Medicaid application) from any source (online or paper, direct from the applicant or via Medicaid Application Center) is considered for GNOCHC eligibility for an applicant who resides in one of the four GNOCHC-participating parishes. In determining eligibility, workers "roll down" through every possible eligibility category and in descending order of benefit package certify individuals for the program(s) for which they are eligible. Further, this roll down procedure applies to both applications and renewals.

Whereas the initial approach favored those who sought help from eligible PCASG providers, the alternative approach favors those who seek help from the Medicaid agency. Enrollment data show that of all GNOCHC eligible individuals enrolled during Demonstration year one, an average of one third came from Medicaid Application Centers (primarily GNOCHC providers) while the other two thirds came from renewals and other application sources.

This enrollment process resulted in an enrolled population in which a minority has a demonstrated relationship with a GNOCHC provider and the majority does not.

Infrastructure investment payment timeline

The approved funding protocol explicitly acknowledges the need for provider capacity building to 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. Specifically, it provides for a targeted payment for infrastructure investment based on applications from participating providers and DHH's assessment of the extent to which the application targets specific criteria, including "to acquire, install and train staff to operate practice management, billing, financial and data collection systems required for payment and encounter reporting."

Funding protocol negotiations anticipated an infrastructure investment funding application process, DHH decisions, infrastructure payments and investments made before the encounter reporting and claims filing deadlines. But, the late June approval of the protocol precluded this progression. Of necessity, the first order priority following the protocol's approval was finalization of program details, including but not limited to encounter data reporting requirements and systems. The infrastructure investment funding process was deferred until the completion of this priority.

Infrastructure investment payment application forms and instructions were released on October 10, and funders were notified of DHH decisions on November 18, four days after the final deadline for reporting Demonstration year 1 encounters. Most providers lacked the financial resources to make needed billing-related investments in advance of final infrastructure investment payment terms and DHH funding decisions. Those who made such investments had little time to customize and test them to ensure a high rate of GNOCHC claims payment.

The infrastructure investment payment timeline resulted in many providers being ill-prepared to meet Demonstration Year 1 claims filing requirements successfully.

Claims filing timeline and process

The STCs require GNOCHC providers to collect data for services furnished to Demonstration enrollees through encounter data as specified by the State, and they require the State to develop mechanisms for the collection, reporting and analysis of such data by July 1, 2011.

The State specified the required encounter data collection mechanisms in the funding protocol submitted to CMS on January 5, 2011. It planned for the implementation of the proposed mechanisms throughout the process of CMS review and approval of the funding protocol. But, the State could not finalize and implement the plans until after the protocol was approved.

Upon approval of the protocol on June 27, 2011, the State completed drafting of the GNOCHC Provider Manual. The manual details encounter data reporting requirements, and it includes required forms, instructions, and deadlines. Following internal circulation and approval, the State issued the manual online on September 9, 2011. On September 15, 2011, it trained providers on the Provider Manual content, and the fiscal intermediary provided a line-by-line review of the CMS-1500 claims filing instructions.

Concurrent with finalization of the Provider Manual, the State worked with the fiscal intermediary to finalize MMIS programming. It also worked with providers to test the approved encounter data collection mechanisms. By July 1, 2011, the State completed testing of Form GNOCHC-1, which is the Excel format for reporting encounters with dates of service October 1, 2010 through September 30, 2011. At the same time, it completed testing the paper Form CMS-1500 for reporting encounters with dates of service on or after October 1, 2011.

Electronic Data Interface (EDI) testing of Form CMS-1500, however, took much longer than expected. The State and its fiscal intermediary worked intensively with GNOCHC providers for more than three months, both individually and as a group, to overcome numerous obstacles to the completion of EDI testing, including:

- Provider delays in obtaining a unique National Provider Identification number for each GNOCHC site;
- Provider delays in completing the Electronic Data Interchange Certification Form required for electronic claims submission by a third party;
- Provider delays in completing the Link/Unlink and Working Relationship Form connecting an individual provider to a professional group or entity for billing purposes;
- Provider misunderstanding of the process for submitting claim files to test environment;
- Provider failure to verify eligibility on date of service;
- Provider misunderstanding of claims filing instructions;
- Provider confusion of draft funding protocol content with approved funding protocol content; and,
- Lack of coordination and/or miscommunication between providers and submitters.

By the end of September, only one provider was able to submit a successful file to the test claims environment. Under normal circumstances, the State would have continued testing until it was confident all providers could successfully submit claims electronically. But, given the Demonstration's encounter data reporting requirements, it had no choice but to conclude EDI testing and move the test claims logic to production.

Per the funding protocol, providers must submit encounter claims for dates for service applicable to the Demonstration Year no later than 45 days following the end of the Demonstration Year, which for Demonstration Year 1 was November 14, 2011. Any claims for Demonstration Year 1 submitted after this deadline were rejected and returned to the provider for untimely filing; and, the encounters were not considered in yearend adjustment for the Demonstration Year 1.

On October 17, 2011, the State began accepting GNOCHC encounter claims for dates of service on or after October 1, 2010. The timeline provided little if any margin for error. Providers had exactly four weeks to successfully submit claims for encounters with dates of service through September 30, 2011. Given the fiscal intermediary's weekly claims processing cycle, this four week window equated to a maximum of four attempts to secure payment for a claim.

But, many provider-specific challenges faced during EDI testing remained in the post-production period. For example, claims were rejected at the file level because the provider and submitter numbers did not match the EDI Certification Form of record. Claims were denied at the encounter level because the provider failed to provide one or more detail lines for covered services. Claims were denied at the detail level because the services were not covered. In all, roughly half of the nearly 50,000 GNOCHC encounter claims submitted by the deadline were denied.

PRELIMINARY OUTCOMES

Qualitative

During Demonstration year 1, interim payments sustained PCASG funding levels for the first three quarters of the Demonstration and preserved health care access restored and expanded with PCASG funds post-Katrina. However, the timing and level of GNOCHC payments were unpredictable.

- Urgent sustainability payments for the October through December 2010 quarter were made on December 28, 2010 following completion of the provider enrollment process.
- Partial interim payments for the January through March 2011 quarter were made at State expense through the Spring, and the balance of interim payments available for the quarter were made in July with federal financial participation following CMS approval of the funding protocol.
- Interim payments for the April through June 2011 quarter were also made in July with federal financial participation following CMS approval of the funding protocol.
- No interim payments were made for the July through September period, in anticipation of encounter rate payments to begin in July. However, electronic claims testing issues delayed encounter claims payments until October, resulting in no GNOCHC revenues for the quarter during the quarter.

Sustaining PCASG funding levels through GNOCHC interim payments posed financial risks to providers. In the nine month interim between the Demonstration effective date and funding protocol approval, providers faced the choice of taking GNOCHC payment on uncertain terms or forgoing payment until the terms were final and understood. Providers generally refused payment for as long as possible. Those who accepted payment did so in good faith and spent the money cautiously, cognizant of the STC requirement to reconcile urgent sustainability payment amounts to the funding protocol once approved.

During funding protocol negotiations, the State pursued means to safeguard against overpayments during the interim payment period subject to recoupment following reconciliation, such as making encounter rate payments for individuals meeting at least four of seven eligibility criteria but not enrolled on date of service. But, CMS favored a coverage model approach with encounter rate payments only for covered services provided to eligible individuals enrolled on date of service.

The result of those negotiations is an approved funding protocol that includes both PCASG and GNOCHC payment methods and requires a squaring of the two with the reconciliation of interim payments. While the amount of GNOCHC urgent sustainability and interim payments amounts and

historical PCASG awards were the same, core program elements affecting payments are different. The most notable differences – eligible populations and payment methodologies – together with the four inputs described above – enrollment timeline, enrollment process, infrastructure investment payment timeline, and claims filing timeline and process – bias the reconciliation process to overpayments.

PCASG award amounts represent a provider's share of the total number of unduplicated PCASG patient counts with adjustments and weights for age and payer type. PCASG patients include all individuals served by a PCASG-funded provider. PCASG had no eligibility criteria or enrollment process for individuals served. Every patient encounter counted in the calculation of PCASG award amounts.

By contrast, GNOCHC revenues depend primarily on encounter rate payments. Encounter rate payments are the product of the encounter rate and the number of paid GNOCHC enrollee encounters. Each paid GNOCHC enrollee encounter requires: (1) a GNOCHC-eligible individual (2) who receives services covered under the Demonstration (3) on a date for which the individual is enrolled in the Demonstration (4) for which a GNOCHC-enrolled provider submits a correct and timely claim.

GNOCHC providers were unlikely to generate sufficient encounter rate payments to offset interim payment amounts because:

- Eligible individuals were not enrolled until December, resulting in few if any enrollee encounters during the October through December 2010 quarter.
- Despite relatively high enrollment growth rates from January through September 2011, total enrollment for Demonstration year 1 remained low relative to PCASG unduplicated patient counts.
- Enrollment was dominated by individuals inexperienced with GNOCHC providers and less likely than PCASG patients to seek services from a GNOCHC provider and generate a paid GNOCHC enrollee encounter.
- Infrastructure investment payment funding decisions came too late to help providers prepare to successfully meet Demonstration year 1 claims filing requirements.
- Demonstration year 1 claims filing deadlines were too short for providers to learn from initial claims filing mistakes.

Concretizing these qualitative outcomes, quantitative outcomes are summarized below and detailed in the Reconciliation Workbook provided with this report.

Quantitative

Reconciliation Workbook

The Reconciliation Workbook provides a complete accounting of the State's reconciliation of interim payments to encounter rate payments, targeted payments, and incentive payments that would have been made. It contains all calculations and supporting data.

Calculations are organized by worksheet, as named and described below:

- ***Rates*** contains the calculation of the supplemental encounter rate.
- ***Site summary*** contains all site-level reconciliation calculations and references the data worksheets; all formulas are provided in row 4.
- ***Organization summary*** aggregates site-level reconciliation calculations to the organization level; all formulas are provided in row 4.

Supporting data are also organized by worksheet:

- ***Primary care encounters*** contains site-level summary data for primary care encounter claims, including paid and denied counts and payments for encounter claims with Demonstration year 1 dates of service submitted on Form CMS-1500 to the fiscal intermediary or Form GNOCHC-1 to DHH.
- ***Basic behavior encounters*** contains site-level summary data for basic behavioral health care encounter claims, including paid and denied counts and payments for encounter claims with Demonstration year 1 dates of service submitted on Form CMS-1500 to the fiscal intermediary or Form GNOCHC-1 to DHH.
- ***SMI behavior encounters*** contains site-level summary data for SMI behavioral health care encounter claims, including paid and denied counts and payments for encounter claims with Demonstration year 1 dates of service submitted on Form CMS-1500 to the fiscal intermediary or Form GNOCHC-1 to DHH.
- ***Interim payment amounts*** contains site-specific interim payment amounts, including urgent sustainability payment amounts, by quarter and year.
- ***NCQA PCMH level*** contains site-specific data on the level and period of NCQA PCMH recognition.
- ***Infrastructure investment expenditures*** contains site-specific summary data on the amount of State-approved infrastructure investment expenditures reported by quarter and year.
- ***Community care coordination expenditures*** contains site-specific summary data on the amount of community care coordination expenditures reported by quarter and year; the total amount allocated by the State for community care coordination payments; and, each provider's share of the total allocation based on the provider's proportion of the total number of uninsured adult encounters with dates of service April 1, 2010 through reported for all participating providers.
- ***Uninsured adult encounters April 2010 through March 2011*** contains site-specific data on the number of uninsured adult encounters reported by participating providers for the period April 1 through June 30, 2011 quarter.
- ***Uninsured adult encounters July through September 2010*** contains site-specific data on the number of uninsured adult encounters for the period July 1 through September 30, 2010 reported by participating providers.

- ***Uninsured adult encounters October through December 2010*** contains site-specific data on the number of uninsured adult encounters reported by participating providers for the period October 1 through December 31, 2010.
- ***Uninsured adult encounters January through March 2011*** contains site-specific data on the number of uninsured adult encounters reported by participating providers for the period January 1 through March 30, 2011.
- ***Approved enrollee encounters April through June 2011*** contains site-specific data on the number of approved primary care GNOCHC enrollee encounters reported by participating providers for the period April 1 through June 30, 2011 quarter.
- ***Administrative costs*** identifies the total State administrative costs claimed for the year, including personnel and professional services contract costs.
- ***Rates*** contains the primary care, basic behavioral health care, and serious mental illness behavioral health care encounter rates; the NCQA PCMH Recognition Levels 1, 2, and 3 rates; and, the supplemental encounter rate.

For purposes of communicating to each provider organization its individual reconciliation outcomes, the workbook includes a worksheet with a standard reporting format:

- ***Site-specific provider*** is a summary report template with a drop down menu listing the names of all participating provider sites; select a site name in the drop down menu and the worksheet automatically populates the template with summary data specific to the selected site, including interim payments, encounter rate payments, NCQA PCMH incentive payments, community care coordination payments, infrastructure investment payments, supplemental payments, and year end adjustment amounts. All formulas are provided.

Interim Payments

During Demonstration year 1, only interim payments were made. The State made a total of $16,507,352 in interim payments to 17 participating provider organizations, including $6,077,078 in urgent sustainability payments for the October through December 2010 period, $5,137,305 in interim payments for the January through March 2011 period, and $5,292,968 in interim payments for the April through June 2011 period. Every provider received the maximum urgent sustainability payment amount, while other interim payment amounts varied based on the provider's choice of interim payment amount options.

Recognizing that timeline for CMS approval of the funding protocol was uncertain and that the financial and operational stability of a number of participating providers was in jeopardy without additional GNOCHC payments, the State elected to offer to participating providers partial interim payments for the January through March 2011 period at State expense. (The State would seek federal financial participation following CMS approval of the funding protocol.)

In early April, each participating provider received a letter outlining its options for the January through March 2011 period:

1) An interim payment amount equal to half of the provider's urgent sustainability amount;
2) An amount of the provider's choosing up to half of the provider's urgent sustainability amount; or,
3) No payment at this time, but able to choose option 1 or 2 through June 30, 2011.

The letter reminded providers of the CMS requirement to reconcile any interim payments to the approved funding protocol, acknowledged the uncertainty around the funding protocol ultimately approved by CMS, and cautioned on the risk of overpayment in the interim and potential payment offsets in the future. Many providers sought to defer receipt of interim payments until the funding protocol was approved and the terms of payment final, but most ultimately requested the maximum amount.

In late June, immediately following CMS approval of the funding protocol, the State offered participating providers additional interim payment options for the January through June 2011 period.

Each provider received a letter outlining three final interim payment choices for the January through March 2011 period:

1) A final interim payment amount *equal to* the difference between the provider's urgent sustainability payment amount for the period October 1, 2010 through December 31, 2010 and the total amount of interim payments made to the provider to date for the period January 1, 2011 through March 31, 2011; or,
2) A final interim payment amount *up to* the difference between the provider's urgent sustainability payment amount for the period October 1, 2010 through December 31, 2010 and the total amount of interim payments made to the provider to date for the period January 1, 2011 through March 31, 2011; or
3) No final interim payment for the period January 1, 2011 through March 31, 2011.

Each provider also received a letter outlining three final interim payment choices for the April through June 2011 period:

1) An interim payment amount *equal to* the provider's urgent sustainability payment amount; or,
2) An interim payment amount *up to* the amount of the provider's urgent sustainability payment amount; or
3) No interim payment.

The deadline for final interim payment requests for the January through June 2011 period was August 31, 2011.

In anticipation of payments to be made for enrollee encounters with dates of service on or after July 1, 2011 and in an effort to reduce providers' risk of overpayment, the State did not offer or make any interim payments for the July through September 2011 period.

See below table for interim payment amounts by provider, quarter and year. Note that payments are classified by the quarter for which payment was intended, not by date of payment.

All urgent sustainability payments were made during the quarter for which they were intended. The STCs approved for the Demonstration by CMS on September 22, 2010 gave the State the authority to make the urgent sustainability payments with federal financial participation during the period for which payment was intended.

Few other interim payments were made during the quarter for which they were intended. As noted above, some interim payments were made during the quarter for which they were intended at State expense pending CMS approval of the funding protocol authorizing federal financial participation in the payments. Most payments were made in a quarter following the quarter for which they were intended, primarily the quarter following CMS approval of the funding protocol.

Interim Payments Per Provider

Provider Organization	Q1	Q2	Q3	Total
Administrators of Tulane Educational Fund	650,189	650,189	650,189	1,950,567
City of New Orleans Health Department	101,606	101,606	58,693	261,905
Common Ground Health Clinic	230,849	230,849	230,849	692,547
Daughters of Charity Services of New Orleans	676,161	676,161	676,161	2,028,483
EXCELth, Inc.	271,719	271,719	271,719	815,157
Jefferson Community Health Care	549,740	549,740	549,740	1,649,220
Jefferson Parish Human Services Authority	499,575	0	0	499,575
Leading Edge Services International	90,377	0	0	90,377
LSU Healthcare Network	189,476	189,476	189,476	568,428
Medical Center of Louisiana	660,780	660,780	660,780	1,982,340
New Orleans Musicians' Assistance Foundation	156,423	156,423	156,423	469,269
NO/AIDS Task Force	167,981	167,981	167,981	503,943
Odyssey House Louisiana	184,698	184,698	184,698	554,094
Sisters of Mercy Ministries	151,245	75,623	0	226,868
St. Bernard Health Center	550,264	412,132	550,264	1,512,660
St. Charles Community Health Center	284,134	148,068	284,134	716,336
St. Thomas Community Health Center	661,861	661,861	661,861	1,985,583
TOTAL	**$6,077,078**	**$5,137,306**	**$5,292,968**	**$16,507,352**

Incentive Payments

According to the Preliminary Reconciliation Report, providers are due a total of $825,895 in incentive payments for NCQA PCMH Recognition for Demonstration year 1. These payments are treated as offsets to interim payments in the Preliminary Reconciliation Report.

NCQA PCMH incentive payments are site-specific. The below tables notes the number of sites at each recognition level (1, 2 or 3), and it summarizes site-specific payments at the organization level. For additional detail, see the Preliminary Reconciliation Workbook.

Incentive Payments Per Provider

Provider Organization	Recognition Level	Payment
Administrators of the Tulane Educational Fund	3 sites, Level 1 2 sites, Level 3	122,039.50
City of New Orleans Health Department	1 site, Level 3	2,061
Common Ground Health Clinic	1 site, Level 3	46,261.25
Daughters of Charity Services of New Orleans	3 sites, Level 3	180,136.25
EXCELth, Incorporated		-
Jefferson Community Health Care	3 sites, Level 1	66,367.00
Jefferson Parish Human Service Authority		-
Leading Edge Services International		-
Louisiana State University School of Medicine	1 site, Level 1	15,554.00
Medical Center of Louisiana at New Orleans	3 sites, Level 1	35,021.00
Metropolitan Human Services District		-
MQVN Community Development		-
New Orleans Musicians Assistance Foundation		-
NO/AIDS Task Force	1 site, Level 3	64,748.75
Odyssey House		-
Plaquemines Primary Care		-
Sisters of Mercy Ministries	1 site, Level 1	959
St. Bernard Community Health Center	1 site, Level 2	20,619.75
St. Charles Community Health Center	1 site, Level 3	93,925.00
St. Thomas Community Health Center	1 site, Level 3	178,202.50
TOTAL		**$825,895**

Targeted Payments

According to the Preliminary Reconciliation Report, providers are due a total of $1,424,920 in targeted payments for Demonstration year 1, including $599,025 for community care coordination expenditures and $737,050 for approved infrastructure investments reported for the period. These payments are treated as offsets to interim payments in the Preliminary Reconciliation Report.

Community Care Coordination

Community care coordination payments due are site-specific, based on expenditures reported by providers for Demonstration year 1, and subject to the limit of funds allocated to the site for community care coordination.

Community care coordination allocations are based on each site's share of the total number of uninsured adult encounters reported for the most recent period available for all providers, which was April 1, 2010 through March 31, 2011. Data were reported under the Primary Care Access and Stabilization Grant program and provided to DHH by the Louisiana Public Health Institute, which administered the program.

Of the 43 participating service sites, six reported community care coordination expenditures in excess of their allocation; and, the amount of community care coordination payment due to each of those sites is capped at the site's allocation amount. All other sites reported expenditures within their allocation limit; and, the amount of community care coordination payment due to each of those sites is equal to the amount of Demonstration year 1 expenditures reported for the site.

Community care coordination payment amounts are summarized below at the organization level. For site-specific detail, see the Preliminary Reconciliation Workbook.

Community Care Coordination Payments Per Provider

Provider Organization	Community Care Coordination Expenditures Reported	Community Care Coordination Allocation	Community Care Coordination Expenditures Reported in Excess of Allocation	Community Care Coordination Payment Due
Administrators of the Tulane Educational Fund	28,500	179,350	(150,850)	19,528
City of New Orleans Health Department	-	111,771	(111,771)	-
Common Ground Health Clinic	17,405	60,066	(42,661)	17,405
Daughters of Charity Services of New Orleans	533,932	205,627	327,765	102,575
EXCELth, Incorporated	7,265	128,232	(120,967)	237
Jefferson Community Health Care	137,080	231,762	(94,682)	127,980
Jefferson Parrish Human Service Authority	7,311	359,085	(351,773)	7,311
Leading Edge Services International	-	4,868	(4,868)	-
Louisiana State University School of Medicine	-	54,734	(54,734)	-
Medical Center of Louisiana at New Orleans	-	577,840	(577,840)	-
Metropolitan Human Services District	-	497,374	(497,374)	-
MQVN Community Development	-	-	-	-
New Orleans Musicians Assistance Foundation	47,599	46,615	984	46,615
NO/AIDS Task Force	223,633	90,019	133,615	90,019
Odyssey House Inc Louisiana	24,885	46,090	(21,205)	24,885
Plaquemines Primary Care	-	29,589	(29,589)	-
Sisters of Mercy Ministries	-	3,918	(3,918)	-
St. Bernard Community Health Center	1,244	39,990	(38,746)	1,244
St. Charles Community Health Center	1,270	115,204	(113,934)	1,270
St. Thomas Community Health Center	159,957	217,866	(57,909)	159,957
TOTAL	**$1,189,542**	**$3,000,000**	**($1,810,458)**	**$599,025**

Infrastructure Investments

Infrastructure investment payments due are site-specific based on outcomes of the 2011 GNOCHC Infrastructure Investment Payments application cycle and DHH-approved expenditures reported by providers for Demonstration year 1.

2011 Application Cycle

On October 11, 2011, DHH released to providers the 2011 Application for GNOCHC Infrastructure Investment Payments. It responded to provider questions on the application through October 28, 2011. Applications were due to DHH by October 31, 2011, and applicants were notified of DHH funding decisions by November 18, 2011.

Funding decisions were based on DHH's assessment of the extent to which the application targets select criteria for infrastructure investments:

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

Applications were assessed on both the extent to which they target infrastructure investment criteria and:

- Detail the work plan for the project and an achievable timeline
- Demonstrate provider capacity to manage the infrastructure project
- Demonstrate cost effectiveness of the investment (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 for health information technology)
- Provide detailed documentation and a reasonable basis for cost estimates included in the application (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

Through the 2011 GNOCHC Infrastructure Investment Payments application cycle:

- 34 applications were received from 12 provider organizations;
- 18 applications and 9 organizations were funded;
- 12 applications were fully funded; all items requested were eligible for funding;
- 6 applications were less than fully funded; one or more items requested were ineligible for funding;
- A total of $1,552,350 in funding requested was approved for the period October 1, 2010 through June 30, 2012.

Site-specific infrastructure investments approved by DHH in the 2011 application cycle are summarized below.

DHH-Approved Infrastructure Investments

Provider Organization	Investment	Amount
Common Ground	Practice management system purchase, installation, and staff training; NCQA PCMH recognition application fees and staff time.	35,715
Daughters of Charity – all sites	Practice management system purchase, installation, and staff training; care management system purchase, installation, and staff training; NCQA PCMH recognition application fees and staff time.	96,413
Interim LSU Hospital	Operations process improvement consultation in preparation for practice management system upgrade.	50,000
Interim LSU Hospital	Telemedicine equipment purchase, installation, and staff training.	13,200
Metropolitan Human Services District – all sites	Practice management system purchase, installation, and staff training	604,141
MQVN Community Development	Practice management and care management staff training.	35,009
MQVN Community Development	Telemedicine equipment purchase, installation, and staff training.	158,522
MQVN Community Development	NCQA PCMH recognition application fees and consultation.	36,820
New Orleans Musicians Assistance Foundation	Quality improvement consultation; practice management consultation and training; NCQA PCMH recognition consultation.	145,415
NO/AIDS Task Force	Practice management system purchase, installation, and staff training; care management system purchase, installation, and staff training.	129,225
Odyssey House	Practice management system purchase, installation, and staff training	37,247
St. Thomas Community Health Center	Population health management system purchase, installation, and staff training	45,740
TOTAL		**$1,387,447**

Approved Expenditures Reported

A total of $737,050 in approved expenditures were reported for the Demonstration year 1, accounting for just over half of the $1,387,447 in infrastructure investment funding approved in the 2011 application cycle. Expenditures approved in the 2011 application cycle and reported for the October 1, 2011 through June 30, 2012 period will be considered for payment in Demonstration year 2. Infrastructure investment payments due for Demonstration year 1 are summarized below at the provider organization level. For site-level detail, see the Preliminary Reconciliation Workbook.

Infrastructure Investment Payments Per Provider

Provider Organization	Infrastructure Investment
Administrators of the Tulane Educational Fund	-
City of New Orleans Health Department	-
Common Ground Health Clinic	12,915
Daughters of Charity Services of New Orleans	5,680
EXCELth, Incorporated	-
Jefferson Community Health Care	-
Jefferson Parish Human Service Authority	-
Leading Edge Services International	-
Louisiana State University School of Medicine	-
Medical Center of Louisiana at New Orleans	-
Metropolitan Human Services District	604,140
MQVN Community Development	-
New Orleans Musicians Assistance Foundation	44,724
NO/AIDS Task Force	49,090
Odyssey House Inc Louisiana	-
Plaquemines Primary Care	-
Sisters of Mercy Ministries	-
St. Bernard Community Health Center	-
St. Charles Community Health Center	-
St. Thomas Community Health Center	20,500
TOTAL	**$737,050**

Encounter Rate Payments

According to the Preliminary Reconciliation Report, providers earned a total of $5,301,337 in encounter rate payments for Demonstration year 1. Of this total, providers received $2,015,585 in encounter rate payments for dates of service July 1, 2011 through September 30, 2011; and, providers are due $3,170,300 in encounter rate payments for dates of service October 1, 2010 through June 30, 2011.

Payments due for the October 1, 2010 through June 30, 2011 period will be offset against interim payment made for the period. Payments made for July 1, 2011 through September 30, 2011 period, during which no interim payments were made, are not considered in the reconciliation of interim payments.

Primary Care Encounters

Analyses of encounter data reported for Demonstration year 1 show that primary care encounters drove both encounter volume and encounter rate payments for the period. Primary care encounters account for 81 percent of the total number of encounters approved for Demonstration year 1 (20,662 of 25,413). Primary care encounter payments account for 91 percent of all encounter rate payments.

Behavioral Health Care Encounters

Behavioral health care encounters account for the remaining 19 percent of encounters approved for Demonstration year 1, with 14 percent (3,548) being basic behavioral health care encounters and 5 percent (1,203) being Serious Mental Illness behavioral health care encounters. Behavioral health care encounter payments account for 9 percent of all encounter rate payments, with 7 percent being basic behavioral health care encounter rate payments and 2 percent being SMI behavioral health care encounter rate payments.

However, in the forthcoming Revised Reconciliation Report, following correction of a claims filing error by one of the two SMI providers that resulted in SMI encounters being coded as basic, DHH expects SMI encounters to account for the majority of behavioral health care encounters and SMI encounter rate payments to account for the majority of all behavioral health care encounter rate payments.

The following table provides the number of primary and behavioral health care encounters approved for payment and the amount of primary and behavioral health care encounter rate payments per provider organization. For site-level detail, see the Preliminary Reconciliation Workbook.

Primary Care and Behavioral Health Encounter Rate Payments Per Provider

Provider Organization	Number of Primary Care Encounters	Primary Care Encounter Rate Payments	Number of Basic BH Encounters	Basic BH Payments	Number of SMI Encounters	SMI Payments	Total Number of Encounters	Total Encounter Rate Payments
Administrators of the Tulane Educational	1,416	333,482.16	292	29,702.04	-	-	1,708	363,184.20
City of New Orleans Health Department	117	27,554.27	-	-	-	-	117	27,554.27
Common Ground	777	182,991.27	-	-	-	-	777	182,991.27
Daughters of Charity	7,928	1,867,123.28	-	-	-	-	7,928	1,867,123.28
EXCELth, Incorporated	159	37,233.58	-	-	-	-	159	37,233.58
Jefferson Community	2,160	459,153.76	6	610.32	-	-	2,166	459,764.08
Jefferson Parish Human Service	-	-	2,479	252,163.88	-	-	2,479	252,163.88
Leading Edge Services	-	-	-	-	-	-	-	-
LSU School of	-	-	33	3,356.76	-	-	33	3,356.76
Medical Center of Louisiana at New	2,334	549,680.34	21	2,136.12	-	-	2,355	551,816.46
Metropolitan Human Services District	-	-	-	-	1,203	129,346.56	1,203	129,346.56
Mary Queen of Vietnam Community	216	47,505.64	-	-	-	-	216	47,505.64
New Orleans Musicians Assistance	224	52,754.24	-	-	-	-	224	52,754.24
NO/AIDS Task Force	-	-	320	32,550.40	-	-	320	32,550.40
Odyssey House Inc	410	96,559.10	383	38,958.76	-	-	793	135,517.86
Plaquemines Primary	5	1,177.55	-	-	-	-	5	1,177.55
Sisters of Mercy	-	-	-	-	-	-	-	-
St. Bernard	2,023	476,121.94	14	1,424.08	-	-	2,037	477,546.02
St. Charles	570	133,399.70	-	-	-	-	570	133,399.70
St. Thomas	2,323	546,352.10	-	-	-	-	2,323	546,352.10
TOTAL	**20,662**	**4,811,088.93**	**3,548**	**360,902.36**	**1,203**	**129,346.56**	**25,413**	**5,301,337.85**

Supplemental Encounter Rate Payments

According to the Preliminary Reconciliation Report, providers are due a total of $21,988,123 in supplemental encounter rate payments. These payments are site-specific, and summarized below at the provider organization level. See the Preliminary Reconciliation Workbook for site-level details.

Supplemental Encounter Rate Payments Per Provider

Provider Organization	Payment Amount
Administrators of the Tulane Educational Fund	1,477,815
City of New Orleans Health Department	101,232
Common Ground Health Clinic	672,285
Daughters of Charity Services of New Orleans	6,859,554
EXCELth, Incorporated	137,572
Jefferson Community Health	1,874,091
Jefferson Parish Human Service Authority	2,144,908
Leading Edge Services International	-
LSU School of Medicine	28,553
Medical Center of Louisiana at New Orleans	2,037,620
Metropolitan Human Services District	1,040,873
Mary Queen of Vietnam Community Development	186,890
New Orleans Musicians Assistance Foundation	193,812
NO/AIDS Task Force	276,874
Odyssey House Inc	686,128
Plaquemines Primary Care	4,326
Sisters of Mercy Ministries	-
St. Bernard Community Health Center	1,762,476
St. Charles Community Health Center	493,182
St. Thomas Community Health Center	2,009,932
TOTAL	**$21,988,123**

Year End Adjustment

Supplemental encounter rate payments are not considered in the reconciliation of interim payments. However, these payments constitute the yearend adjustment to occur simultaneously with the reconciliation of interim payments for Demonstration year 1, and the yearend adjustment effectively offsets interim overpayments for most providers.

In sum, according to the Preliminary Reconciliation Report:

- A total of $16.5 million in interim payments were made to 17 provider organizations.
- Provider organizations are due a total of $5.3 million in targeted, incentive and encounter rate payments.
- Interim payments exceed payments due by $11.1 million.

- At reconciliation, every provider that received any amount of interim payments was overpaid.
- Providers are due a total of $21.9 million in supplemental encounter rate payments.

The yearend adjustment:

- Eliminates interim overpayments and generates payments due for 12 of 20 provider organizations;
- Reduces but does not eliminate interim overpayments for six provider organizations; and,
- Makes no change for two provider organizations, as they are due no supplemental encounter rate payments.

The following table summarizes the preliminary reconciliation, including yearend adjustment outcomes, at the provider organization level.

Summary of Preliminary Reconciliation Outcomes by Participating Provider Organization

Provider Organization	Total Interim Payment	Total Payment Due	Interim (Over)/Under Payment	Supplemental Payment Due	Year End Adjustment Amount Due Provider/(Due DHH)
Administrators of the Tulane Educational Fund	1,950,567.00	361,709.28	(1,588,857.72)	1,477,791.26	(111,066.46)
City of New Orleans Health Dept	261,905.00	21,137.56	(240,767.44)	101,230.43	(139,537.01)
Common Ground Health Clinic	692,547.00	258,630.35	(433,916.65)	668,813.02	234,896.37
Daughters of Charity Services of New Orleans	2,028,483.00	1,469,281.27	(559,201.73)	6,859,443.26	6,300,241.53
EXCELth, Incorporated	815,157.00	22,845.49	(792,311.51)	137,569.56	(654,741.95)
Jefferson Community Health Care	1,649,220.00	366,269.01	(1,282,950.99)	1,874,060.81	591,109.82
Jefferson Parish Human Service Authority	499,575.00	182,371.55	(317,203.45)	2,144,873.84	1,827,670.39
Leading Edge Services International	90,377.00	-	(90,377.00)	-	(90,377.00)
Louisiana State University School of Medicine	568,428.00	15,960.88	(552,467.12)	28,552.17	(523,914.95)
Medical Center of Louisiana at New Orleans	1,982,340.00	315,995.45	(1,666,344.55)	2,037,586.89	371,242.34
Metropolitan Human Services District	-	733,487.55	733,487.55	1,040,856.49	1,774,344.04
MQVN Community Development	-	19,782.84	19,782.84	186,886.95	206,669.79
New Orleans Musicians Assistance Foundation	469,269.00	118,422.88	(350,846.12)	193,808.69	(157,037.43)
NO/AIDS Task Force	503,943.00	236,407.73	(267,535.27)	276,869.56	9,334.29
Odyssey House Inc Louisiana	554,094.00	87,319.86	(466,774.14)	686,117.37	219,343.23
Plaquemines Primary Care	-	-	-	4,326.09	4,326.09
Sisters of Mercy Ministries	226,867.50	959.00	(225,908.50)	-	(225,908.50)
St Bernard Community Health Center	1,512,660.00	289,818.70	(1,222,841.30)	1,765,908.64	543,067.34
St Charles Community Health Center	716,336.33	145,266.18	(571,070.15)	493,173.90	(77,896.25)
St Thomas Community Health Center	1,985,583.00	686,960.35	(1,298,622.65)	2,009,899.94	711,277.29
TOTAL	**16,507,351.83**	**5,332,625.94**	**(11,174,725.89)**	**21,987,768.86**	**10,813,042.97**

Revised Reconciliation Report

As evidenced by the outcomes of the Preliminary Reconciliation Report, paid enrollee encounters drive both the reconciliation and yearend adjustment; and, the volume of paid enrollee encounters makes or breaks the year for providers that received interim payments.

As such, the State will take the following actions in Demonstration year 2 to prevent the reconciliation from resulting in a contraction of health care access preserved by interim payments during Demonstration year 1. It will:

- Take no action on over or under payments identified in the Preliminary Reconciliation Report;
- Allow providers until February 8, 2012 to correct denied claims for encounters with dates of service during Demonstration year 1 submitted by the November 14, 2011 deadline;
- Provide individualized claims filing instruction targeted to each provider's unique error patterns;
- Submit to CMS in March a revised reconciliation report reflective of denied claim corrections; and,
- Take action on over or under payments identified in the Revised Reconciliation Report.

ENCOUNTER DATA FINDINGS

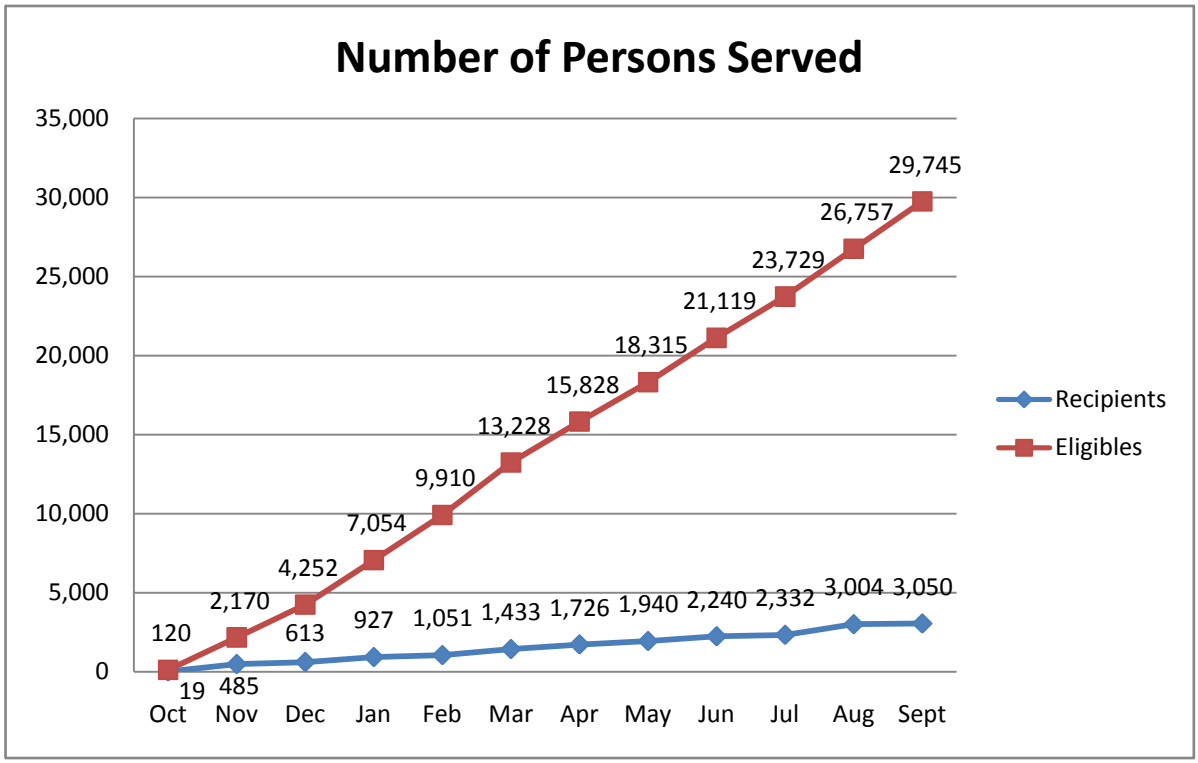
Encounter data analyses of enrollee encounter data reported for Demonstration year 1 provide the following information about the number of persons served and the cost of providing care to persons served under the Demonstration.

NUMBER OF PERSONS SERVED

Consistent with enrollment growth, the number of persons served increased markedly throughout the year. And, likely consistent with the Demonstration's enrollment approach, primary care and behavioral health care service recipients accounted 13 percent of total enrollment for the year. As described earlier in this report, any application (GNOCHC or any other program-specific application or a general Medicaid application) from any source (online or paper, direct from the applicant or via Medicaid Application Center) is considered for GNOCHC eligibility for an applicant who resides in one of the four GNOCHC-participating parishes. In determining eligibility, workers "roll down" through every possible eligibility category and in descending order of benefit package certify individuals for the program(s) for which they are eligible. Further, this roll down procedure applies to both applications and renewals.

With this approach, enrollment is driven by those who seek help from the Medicaid agency. Enrollment data show that of all GNOCHC eligible individuals enrolled during Demonstration year one, an average of one third came from Medicaid Application Centers (primarily GNOCHC providers) while the other two thirds came from renewals and other application sources. The result is an enrolled population in which a minority has a demonstrated relationship with a

GNOCHC provider and the majority does not. Relatively low rates of service receipt among enrollees may reflect enrollees' unfamiliarity and/or inexperience with participating providers.



Cost of Providing Care

The driver of the cost of providing care to Demonstrational enrollees is the primary care encounter. It is the most utilized service, and the primary care encounter rate payments account for the vast majority of encounter rate payments. Of the total number of encounter claims approved for Demonstration year 1, 86 percent (19,479 of 22,722) were primary care encounters. Of the total amount of encounter rate payments made and/or due to participating providers for Demonstration year 1, primary care encounter rate payments account for 93 percent. Behavioral health care encounter rate payments account for the remaining 7 percent of the total.

In consideration of child-related status, childless adults drive the cost of providing care by both enrollment volume and service utilization. Childless adults (without minor children in the home) account for 68 percent of total enrollment and 80 percent of all encounter rate payments, while parents (adults with minor children in the home) account for 32 percent of total enrollment and 20 percent of all encounter rate payments.

The data provide preliminary support to two related evaluation design hypotheses. The first hypothesis – that childless adults will utilize relatively more behavioral health care services than parents – is supported by data showing that as a percentage of total childless adult enrollment the number of enrollees who received behavioral health services was more than twice that of parents (1.98 percent compared with 0.75 percent) for Demonstration year 1. The second hypothesis – that the cost of providing care to childless adults will be relatively higher for childless adults than

parents – is supported by data showing that the cumulative Per Enrollee Per Month cost of providing behavioral health care services to childless adults was approximately two and a half times higher than that for parents ($2.34 compared with $0.90) for Demonstration year 1.

The below tables provide additional detail on the cost of providing care to persons under Demonstration, including but not limited to total encounter rate payments (based on date of service); number of enrollees, encounters, and recipients; encounter rate payments per enrollee per month; and, encounter rate payments per recipient per month. The first table provides the data for all Demonstration enrollees. The second table provides the data for Demonstration enrollees with minor children in the home (parents). The third table provides the data for Demonstration enrollees without minor children in the home (childless adults).

Service Utilization by and Cost of Providing Care to All Demonstration Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$3,404.37	120	19	19	$28.37	$179.18	$3,404	20	$28.37	19	$179.18
November	$132,207.29	2,170	575	485	$60.93	$272.59	$135,612	2,290	$59.22	504	$269.07
December	$160,399.83	4,252	718	613	$37.72	$261.66	$296,011	6,542	$45.25	1,117	$265.01
January	$240,551.36	7,054	1,139	927	$34.10	$259.49	$536,563	13,596	$39.46	2,044	$262.51
February	$269,053.58	9,910	1,264	1,051	$27.15	$256.00	$805,616	23,506	$34.27	3,095	$260.30
March	$367,075.33	13,228	1,716	1,433	$27.75	$256.16	$1,172,692	36,734	$31.92	4,528	$258.99
April	$440,769.90	15,828	2,063	1,726	$27.85	$255.37	$1,613,462	52,562	$30.70	6,254	$257.99
May	$519,094.99	18,315	2,445	1,940	$28.34	$267.57	$2,132,557	70,877	$30.09	8,194	$260.26
June	$593,223.99	21,119	2,816	2,240	$28.09	$264.83	$2,725,781	91,996	$29.63	10,434	$261.24
July	$585,690.83	23,729	2,730	2,332	$24.68	$251.15	$3,311,471	115,725	$28.62	12,766	$259.40
August	$752,916.63	26,757	3,604	3,004	$28.14	$250.64	$4,064,388	142,482	$28.53	15,770	$257.73
Sept	$801,850.09	29,745	3,633	3,050	$26.96	$262.90	$4,866,238	172,227	$28.25	18,820	$258.57
Total	**$4,866,238.19**			**18,820**			**$21,663,795**	**728,657**	**$29.73**		

Service Utilization by and Cost of Providing Care to Parent Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$572.74	28	3	3	$20.46	$190.91	$573	28	$20.46	3	$190.91
November	$21,431.41	520	91	82	$41.21	$261.36	$22,004	548	$40.15	85	$258.87
December	$33,378.28	1,038	144	133	$32.16	$250.96	$55,382	1,586	$34.92	218	$254.05
January	$42,643.84	1,784	193	171	$23.90	$249.38	$98,026	3,370	$29.09	389	$252.00
February	$53,916.25	2,717	242	218	$19.84	$247.32	$151,943	6,087	$24.96	607	$250.32
March	$70,642.97	3,790	317	281	$18.64	$251.40	$222,585	9,877	$22.54	888	$250.66
April	$92,738.81	4,748	429	355	$19.53	$261.24	$315,324	14,625	$21.56	1,243	$253.68
May	$108,973.46	5,674	511	400	$19.21	$272.43	$424,298	20,299	$20.90	1,643	$258.25
June	$126,160.18	6,627	580	479	$19.04	$263.38	$550,458	26,926	$20.44	2,122	$259.41
July	$123,287.92	7,590	577	498	$16.24	$247.57	$673,746	34,516	$19.52	2,620	$257.15
August	$168,155.25	8,645	796	691	$19.45	$243.35	$841,901	43,161	$19.51	3,311	$254.27
September	$176,558.24	9,595	778	687	$18.40	$257.00	$1,018,459	52,756	$19.31	3,998	$254.74
Total	**$1,018,459.35**		**4,661**	**3,998**			**$4,374,700**	**213,779**	**$20.46**		

Service Utilization by and Cost of Providing Care to Childless Adult Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$2,831.63	92	16	16	$30.78	$176.98	$2,832	92	$30.78	16	$176.98
November	$110,775.88	1,650	484	403	$67.14	$274.88	$113,608	1,742	$65.22	419	$271.14
December	$127,021.55	3,214	574	480	$39.52	$264.63	$240,629	4,956	$48.55	899	$267.66
January	$197,907.52	5,270	946	756	$37.55	$261.78	$438,537	10,226	$42.88	1,655	$264.98
February	$215,137.33	7,193	1,022	833	$29.91	$258.27	$653,674	17,419	$37.53	2,488	$262.73
March	$296,432.36	9,438	1,399	1,152	$31.41	$257.32	$950,106	26,857	$35.38	3,640	$261.02
April	$348,031.09	11,080	1,634	1,371	$31.41	$253.85	$1,298,137	37,937	$34.22	5,011	$259.06
May	$410,121.53	12,641	1,934	1,540	$32.44	$266.31	$1,708,259	50,578	$33.77	6,551	$260.76
June	$467,063.81	14,492	2,236	1,761	$32.23	$265.23	$2,175,323	65,070	$33.43	8,312	$261.71
July	$462,402.91	16,139	2,153	1,834	$28.65	$252.13	$2,637,726	81,209	$32.48	10,146	$259.98
August	$584,761.38	18,112	2,808	2,313	$32.29	$252.82	$3,222,487	99,321	$32.45	12,459	$258.65
Sept	$625,291.85	20,150	2,855	2,363	$31.03	$264.62	$3,847,779	119,471	$32.21	14,822	$259.60
Total	**$3,847,778.84**		**18,061**	**14,822**			**$17,289,095**	**514,878**	**$33.58**		

DATA AND FINDINGS OF HEALTH STATUS OF THE POPULATION SERVED

Findings on health status of the population served are not available at this time. Demonstration encounter data analysis is ongoing and DHH will report its progress on health status findings in quarterly and annual reports to CMS in Demonstration year 2.

PROGRAM OPERATIONS

During Demonstration year 1, DHH substantially completed program start up, paving the way for routine program operations in Demonstration year 2. Completion of program start up activities required CMS approval of key elements of the Demonstration terms and conditions central to program operations. These elements include:

- STC Attachment B – Evaluation Design;
- STC Attachment C – GNOCHC Funding and Reimbursement Protocol;
- STC Attachment D – Administrative Cost Claiming Protocol;
- STC Attachment E – Accounting and Audit Protocol; and
- An Evolution Plan to preserve health care access restored by PCASG and facilitate financial sustainability through diverse means of financing beginning January 1, 2012.

Below is a summary of the State's progress toward CMS approval of these attachments during Demonstration year 1.

FUNDING AND REIMBURSEMENT PROTOCOL

On January 5, 2011, DHH submitted to CMS a first draft of the funding and reimbursement protocol, including covered service definitions, reimbursement methodologies, and encounter data reporting requirements. It participated in numerous teleconferences with CMS staff, responded to CMS inquiries, supplied requested information, and revised the draft protocol and related documents as requested. CMS approved the funding protocol on June 27, 2011.

EVALUATION DESIGN

On April 1, 2011, DHH submitted to CMS a first draft of the evaluation design. It prioritized funding protocol negotiations and deferred attention to the evaluation design pending CMS approval of the funding protocol. Upon approval of the funding protocol on June 27, 2011, the State resumed active pursuit of CMS approval of the evaluation design. Negotiations continued through the Demonstration year's end; CMS approved the evaluation design on December 7, 2011.

ADMINISTRATIVE COST CLAIMING PROTOCOL

On February 11, 2011, DHH submitted to CMS a first draft of the administrative cost claiming protocol. It prioritized funding protocol negotiations and deferred attention to the administrative cost claiming pending CMS approval of the funding protocol. Upon approval of the funding protocol on June 27, 2011, the State resumed active pursuit of CMS approval of the administrative cost claiming protocol. Negotiations continued through the Demonstration year's end; CMS approved

the administrative cost claiming protocol on January 10, 2012. Due to the timing of the protocol's approval, no administrative costs for Demonstration year 1 were claimed during the period; all Demonstration year 1 administrative costs will be claimed retrospectively as prior period adjustments.

Accounting and Audit Protocol

On March 1, 2011, DHH submitted to CMS a first draft of the accounting and audit protocol to CMS. It prioritized funding protocol negotiations and deferred attention to the accounting and audit protocol pending CMS approval of the funding protocol. Upon approval of the funding protocol on June 27, 2011, the State resumed active pursuit of CMS approval of the accounting and audit protocol. Negotiations continued through the Demonstration year's end; the audit protocol remains under CMS review at this writing.

Evolution plan

On June 29, 2011, DHH submitted to CMS a plan to evolve primary and behavioral health care access restored by PCASG and preserved by the Demonstration and to facilitate financial sustainability through diverse means of financing, including but not limited to Medicaid, CHIP, and other payer sources as the revenue base. It actively pursued approval of the plan through the Demonstration year's end. It participated in numerous teleconferences with CMS staff, responded to CMS inquiries, supplied requested information, and revised the protocol and related documents as requested. The plan remains under CMS review at this writing.

Financial

State Matching Funds

DHH formalized State and Federal commitments regarding the source for the non-Federal share of expenditures under the Demonstration. DHH submitted a successful application for the U.S. Housing and Urban Development Community Development Block Grant (CDBG) funding to serve as the source for the non-Federal share of expenditures under the Demonstration, and established with the Louisiana Division of Administration, which administers state's CDBG program, a Cooperative Endeavor Agreement (CEA) to implement the grant award consistent with the terms of the Demonstration.

At the time of the CEA's approval, the agency committed funds to the limit of its budget authority under the CDBG program, then $16.8 million. Later, when the agency had additional budget authority, the CEA was amended to the full amount of $32.5 million for the 39-month term of the Demonstration.

CMS 64 Reporting

In implementing CMS 64 reporting for the Demonstration, two noteworthy administrative difficulties were the classification of enrolled eligible individuals by Medicaid Eligibility Group and the classification of enrolled eligible providers by Type of Service.

Medicaid Eligibility Group

As outlined in the STC 42. f., GNOCHC waiver expenditures must reported on the CMS 64.9 by eligibility group, specifically GNOCHC I (individuals with family income 0 though 133 percent FPL) and GNOCHC II (individuals with family income 134 though 200 percent FPL). Expenditures were not initially reported as such, but the reporting was later corrected, as explained below.

In its planning for implementation of the demonstration, DHH originally considered four eligibility type cases, one pair based on income (0-133 FPL and 134-200 FPL) and another pair based on child-related status (with or without children in the home). The income pair was intended to meet CMS financial reporting requirements and assist the State with planning for the transition of demonstration enrollees to Medicaid (<133 FPL) or the Exchange (>133 FPL) in 2014. The child-related pair was intended to meet State needs with regard to service utilization analysis, benefit design and rate setting, as well as waiver evaluation (e.g., testing the theory that childless adults will place higher demands on the health care system than parents).

Ultimately, however, the State created only the child-related pair of type cases in its Medicaid Eligiblity Data System (MEDS), Category 30 (GNOCHC) Type 102 (Adults with children in the home) and Category 30 (GNOCHC) Type 103 (Adults without children). It did so for practical purposes in consideration of front line work processes for eligibility determination. As a first step in application processing, eligibility workers must choose a type case in which to pend an application based on a quick review of application information. A quick review was possible with child-related criteria – is there a child in the home? – whereas a judgment of greater or less than 133 FPL requires a full review of household composition and income, including "working a budget."

Cognizant of the CMS requirement to report enrollment by income group, the State made provisions for enrollee counts by FPL through backend reporting after the application process had been completed, including the treatment of income. It did not, however, recognize the need to provide for the transfer of income group markers to from MEDS to MMIS as it planned and implemented claims payment systems edits to allow for processing of GNOCHC applications. Without these income distinctions in MMIS, waiver expenditure data could not be grouped by FPL in the CMS 64.9.

Unfortunately, this oversight was not identified until after the first quarter financial report was completed. MEDS and MMIS systems changes were later put in place to allow for required reporting by income group in subsequent quarters, as well as prior adjustments to the first quarter.

Type of Service

As approved by CMS on September 22, 2010, Demonstration terms and conditions defined eligible providers as GNOCHC "clinics," as they had been consistently termed under the PCASG program. Correspondingly, DHH created a unique provider type for enrolling eligible providers into the Demonstration (Provider Type 99), including a provider agreement employing the term "clinic" throughout. And, paralleling funding and reimbursement protocol negotiations, DHH built its Demonstration claims payment system on the basis of this Demonstration provider type, with GNOCHC encounter rate payments limited to billing provider identification numbers assigned to Provider Type 99.

It was not until late in funding protocol negotiations and claims payment system development that CMS and DHH recognized a problem with this provider classification. While the term "clinic" could be rightly applied to all participating providers under PCASG, under Medicaid the term has distinct meaning and implications that cannot be rightly applied to all providers under the Demonstration. Under Medicaid law and regulations, Demonstration providers are classified as Federally Qualified Health Centers, Mental Health Clinics, or Physician Groups.

The distinction has consequences from a financial reporting standpoint. Demonstration expenditures must be reported by type of service. Prior to discovering this classification issue, DHH reported the first quarter of Demonstration expenditures as "clinic services." Once discovered, it worked with CMS to identify a means of correctly reporting Demonstration expenditures by type of service without fundamental changes to the Demonstration claims payment system already developed.

The mutually agreed upon solution was the addition to DHH's claims payment system of a mechanism to cross walk payments made to a Provider ID unique to the Demonstration to the provider's corresponding Medicaid Provider ID (The STCs require Demonstration participating providers to be Medicaid participating providers). This mechanism drives the expenditures into the appropriate Medicaid Type of Service, whether Federally Qualified Health Center (28), Clinic Services (10), or Physician Services (5A) on the CMS 64.9 Waiver Form. It was used for both subsequent quarterly expenditure reporting and prior period adjustments to correct for the classification.

CONSUMER ISSUES

Issues identified by consumers early in Demonstration year 1 stemmed from the program's effective date preceding the development and implementation of key program elements, including systems to enroll eligible individuals and providers and covered service definitions.

ENROLLMENT OF ELIGIBLE INDIVIDUALS

In the first quarter of the Demonstration, consumers sought to apply for coverage before enrollment systems were in place at either the provider or the Medicaid agency level. By the end of the first quarter, eligibility policy, procedures, systems and staff training were in place, and providers were enrolled in the Demonstration and certified as Medicaid Application Centers. Through the second quarter, Medicaid agency staff eliminated the start up application backlog; and, in cooperation with providers, it streamlined the Application Center process to prevent backlog going forward. By the third quarter, the enrollment process had normalized.

ENROLLMENT OF ELIGIBLE PROVIDERS

In the first quarter, consumers sought service locations before provider enrollment was completed. In the second quarter, approval notices began directing enrollees to call the Medicaid Customer Service toll-free hotline to locate participating providers, and a listing of participating providers was developed for consumer use.

COVERED SERVICES

Clarity on covered services was a challenge from the approval of the terms and conditions through CMS approval of the funding protocol in June and CMS approval of the state's request for an amendment to the STCs to remove pharmacy from the table of covered services in October. The STCs approved on September 22, 2010 included a table of covered services, but absent CMS-approved service definitions it was impossible for DHH to communicate clearly to providers and enrollees which services were covered.

Pharmacy

Particularly confusing was the inclusion of pharmacy in the table of covered services in the STCs. The State intended for Demonstration enrollees to continue to have access to a pharmacy benefit in the same manner as under the former PCASG Demonstration. Under PCASG, patients had access to low or no cost pharmacy services through existing sources, including pharmaceutical companies' prescription assistance programs, State-funded programs, and retail pharmacies with low-cost generic programs.

But, as with "clinic," the term "pharmacy" has a distinct meaning under Medicaid, different from under PCASG. The consequence of this difference was temporary loggerhead between CMS and DHH over the pharmacy issue. CMS required a service definition that DHH estimated to be cost prohibitive within the scope of the Demonstration's expenditure limit; and, CMS would not approve the funding protocol with a lesser benefit.

The mutually agreed upon solution was the inclusion in the funding protocol of a pharmacy benefit that CMS could approve, post-dated to October 1, 2011, to be immediately followed by an amendment request from the State to remove the pharmacy benefit from the STCs prior to the benefit's effective date. On the basis of this agreement, the funding protocol was approved by CMS on June 27, 2011.

Upon completion of the public process, the State submitted to CMS on August 22, 2011 an amendment request to remove pharmacy from the table of standard benefits in the STCs. CMS approved the request on October 20, 2011, and provided written confirmation that it would not consider the State out of compliance with the STCs between October 1 and October 20 because the State submitted its request prior to the October 1, 2011 implementation date.

The favorable resolution of this issue was critical for eligible individuals in need of prescription assistance, as the Demonstration could not afford to provide a pharmacy benefit and prescription assistance programs bar the participation of individuals with drug coverage. With the pharmacy benefit removed from Demonstration terms and conditions, DHH was able to clarify the limits of the GNOCHC program to prescription assistance programs and ensure continued access to prescription assistance for Demonstration enrollees.

Specialty Care

A second point of confusion on covered services was access to specialty care. Historically, including under PCASG, the primary point of access to specialty care services for Demonstration-eligible individuals was the Medical Center of Louisiana at New Orleans (MCLNO), which is a cornerstone of the State hospital system serving the low-income uninsured with Disproportionate Share Hospital (DSH) funding. The inclusion of a specialty care services in the GNOCHC Demonstration terms and conditions prompted from MCLNO the question of whether low-income uninsured adults enrolled in GNOCHC would continue to be eligible for MCLNO's Free Care program. In consideration of the question, DHH's GNOCHC and DSH program managers determined that MCLNO expenditures on services provided to GNOCHC enrollees but not covered under the Demonstration would continue to meet the DSH program requirements.

On the basis of DHH's determination, MCLNO management began the process of educating its intake staff and clinical practitioners of the clarification. However, as with any large organization, understanding was not immediately universal, and for several weeks GNOCHC and MCLNO managers troubleshot misinformation and miscommunication to ensure that eligible individuals maintained access to needed MCLNO services.

Ultimately, DHH's decision to consider GNOCHC enrollees eligible for DSH resulted in an overhaul of the MCLNO intake process to prioritize the Medicaid application process. Admission to MCLNO outpatient services now uniformly begins with a Medicaid application. If the applicant is enrolled in GNOCHC, s/he is automatically eligible for Free Care. Only if denied for GNOCHC (which is necessarily preceded by denial for Medicaid and CHIP) is a Free Care program application taken.

This is an important shift for this DSH provider, which due to its cost-based reimbursement method had little incentive to invest resources in Medicaid enrollment prior to GNOCHC. DHH is hopeful that MCLNO's experience under GNOCHC will be transferred to other LSU safety net hospitals throughout the state and will facilitate enrollment in the 2014 Medicaid eligibility expansion to a statewide population substantially similar to that served under this Demonstration in the New Orleans region.

Eligibility Verification

Multiple barriers to eligibility verification complicated enrollee access to and provider delivery of Demonstration services, including the timeline for implementation of the enrollment system, the timeline for issuance of plastic identification cards to GNOCHC enrollees, and providers' learning curve on use of the Medicaid eligibility verification system. Prior to overcoming these barriers, providers were not always clear on what services a patient was covered for or which providers could claim payment for providing them. The resulting issue for consumers was confusion and complexity in accessing health care services.

The first barrier to eligibility verification was the timeline for implementation of the enrollment system. As previously discussed, eligibility decisions did not begin until the end of the first quarter; and, the pace of eligibility decisions, from date of application to date of decision notice, was

relatively slow during the second quarter, although application processing times improved as initial backlog was eliminated.

A second barrier was the timeline for issuance of plastic identification cards to GNOCHC eligible individuals once enrolled in the Demonstration. While DHH prepared for card issuance, enrollees were mailed approval notices stating that no card would be issued for the program. These approval letters were point in time, and providers were directed to Medicaid's electronic and telephone eligibility verification systems to verify eligibility a date of service.

In May, DHH began issuing cards to GNOCHC enrollees. The card issuance process, including the determination of the type of card to issue, the brochure to issue with the card, and related systems changes, took longer than expected because, although it began with GNOCHC, it quickly encompassed all Medicaid eligibility groups. Decision making on the card and brochure to use for GNOCHC prompted a review of the cards and brochures used for all other Medicaid programs. The review brought to light complexity and confusion surrounding the use of a pink card and corresponding brochure for Family Planning eligibles and a white card and corresponding brochure for all other Medicaid eligibles.

The use of two different cards required the agency to manage two production lines. It also led to a problematic tendency, among providers and recipients alike, to view card color as a proxy for covered services. It is often assumed that a pink card equals family planning benefits only, and a white card equals full Medicaid benefits. But, because it is common for individuals to change eligibility category and continue the use of a card from a prior certification, assumptions about eligibility and benefits based on card color are error prone.

Adding a third product line, with a unique GNOCHC card and GNOCHC brochure, would have only compounded the problem. Further complicating matters, eligibility policy permits individuals who meet the separate eligibility requirements for the GNOCHC and Family Planning demonstrations to be enrolled in both programs simultaneously, potentially creating a fourth product line to issue both GNOCHC and Family Planning cards and brochures to these dually eligible individuals.

After careful consideration, the agency decided that going forward all programs would use a white card and a universal brochure. Implementation of the decision began with provider education targeted to the Greater New Orleans area and focused on the GNOCHC Demonstration. A series of website postings and remittance advice messages reminded providers to verify eligibility and alerted them to the use of a single white card for both the full benefit Medicaid program and the limited benefit GNOCHC Demonstration. Beginning May 28, 2011, white cards and newly developed universal brochures were issued to existing GNOCHC enrollees without a card from a prior certification, followed by daily issuance to new enrollees.

In July, the change continued with a statewide provider education effort of focused on the Family Planning program. A series of website postings and remittance advice messages similar to those in May reminded providers to verify eligibility and alerted them to the use of a single white card for both the full benefit Medicaid program and the limited benefit family planning program. Effective

August 1, 2011, the pink "Take Charge" card and brochure were replaced by the white card and universal brochure.

A third barrier was providers' learning curve on use of the Medicaid eligibility verification system relative to GNOCHC. For providers that routinely use the Medicaid online and/or telephone eligibility verification system, needed education was limited to GNOCHC as a new coverage type, with limited benefits, a limited provider network, and the possibility of concurrent enrollment in GNOCHC and the Take Charge Family Planning program or in GNOCHC and Medicaid in cases where an individual is found eligible for Medicaid coverage retroactively during an active GNOCHC certification period. Toward that end, DHH developed a GNOCHC information page on its provider website and directed providers to it on multiple remittance advices.

For some GNOCHC providers, additional education was needed. Although PCASG required Medicaid provider enrollment, not all PCASG providers actively participated in the Medicaid program. Those that did not were unaccustomed to the enrollment of eligible individuals and the billing for covered services under Medicaid. For these providers, this learning curve extended beyond the GNOCHC particulate to the use of the Medicaid eligibility verification system in general. To meet the needs of these providers, DHH targeted additional education efforts, in person, by email and telephone in both group and individual settings.

CONCLUSION

During Demonstration year 1, DHH successfully met the schedule established in the STCs by CMS for deliverables during the period. Through these milestone successes, the State accomplished its Phase 1 goals, most notably:

- It enrolled tens of thousands of eligible, low-income uninsured adults into basic health care coverage.
- It transformed PCASG awardees into coverage model-driven health care providers with routine Medicaid enrollment and billing processes.
- It transitioned provider revenues from PCASG grant-like interim payments to Medicaid-like enrollee encounter rate payments while preserving health care access restored by and sustaining the medical home model begun under PCASG.
- Substantially completed program start up, paving the way for routine program operations in Demonstration year 2.

GNOCHC Annual Report

FFY12

State of Louisiana Greater New Orleans
Community Health Connection Demonstration
11-W-00252/6

Submitted to CMS
January 31, 2013

INTRODUCTION

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00252/6, Section 1115(a) Demonstration, 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 Greater New Orleans Community Health Connection (GNOCHC) Annual Report for Demonstration Year 2 (October 1, 2011 through September 30, 2012). Due to be submitted to CMS by November 30, 2012, but submitted on January 31, 2013 under an extension granted to the State, this document satisfies the requirements of STC V. 38 – Annual Report.

This draft documents accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration during Year 2. It also contains:

- Updates on the financial sustainability of the GNOCHC providers;
- Data and findings of health status of the population served under the Demonstration;
- The number of persons served and the allocation of funds per GNOCHC provider under the Demonstration;
- Data and findings of cost of providing care to persons served under the Demonstration;
- Updates on the State's success in meeting the milestones listed in section VIII; and
- The progress and outcome of any GNOCHC program receiving FFP.

BACKGROUND

Through the Greater New Orleans Community Health Connection program, Louisiana will:

- Preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with Primary Care Access and Stabilization Grant (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.
    - 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.

YEAR IN REVIEW

During Demonstration Year 2, the State successfully met the schedule established in the STCs by CMS for the following deliverables during the period. It:

- Actively participated in the monthly calls as described in V. 35.
- Submitted timely the quarterly reports as described in V. 36, including the budget neutrality reporting described in VI. 42.
- Provided quarterly expenditure reports (Form CMS-64) as described in VI. 40.
- Submitted quarterly encounter data to MSIS as described in IV. 26.
- Ensured providers submitted sustainability plans & progress reports as described in IV. 20.
- Ensured providers submitted quarterly infrastructure investment expenditure reports as described in Attachment C – Funding and Reimbursement Protocol.

In addition to the deliverables above, the State also:

- Secured from CMS approval of the Accounting and Audit Protocol, Administrative Cost Claiming Protocol, Evaluation Design, and Evolution Plan.
- Submitted to CMS an amendment request to modify the Funding and Reimbursement Protocol, based on provider feedback, to improve the payment structure and address concerns surrounding accountability and administrative costs.

One notable deviation from the Demonstration Year 2 schedule as anticipated in the milestones outlined in section VIII of the STCs was a delay in the planned implementation of the Evolution Plan.

Although the State submitted its draft Evolution Plan in accordance with the July 1, 2011 deadline set in the STCs and although the planned implementation of the Evolution Plan was originally scheduled to begin by January 1, 2012, CMS did not approve the Evolution Plan until June 22, 2012. Implementation of the Inter-pregnancy Care Coordination program, the single remaining component of the original Evolution plan, began on July 1, 2012. (*See pg.24 for additional information on this issue.*)

It should also be noted that the State was required, per STC V. 37. to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (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 Affordable Care Act, including a simplified, streamlined process for transitioning eligible enrollees from the Demonstration to Medicaid or the Exchange in 2014.

Per the STCs, the State must submit a draft plan to CMS by July 1, 2012, implement the plan by January 1, 2013, and include updates on the implementation or revision of the plan in each quarterly report required by STC IV. 36.

In light, however, of the June 28, 2012 Supreme Court ruling on the Patient Protection and Affordable Care Act, specifically as it relates to the Medicaid expansion, and the State's need to carefully review the Court's decision in its entirety, the State requested an extension of the July 1st deadline for the draft Transition Plan.

As of this writing, the State is not planning to implement the Medicaid expansion, and any other decision regarding the future of the GNOCHC enrollees will be determined when regulations and guidance related to the implementation of a Federally-Facilitated Exchange are complete.

ACCOMPLISHMENTS

In Demonstration Year 1, the State accomplished its Phase 1 goals by enrolling thousands of eligible, low-income, uninsured adults into basic health care coverage; transforming PCASG awardees into coverage model-driven health care providers with routine Medicaid enrollment and billing processes and encounter rate payments; and substantially completing program start up, paving the way for routine program operations in Demonstration Year 2.

In Demonstration Year 2, as it entered into Phase 2 of the waiver, the State continued to enroll thousands of eligible adults into the Waiver; finalized the remaining key elements of the terms and conditions of the Demonstration; and established and maintained routine operations to enable providers to move toward the goal of self-sustainability at the waiver's end in December 2013.

The following sections detail the State's accomplishments.

ENROLLMENT OF ELIGIBLE INDIVIDUALS

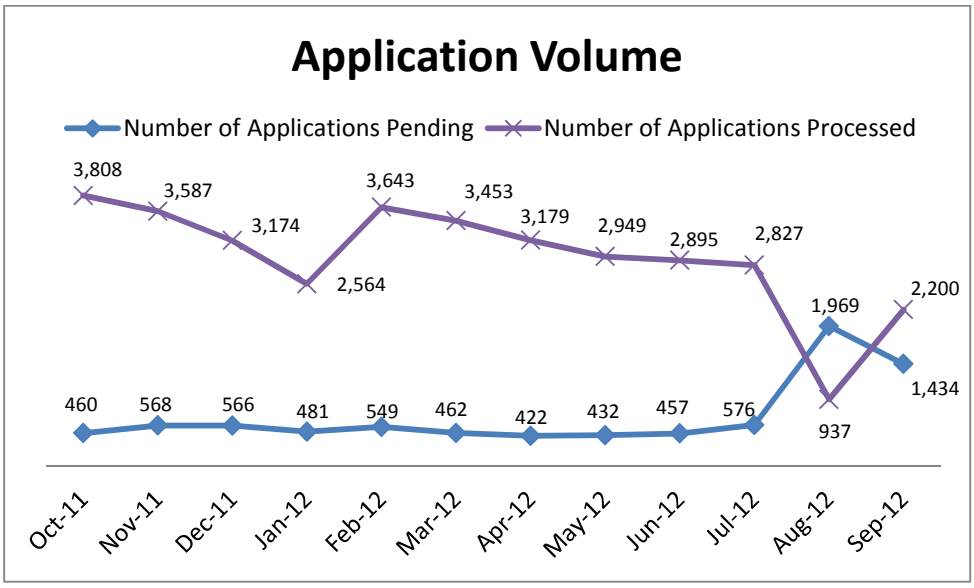
In the last two quarters of Demonstration Year 1, the enrollment process that had been initially impeded by issues with program implementation stabilized and averaged approximately 3,146 applications processed per month, with an average of 556 applications pending each month.

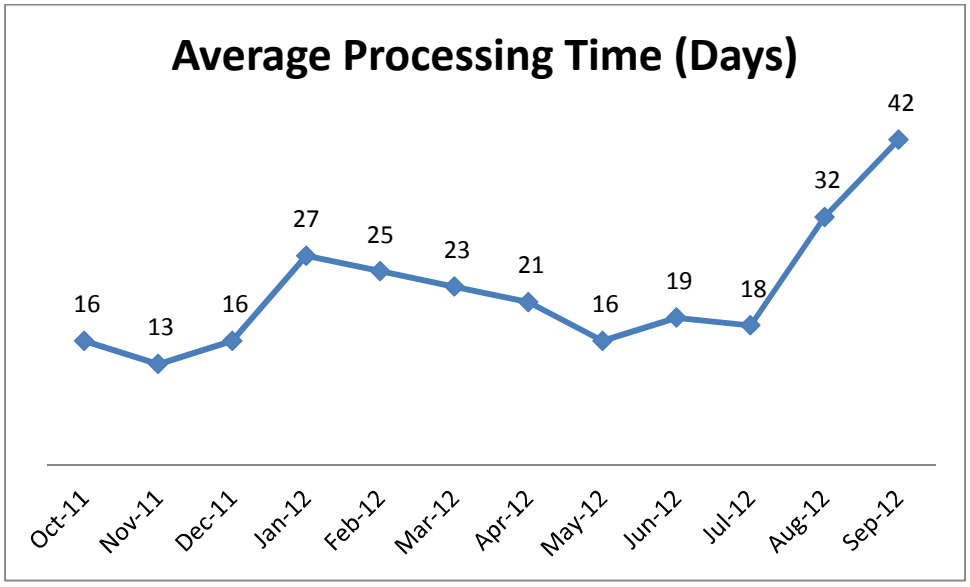
For the first three quarters of Demonstration Year 2, application continued this same trend, with averages of 3,250 applications processed per month and 493 applications pending each month. Application processing time was slightly more unstable during this period – with a low of 13 days in November 2011 and a peak of 27 days in January 2012, as Medicaid eligibility staff prioritized determinations related to implementation of the Department's new Bayou Health plans – but overall, processing time averaged 20 days, one day less than the average processing time during last two quarters of Demonstration Year 1.

In the last quarter of Demonstration Year 2, however, both application volume and application processing times shifted dramatically. Only 937 applications were approved in August and 2,200 in September, and processing time increased to an average of 32 days processing time in August and 42 days in September. This shift was due to two factors: staffing issues in the Region 1 (Orleans)

Medicaid office, which typically approves 40-50% of GNOCHC applications, and the impact of Hurricane Isaac, which made landfall in southern Louisiana on August 28, 2012, resulting in statewide office closures and, for several weeks thereafter, reassignments of eligibility staff to support recovery efforts. Similar increases were seen in all other Medicaid programs.

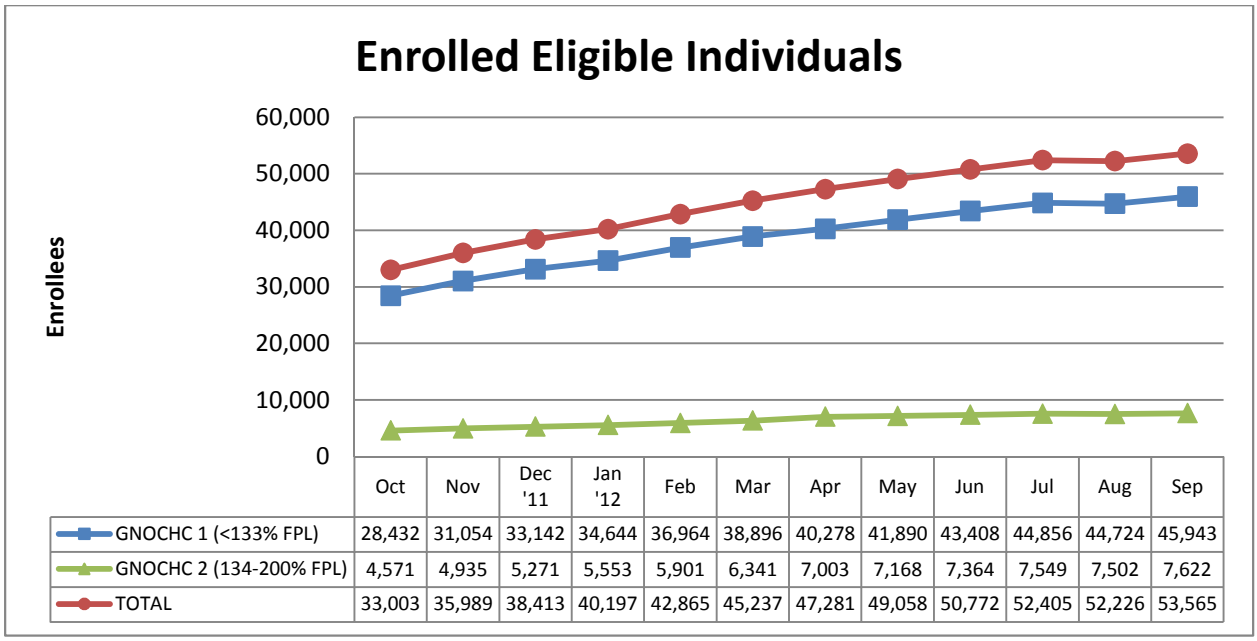
At the time of this writing, application processing time has decreased only slightly from the end of Demonstration Year 2, and there continues to be a large number of pending applications each month as a result of the backlogs that began in August and September 2012. GNOCHC staff will continue to monitor the situation and provide CMS with monthly updates on the progress made to reduce this backlog.





At the start of Demonstration Year 2, monthly enrollment growth slowly decreased from the percentage increases in the teens seen at the end of Demonstration Year 1 to an average of 9% in the first quarter one and 7% in the second quarter. Enrollment slowed further in the second half of year, growing by an average of only 4% monthly in the third quarter and an average of 2% monthly in the fourth quarter, with total enrolling ending at 53,565 for Demonstration Year 2.

As in Demonstration Year 1, enrollment continues to be biased heavily toward the low end of the income spectrum, with 86 percent of enrollees with income below 133 percent of the Federal Poverty Level (FPL).



	Oct	Nov	Dec '11	Jan '12	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
GNOCHC 1 (<133% FPL)	28,432	31,054	33,142	34,644	36,964	38,896	40,278	41,890	43,408	44,856	44,724	45,943
GNOCHC 2 (134-200% FPL)	4,571	4,935	5,271	5,553	5,901	6,341	7,003	7,168	7,364	7,549	7,502	7,622
TOTAL	33,003	35,989	38,413	40,197	42,865	45,237	47,281	49,058	50,772	52,405	52,226	53,565

PROVIDER ENROLLMENT

At the start of Demonstration Year 2, 18 organizations, including 39 service sites, remained active participants in the GNOCHC program.

Over the course of the year, three types of changes in provider enrollment occurred: site relocations, site ownership transfers, and site openings.

SITE RELOCATIONS

- In February, St. Thomas Community Health Center relocated primary care services from 1020 St. Andrew St. to a newly renovated building at 1936 Magazine Street. The St. Andrew site is currently used for specialty care services.
- In late March, the Tulane Community Health Center at Covenant House changed its name to the Ruth U. Fertel / Tulane Community Health Center and relocated from 611 N. Rampart to 711 N. Broad St. in New Orleans.

- In May, Medical Center of Louisiana at New Orleans' HIV Outpatient Program relocated from 136 S. Roman St. to 2235 Poydras St. in New Orleans.

SITE OWNERSHIP TRANSFERS

- Daughters of Charity Services of New Orleans (DCSNO) entered into an affiliation agreement with Marillac Community Health Centers (MCHC), effective March 1, 2012, to transfer clinic operations and administration to Marillac, with the express purpose of achieving Federally Qualified Health Center (FQHC) Look-Alike status for DCSNO's three Community Health Centers.

SITE OPENINGS

- In February, St. Thomas Community Health Center began providing primary care services in a newly renovated building at 1935 Magazine St., just across the street from its original location on St. Andrew St.
- Daughters of Charity/Marillac opened a new satellite FQHC clinic in New Orleans East in early May.
- Access Health Louisiana (formerly St. Charles Community Health Center, and as it is still recognized by DHH) opened a satellite FQHC clinic in Belle Chasse (Plaquemines Parish) in early June.

At year's end, 18 organizations, including 41 service sites, remained active participants in the GNOCHC program. Additionally, a new Inter-Pregnancy Care Coordination (IPC) service component began on July 1, 2012; this new service is being provided by the City of New Orleans Health Department at existing service locations.

GNOCHC Enrolled Providers

Organization	Service Site Name	Service Site Location
Administrators of the Tulane Educational Fund	Tulane Community Health On The Move	***Mobile site*** / 1430 Tulane Ave, New Orleans
	New Orleans Children's Health Project	***Mobile site*** / 1430 Tulane Ave, New Orleans
	Drop In Center	1428 N Rampart St, New Orleans
	Walter L. Cohen School Based Health Clinic	3520 Dryades St, New Orleans
	Adolescent Drop-In Clinic	611 N Rampart St, New Orleans
	Ruth U. Fertel Tulane Community Health Center	711 N Broad St, New Orleans
City of New Orleans Health Department	Health Care for the Homeless	2222 Simon Boliver Ave Fl 2, New Orleans
Common Ground Health Clinic	Common Ground Health Clinic	1400 Teche St, New Orleans
Daughters of Charity Services of New Orleans / Marillac Community Health Centers	Carrollton	3201 S Carrollton, New Orleans
	Metairie	111 N Causeway, Metairie
	Gentilly	1030 Lesseps St, New Orleans
	New Orleans East	5640 Read Blvd, Ste 550, New Orleans

GNOCHC Enrolled Providers

Organization	Service Site Name	Service Site Location
EXCELth, Incorporated	Gentilly	2050 Caton St, New Orleans
	Algiers	4422 General Meyer Ave/Ste 103, New Orleans
Jefferson Community Health Care Centers	Avondale	4028 US Hwy 90, Avondale
	Marrero	1855 Ames Blvd, Marrero
	River Ridge	11312 Jefferson Hwy, River Ridge
Jefferson Parish Human Service Authority	West Jefferson	5001 Westbank Expy, Marrero
	East Jefferson	2400 Edenborn Ave, Metairie
Louisiana State University School of Medicine	LSU Healthcare Network Behavioral Health	3450 Chestnut St, New Orleans
Medical Center of Louisiana at New Orleans	Interim LSU Public Hospital – LB Landry Community Clinic	1200 L B Landry Ave, New Orleans
	Interim LSU Public Hospital – HIV OP Program	2235 Poydras St., New Orleans
	Interim LSU Public Hospital – Medical Home Care	1400 Poydras St, New Orleans
	University Medical Office Building	2025 Gravier St, New Orleans
Metropolitan Human Services District	Algiers	4422 Gen Meyer Ave, Ste. 201, New Orleans
	St Bernard	7407 St Bernard Ave, Ste. A, Arabi
	New Orleans East	5552 Read Blvd, New Orleans
	Central City	2221 Philip St, New Orleans
	Chartres-Ponchartrain	719 Elysian Fields Ave, New Orleans
Mary Queen of Vietnam Community Development Corporation	NOELA	4626 Alcee Fortier Blvd, Ste. D, New Orleans
New Orleans Musicians Assistance Foundation	New Orleans Musicians Assistance Clinic	2820 Napoleon Ave #890, New Orleans
NO/AIDS Task Force	NO/AIDS Task Force	2601 Tulane Ave, New Orleans
Odyssey House Inc Louisiana	Odyssey House	1125 N Tonti St, New Orleans
Plaquemines Primary Care	Plaquemines Primary Care, Inc	26851 Hwy 23, Ste. A, Port Sulphur
Sisters of Mercy Ministries	Mercy Family Center	110 Veterans Memorial Blvd, Ste. 425, Metairie
St. Charles Community Health Center / Access Health Louisiana	St Bernard Community Health Center	7718 W Judge Perez Dr., Arabi
	St Charles Community Health Center	200 W Esplanade Ave., Kenner
	Belle Chasse Community Health	8200 Hwy 23, Belle Chasse
St Thomas Community Health Center	St Thomas Community Health Center	1020 St Andrew St., New Orleans
	St Thomas Community Health Center	2405 Jackson Ave., New Orleans
	St Thomas Community Health Center	1936 Magazine St., New Orleans

PROVIDER PAYMENTS

PAYMENT METHOD OVERVIEW

The Funding Protocol approved on June 28, 2011 provides for three reimbursement methodologies in Demonstration Year 2: 1) targeted payments, 2) incentive payments, and 3) encounter rate payments.

1) Targeted payments

The protocol provides for one type of targeted payment in DY2: infrastructure investment payments.

INFRASTRUCTURE INVESTMENT PAYMENTS are permitted throughout the Demonstration, not to exceed ten percent of total computable expenditures. Infrastructure investment payments cover expenditures to support the providers' delivery of services, billing for services, financial accountability, and encounter/quality reporting. Payments will be based on applications from participating providers and the State's assessment of the extent to which a provider's application meets designated criteria for targeted infrastructure investment. They will not cover any costs for the acquisition, construction or renovation of bricks and mortar.

2) Incentive payments

The protocol provides for quarterly *NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) PATIENT CENTERED MEDICAL HOME (PCMH) RECOGNITION INCENTIVE PAYMENTS*, not to exceed ten percent of total computable expenditures. The amount of a provider's quarterly 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 number of enrollee encounters for the prior quarter.

3) Encounter rate payments

The protocol defines encounter rates as payments made on a per visit/encounter basis to eligible providers for covered services received by enrolled eligible individuals from qualified practitioners. Three types of encounters are payable under GNOCHC: primary care, basic behavioral health care, and Serious Mental Illness (SMI) behavioral health care. Each encounter type has its own rate which is fixed for all providers. All encounter rates cover a bundle of services.

The *PRIMARY CARE ENCOUNTER RATE* covers 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 and radiology services that are routinely available in a primary care setting or through contracted services.

The *BASIC BEHAVIORAL HEALTH CARE ENCOUNTER RATE* covers 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). Basic 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 do not

include primary care services. All providers are eligible for the basic behavioral health care encounter rate.

The *SMI BEHAVIORAL HEALTH CARE ENCOUNTER RATE* covers services provided to enrollees who meet the federal SMI definition, including those who also have a co-occurring addictive disorder. SMI behavioral health care services include mental health and/or substance abuse screening, assessment, counseling, medication management, follow-up and community support services. Only two providers are eligible for the SMI behavioral health care encounter rate. SMI payments may not exceed ten percent of total computable expenditures.

The protocol also provides for a yearend adjustment consisting of *SUPPLEMENTAL ENCOUNTER RATE PAYMENTS*. For each Demonstration Year, the State will subtract the sum of all payments made under the Demonstration for that year, including payments for State administrative costs and targeted payments, incentive payments and encounter rate payments for dates of service during the year, from the limit of total computable expenditures allowed under the Demonstration.

If the sum of all payments made is less than the limit of total computable expenditures allowed 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 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. To be considered in the yearend adjustment, encounter reports for dates of service during Demonstration year must be submitted not later than 45 days after the end of the Demonstration year as specified in the GNOCHC Provider Manual.

EXPENDITURE TRACKING & RECONCILIATION

The DY2 Expenditure Tracking & Reconciliation Workbook provides a complete accounting of all encounter rate payments, targeted payments, and incentive payments made to GNOCHC providers in Demonstration Year 2. It also contains calculations for each provider's year-end supplemental payment.

Calculations are organized by worksheet, as named and described below:

- ***Rates*** contains the calculation of the supplemental encounter rate.
- ***Site Summary*** contains all site-level reconciliation calculations and references the data worksheets.
- ***Organization Summary*** aggregates site-level reconciliation calculations to the organization level.

Supporting data are also organized by worksheet:

- ***Encounters*** contains site-level summary data for primary care, basic behavioral health care, and SMI behavioral health care encounter claims, including paid and denied counts and payments for encounter claims with Demonstration Year 2 dates of service submitted on Form CMS-1500 to the fiscal intermediary.
- ***NCQA*** contains site-specific data on the level and period of NCQA PCMH recognition.
- ***Infrastructure*** contains site-specific summary data on the amount of State-approved infrastructure investment expenditures reported by quarter and year.
- ***Administrative Costs*** identifies the total State administrative costs claimed for the year, including personnel and professional services contract costs.
- ***Rates*** contains the primary care, basic behavioral health care, and serious mental illness behavioral health care encounter rates; the NCQA PCMH Recognition Levels 1, 2, and 3 rates; and the supplemental encounter rate.

For purposes of communicating to each provider organization its individual reconciliation outcomes, the workbook includes a worksheet with a standard reporting format:

- ***Site-specific provider*** is a summary report template with a drop down menu listing the names of all participating provider sites; select a site name in the drop down menu and the worksheet automatically populates the template with summary data specific to the selected site, including encounter rate payments, NCQA PCMH incentive payments, infrastructure investment payments, supplemental payments, and total DY2 payment amounts.

Incentive Payments

In Demonstration Year 2, providers earned a total of $573,475.50 in incentive payments for NCQA PCMH Recognition.

NCQA PCMH incentive payments are site- and quarter-specific. The below tables notes the number of sites at each recognition level (1, 2 or 3), and it summarizes site-specific payments at the organization level.

For additional detail, see the DY2 Expenditure Tracking & Reconciliation Workbook.

Incentive Payments Per Provider

Provider Organization	*Recognition Level*	*Payment*
Administrators of the Tulane Educational Fund	2 sites, Level 3	$43,052.50
City of New Orleans Health Department	-	-
Common Ground Health Clinic	1 site, Levels 2/3	$22,330.00
Daughters of Charity Services of New Orleans / Marillac CHC	3 sites, Level 3 for three quarters	$193,715.00
EXCELth, Incorporated	2 sites, Level 3 for various quarters	$65,938.75
Jefferson Community Health Care	3 sites, Level 1	$57,267.00
Jefferson Parish Human Service Authority	N/A	-
Louisiana State University School of Medicine	1 site, Level 1	-
Medical Center of Louisiana at New Orleans	3 sites, Level 1 for three quarters	$34,769.00
Metropolitan Human Services District	N/A	-
MQVN Community Development	1 site, Level 1	$7,518.00
New Orleans Musicians Assistance Foundation	N/A	-
NO/AIDS Task Force	1 site, Level 3	$10,242.50
Odyssey House	N/A	-
Plaquemines Primary Care	N/A	-
Sisters of Mercy Ministries	N/A	-
St. Charles Community Health Center / Access Health Louisiana	1 site, Level 2 for three quarters; 1 site, Level 3 for three quarters	$75,594.00
St. Thomas Community Health Center	1 site, Level 3 for three quarters	$63,048.75
TOTAL		**$573,475.50**

Targeted Payments

In Demonstration Year 2, providers received a total of $559,869.87 in targeted payments for approved infrastructure investments reported for the period.

Infrastructure Investments

Infrastructure investment payments due are site-specific based on outcomes of the 2011 and 2012 GNOCHC Infrastructure Investment Payments application cycles and DHH-approved expenditures reported by providers for Demonstration Year 2.

2011 Application Cycle

On October 11, 2011, DHH released to providers the 2011 Application for GNOCHC Infrastructure Investment Payments. Applications were due to DHH by October 31, 2011, and applicants were notified of DHH funding decisions by November 18, 2011.

Funding decisions were based on DHH's assessment of the extent to which the application targets select criteria for infrastructure investments:

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

Applications were assessed on both the extent to which they target infrastructure investment criteria and:

- Detail the work plan for the project and an achievable timeline
- Demonstrate provider capacity to manage the infrastructure project
- Demonstrate cost effectiveness of the investment (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 for health information technology)
- Provide detailed documentation and a reasonable basis for cost estimates included in the application (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

Through the 2011 GNOCHC Infrastructure Investment Payments application cycle:

- 34 applications were received from 12 provider organizations;
- 18 applications and 9 organizations were funded;
- 12 applications were fully funded; all items requested were eligible for funding;
- 6 applications were less than fully funded; one or more items requested were ineligible for funding;
- A total of $1,387,447 in funding requested was approved for the period October 1, 2010 through June 30, 2012.

2012 Application Cycle

An additional cycle of infrastructure awards was announced in June 2012 to solicit applications from those providers who were not awarded funding in the 2011 cycle or for those providers who needed additional funding to complete the projects originally approved. DHH staff utilized the same application process and the same criteria to assess the new requests, and through this additional cycle:

- 5 applications were received from 3 provider organizations;
- All 5 applications were fully funded;
- A total of $153,231 in funding was approved for the period July 1, 2012 through September 30, 2012.

Site-specific infrastructure investments approved by DHH in the 2011 and 2012 application cycles are summarized below.

DHH-Approved Infrastructure Investments

Provider Organization	*Investment*	*Amount*
Administrators of the Tulane Educational Fund	2012 – NCQA Coordination; HIT staff training; practice management software purchases	$49,982
Common Ground	2011 - Practice management system purchase, installation, and staff training; NCQA PCMH recognition application fees and staff time.	$35,715
	2012 – Additional funding for HIT hardware; staff training; conversion of paper records to electronic charts	$91,264
Daughters of Charity / Marillac CHC	2011 - Practice management system purchase, installation, and staff training; care management system purchase, installation, and staff training; NCQA PCMH recognition application fees and staff time.	$96,413

DHH-Approved Infrastructure Investments		
Provider Organization	***Investment***	***Amount***
Interim LSU Hospital	2011- Operations process improvement consultation in preparation for practice management system upgrade.	$50,000
Interim LSU Hospital	2011 - Telemedicine equipment purchase, installation, and staff training.	$13,200
Metropolitan Human Services District	2011 - Practice management system purchase, installation, and staff training	$604,141
MQVN Community Development	2011- Practice management and care management staff training.	$35,009
MQVN Community Development	2011 - Telemedicine equipment purchase, installation, and staff training.	$158,522
MQVN Community Development	2011 - NCQA PCMH recognition application fees and consultation.	$36,820
New Orleans Musicians Assistance Foundation	2011 - Quality improvement consultation; practice management consultation and training; NCQA PCMH recognition consultation.	$145,415
NO/AIDS Task Force	2011 - Practice management system purchase, installation, and staff training; care management system purchase, installation, and staff training.	$129,225
Odyssey House	2011 - Practice management system purchase, installation, and staff training *(NOTE: This original award was declined by the provider organization, as they found an alternative solution.)*	$37,247
	2012 – Practice Management software purchase and training	$11,985
St. Thomas Community Health Center	2011 - Population health management system purchase, installation, and staff training	$45,740
TOTAL		**$1,540,678**

Approved Expenditures Reported

As noted in the annual report for Demonstration Year 1, $737,050 in approved expenditures were reported for DY1, accounting for just over half of the $1,387,447 in infrastructure investment funding approved in the 2011 application cycle.

$559,870 in approved expenditures were reimbursed in Demonstration Year 2, bringing the total amount of expenditures to $1,296,920, which is 84.2 percent of the total $1,540,678 awarded to providers through both the 2011 and 2012 application cycles.

Infrastructure investment payments made for Demonstration Year 2 are summarized below at the provider organization level. For site-level detail, see the DY2 Expenditure Tracking & Reconciliation Workbook.

Infrastructure Investment Payments Per Provider	
Provider Organization	***Payment Amount***
Administrators of the Tulane Educational Fund	$46,816.86
City of New Orleans Health Department	$0.00
Common Ground Health Clinic	$82,746.62
Daughters of Charity / Marillac CHC	$31,061.91
EXCELth, Incorporated	$0.00
Jefferson Community Health Care	$0.00
Jefferson Parish Human Service Authority	$0.00
Louisiana State University School of Medicine	$0.00
Medical Center of Louisiana at New Orleans	$61,483.21
Metropolitan Human Services District	$0.00
MQVN Community Development	$134,967.44
New Orleans Musicians Assistance Foundation	$100,690.73
NO/AIDS Task Force	$80,038.10
Odyssey House Inc Louisiana	$11,985.00
Plaquemines Primary Care	$0.00
Sisters of Mercy Ministries	$0.00
St. Charles Community Health Center / Access Health Louisiana	$0.00
St. Thomas Community Health Center	$10,080.00
TOTAL	**$559,869.87**

Encounter Rate Payments

In Demonstration Year 2, providers were paid a total of $16,307,102.75 for encounter claims.

Primary Care Encounters

Analyses of encounter data reported for Demonstration Year 2 show that primary care encounters drove both encounter volume and encounter rate payments for the period. Primary care encounters account for 83.4 percent of the total number of encounters approved for Demonstration year 2 (63,873 of 76,543). Primary care encounter payments account for 91.9 percent of all encounter rate payments.

Behavioral Health Care Encounters

Behavioral health care encounters account for the remaining 16.6 percent of encounters approved for Demonstration Year 2, with 8.9 percent (6,791) being basic behavioral health care encounters and 7.7 percent (5,879) being Serious Mental Illness behavioral health care encounters. Behavioral health care encounter payments account for 8.1 percent of all encounter rate payments, with 4.2 percent being basic behavioral health care encounter rate payments and 3.9 percent being SMI behavioral health care encounter rate payments.

The following table provides the number of primary and behavioral health care encounters approved for payment and the amount of primary and behavioral health care encounter rate payments per provider organization. For site-level detail, see the DY2 Expenditure Tracking & Reconciliation Workbook.

Primary Care and Behavioral Health Encounter Rate Payments Per Provider

Provider Organization	Number of Primary Care Encounters	Primary Care Encounter Rate Payments	Number of Basic BH Encounters	Basic BH Payments	Number of SMI Encounters	SMI Payments	Total Number of Encounters	Total Encounter Rate Payments
Administrators of the Tulane Educational Fund	3,226	$759,755.26	661	$67,236.72	0	$0.00	3,887	$826,991.98
City of New Orleans Health Department	85	$19,547.33	0	$0.00	0	$0.00	85	$19,547.33
Common Ground Health Clinic	1,340	$315,380.38	0	$0.00	0	$0.00	1,340	$315,380.38
Daughters of Charity Services of New Orleans / Marillac CHC	12,920	$3,041,879.04	199	$20,242.28	0	$0.00	13,119	$3,062,121.32
EXCELth, Inc.	6,078	$1,388,016.80	173	$17,596.86	0	$0.00	6,251	$1,405,613.66
Jefferson Community Health	8,780	$2,064,214.31	191	$19,428.52	0	$0.00	8,971	$2,083,642.83
Jefferson Parish Human Service Authority	0	$0.00	2,505	$254,620.16	1,339	$143,789.18	3,844	$398,409.34
LSU School of Medicine	0	$0.00	137	$13,935.64	0	$0.00	137	$13,935.64
Medical Center of Louisiana at New Orleans	14,002	$3,297,466.16	235	$23,904.20	0	$0.00	14,237	$3,321,370.36
Metropolitan Human Services District	0	$0.00	0	$0.00	4,540	$487,938.25	4,540	$487,938.25
Mary Queen of Vietnam Community Development	1,346	$316,788.95	2	$203.44	0	$0.00	1,348	$316,992.39
New Orleans Musicians Assistance Foundation	684	$161,064.33	26	$2,644.72	0	$0.00	710	$163,709.05
NO/AIDS Task Force	461	$108,369.60	89	$9,053.08	0	$0.00	550	$117,422.68
Odyssey House Inc	1,203	$282,882.51	2,411	$245,165.20	0	$0.00	3,614	$528,047.71
Plaquemines Primary Care	240	$56,522.40	0	$0.00	0	$0.00	240	$56,522.40
Sisters of Mercy Ministries	0	$0.00	7	$712.04	0	$0.00	7	$712.04
St. Charles Community Health / Access Health Louisiana	7,260	$1,702,945.63	0	$0.00	0	$0.00	7,260	$1,702,945.63
St. Thomas Community Health	6,248	$1,470,033.16	155	$15,766.60	0	$0.00	6,403	$1,485,799.76
TOTAL	**63,873**	**$14,984,865.86**	**6,791**	**$690,509.46**	**5,879**	**$631,727.43**	**76,543**	**$16,307,102.75**

Supplemental Encounter Rate Payments

Based on calculations in the DY2 Expenditure Tracking & Reconciliation Workbook, providers are due a total of $11,102,562 in supplemental encounter rate payments. These payments are site-specific, and summarized below at the provider organization level. See the DY2 Expenditure Tracking & Reconciliation Workbook for site-level details.

Supplemental Encounter Rate Payments Per Provider

Provider Organization	*Payment Amount*
Administrators of the Tulane Educational Fund	$563,809.35
City of New Orleans Health Department	$12,329.25
Common Ground Health Clinic	$194,367.00
Daughters of Charity Services of New Orleans / Marillac CHC	$1,902,910.95
EXCELth, Incorporated	$906,707.55
Jefferson Community Health	$1,301,243.55
Jefferson Parish Human Service Authority	$557,572.20
LSU School of Medicine	$19,871.85
Medical Center of Louisiana at New Orleans	$2,065,076.85
Metropolitan Human Services District	$658,527.00
Mary Queen of Vietnam Community Development	$195,527.40
New Orleans Musicians Assistance Foundation	$102,985.50
NO/AIDS Task Force	$79,777.50
Odyssey House Inc	$524,210.70
Plaquemines Primary Care	$34,812.00
Sisters of Mercy Ministries	$1,015.35
St. Charles Community Health Center / Access Health Louisiana	$1,053,063.00
St. Thomas Community Health Center	$928,755.15
TOTAL	**$11,102,562.15**

Total DY2 Payments

In sum, according to the DY2 Expenditure Tracking & Reconciliation Workbook:

- A total of $16.3 million in encounter payments were made to 18 provider organizations.
- Incentive payments for NCQA PCHM recognition totaled $573K.
- Targeted payments for infrastructure investments totaled $560K.
- Providers were due a total of $11.1 million in supplemental encounter rate payments.
- Total DY2 payments to providers total $28.5 million.

The following table summarizes DY2 payments at the provider organization level.

Summary of All DY2 Payments by Participating Provider Organization

Provider Organization	Total NCQA Incentive Payments	Total Infrastructure Investment Payments	Total Encounter Rate Payments	Total Supplemental Payment	Total DY2 Payments
Administrators of the Tulane Educational Fund	$43,052.50	$46,816.86	$826,991.98	$563,809.35	$1,480,670.69
City of New Orleans Health Dept	$0.00	$0.00	$19,547.33	$12,329.25	$31,876.58
Common Ground Health Clinic	$22,330.00	$82,746.62	$315,380.38	$194,367.00	$614,824.00
Daughters of Charity / Marillac CHC	$193,715.00	$31,061.91	$3,062,121.32	$1,902,910.95	$5,189,809.18
EXCELth, Incorporated	$65,938.75	$0.00	$1,405,613.66	$906,707.55	$2,378,259.96
Jefferson Community Health Care	$57,267.00	$0.00	$2,083,642.83	$1,301,243.55	$3,442,153.38
Jefferson Parish Human Service Authority	$0.00	$0.00	$398,409.34	$557,572.20	$955,981.54
Louisiana State University School of Medicine	$0.00	$0.00	$13,935.64	$19,871.85	$33,807.49
Medical Center of Louisiana at New Orleans	$34,769.00	$61,483.21	$3,321,370.36	$2,065,076.85	$5,482,699.42
Metropolitan Human Services District	$0.00	$0.00	$487,938.25	$658,527.00	$1,146,465.25
MQVN Community Development	$7,518.00	$134,967.44	$316,992.39	$195,527.40	$655,005.23
New Orleans Musicians Assistance Foundation	$0.00	$100,690.73	$163,709.05	$102,985.50	$367,385.28
NO/AIDS Task Force	$10,242.50	$80,038.10	$117,422.68	$79,777.50	$287,480.78
Odyssey House Inc Louisiana	$0.00	$11,985.00	$528,047.71	$524,210.70	$1,064,243.41
Plaquemines Primary Care	$0.00	$0.00	$56,522.40	$34,812.00	$91,334.40
Sisters of Mercy Ministries	$0.00	$0.00	$712.04	$1,015.35	$1,727.39
St Charles Community Health Center / Access Health Louisiana	$75,594.00	$0.00	$1,702,945.63	$1,053,063.00	$2,831,602.63
St Thomas Community Health Center	$63,048.75	$10,080.00	$1,485,799.76	$928,755.15	$2,487,683.66
TOTAL	**$573,475.50**	**$559,869.87**	**$16,307,102.75**	**$11,102,562.15**	**$28,543,010.27**

ENCOUNTER DATA FINDINGS

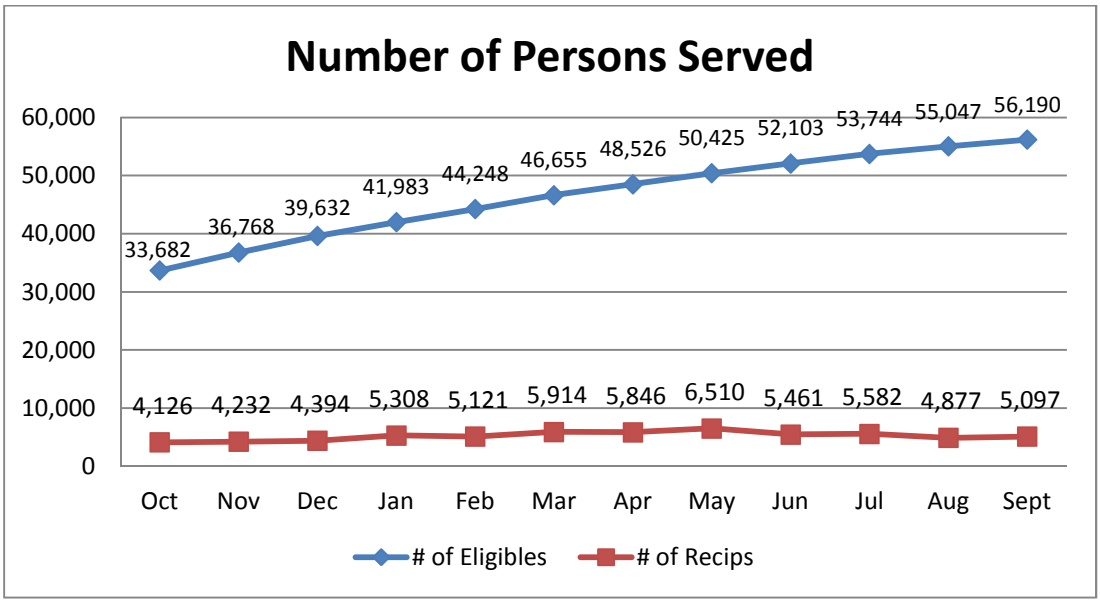
Encounter data analyses of enrollee encounter data reported for Demonstration Year 2 provide the following information about the number of persons served and the cost of providing care to persons served under the Demonstration.

NUMBER OF PERSONS SERVED

Despite the steady, but gradually decreasing rate of growth in enrollment throughout Demonstration Year 2, the number of persons served remained flat throughout the year. Primary care and behavioral health care service recipients accounted for only 11.2 percent of total enrollment for the year.

As described in previous reports, any application (GNOCHC or any other program-specific application or a general Medicaid application) from any source (online or paper, direct from the applicant or via Medicaid Application Center) is considered for GNOCHC eligibility for an applicant who resides in one of the four GNOCHC-participating parishes. In determining eligibility, workers "roll down" through every possible eligibility category and in descending order of benefit package certify individuals for the program(s) for which they are eligible. Further, this roll down procedure applies to both applications and renewals.

With this approach, enrollment is driven by those who seek help from the Medicaid agency. Enrollment data show that of all GNOCHC eligible individuals enrolled during Demonstration Year 2, only 35% came from Medicaid Application Centers (i.e. GNOCHC and non-GNOCHC providers). An average of 44% came from applications that originated online or at a Medicaid regional office, 15% came from renewals, and 4% originated from other application sources. As in DY1, the result is an enrolled population in DY2 in which only a minority has a demonstrated relationship with a GNOCHC provider; the majority does not. Relatively low rates of service receipt among enrollees may again reflect enrollees' unfamiliarity and/or inexperience with participating providers.



Cost of Providing Care

The driver of the cost of providing care to Demonstration enrollees is the primary care encounter. It is the most utilized service, and the primary care encounter rate payments account for the vast majority of encounter rate payments. Of the total number of encounter claims approved for Demonstration Year 2, 83.4 percent (63,873 of 76,543) were primary care encounters. Of the total amount of encounter rate payments made and/or due to participating providers for Demonstration Year 2, primary care encounter rate payments account for 91.9 percent. Behavioral health care encounter rate payments account for the remaining 8.1 percent of the total.

In consideration of child-related status, childless adults drive the cost of providing care by both enrollment volume and service utilization. Childless adults (without minor children in the home) account for 68.8 percent of total enrollment and 77.9 percent of all encounter rate payments, while parents (adults with minor children in the home) account for 31.3 percent of total enrollment and 22.1 percent of all encounter rate payments.

As in Demonstration Year 1, DY2 data provide support to two related evaluation design hypotheses. The first hypothesis – that childless adults will utilize relatively more behavioral health care services than parents – is supported by data showing that, as a percentage of total childless adult enrollment, the number of enrollees who received behavioral health services was four times that of parents (2.27 percent compared with 0.56 percent) for Demonstration Year 2. The second hypothesis – that the cost of providing care to childless adults will be relatively higher for childless adults than parents – is supported by data showing that the cumulative Per Enrollee Per Month cost of providing behavioral health care services to childless adults was more than one and a half times higher than that for parents ($20.60 compared with $33.08) for Demonstration Year 2.

The below tables provide additional detail on the cost of providing care to persons under Demonstration, including but not limited to total encounter rate payments (based on date of service); number of enrollees, encounters, and recipients; encounter rate payments per enrollee per month; and, encounter rate payments per recipient per month. The first table provides the data for all Demonstration enrollees. The second table provides the data for Demonstration enrollees with minor children in the home (parents). The third table provides the data for Demonstration enrollees without minor children in the home (childless adults).

Service Utilization by and Cost of Providing Care to All Demonstration Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$1,080,273.94	33,682	5,048	4,126	$32.07	$261.82	$1,080,274	33,682	$32.07	4,126	$261.82
November	$1,111,367.83	36,768	5,198	4,232	$30.23	$262.61	$2,191,642	70,450	$31.11	8,358	$262.22
December	$1,130,491.88	39,632	5,385	4,394	$28.52	$257.28	$3,322,134	110,082	$30.18	12,752	$260.52
January	$1,384,698.81	41,983	6,607	5,308	$32.98	$260.87	$4,706,832	152,065	$30.95	18,060	$260.62
February	$1,323,024.64	44,248	6,316	5,121	$29.90	$258.35	$6,029,857	196,313	$30.72	23,181	$260.12
March	$1,573,513.40	46,655	7,382	5,914	$33.73	$266.07	$7,603,371	242,968	$31.29	29,095	$261.33
April	$1,535,764.34	48,526	7,240	5,846	$31.65	$262.70	$9,139,135	291,494	$31.35	34,941	$261.56
May	$1,731,468.11	50,425	8,112	6,510	$34.34	$265.97	$10,870,603	341,919	$31.79	41,451	$262.25
June	$1,447,229.38	52,103	6,715	5,461	$27.78	$265.01	$12,317,832	394,022	$31.26	46,912	$262.57
July	$1,459,716.05	53,744	6,775	5,582	$27.16	$261.50	$13,777,548	447,766	$30.77	52,494	$262.46
August	$1,235,942.36	55,047	5,779	4,877	$22.45	$253.42	$15,013,491	502,813	$29.86	57,371	$261.69
Sept	$1,298,960.87	56,190	6,013	5,097	$23.12	$254.85	$16,312,452	559,003	$29.18	62,468	$261.13
Total	**$16,312,451.61**		**76,570**	**62,468**							

Service Utilization by and Cost of Providing Care to Parent Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$243,942.35	10,781	1,090	932	$22.63	$261.74	$243,942	10,781	$22.63	932	$261.74
November	$236,486.19	11,798	1,070	923	$20.04	$256.21	$480,429	22,579	$21.28	1,855	$258.99
December	$241,594.86	12,748	1,092	940	$18.95	$257.02	$722,023	35,327	$20.44	2,795	$258.33
January	$319,494.23	13,465	1,442	1,185	$23.73	$269.62	$1,041,518	48,792	$21.35	3,980	$261.69
February	$289,069.09	13,985	1,301	1,104	$20.67	$261.84	$1,330,587	62,777	$21.20	5,084	$261.72
March	$349,459.82	14,684	1,554	1,315	$23.80	$265.75	$1,680,047	77,461	$21.69	6,399	$262.55
April	$366,541.48	15,181	1,643	1,401	$24.14	$261.63	$2,046,588	92,642	$22.09	7,800	$262.38
May	$364,246.04	15,657	1,627	1,360	$23.26	$267.83	$2,410,834	108,299	$22.26	9,160	$263.19
June	$318,706.00	16,093	1,410	1,211	$19.80	$263.18	$2,729,540	124,392	$21.94	10,371	$263.19
July	$310,213.03	16,433	1,382	1,177	$18.88	$263.56	$3,039,753	140,825	$21.59	11,548	$263.23
August	$269,701.82	16,810	1,206	1,056	$16.04	$255.40	$3,309,455	157,635	$20.99	12,604	$262.57
September	$288,484.13	17,060	1,281	1,116	$16.91	$258.50	$3,597,939	174,695	$20.60	13,720	$262.24
Total	**$3,597,939.04**		**16,098**	**13,720**							

Service Utilization by and Cost of Providing Care to Childless Adult Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$836,331.59	22,901	3,958	3,194	$36.52	$261.84	$836,332	22,901	$36.52	3,194	$261.84
November	$874,881.64	24,970	4,128	3,309	$35.04	$264.39	$1,711,213	47,871	$35.75	6,503	$263.14
December	$888,897.02	26,885	4,293	3,454	$33.06	$257.35	$2,600,110	74,756	$34.78	9,957	$261.13
January	$1,065,204.58	28,518	5,165	4,123	$37.35	$258.36	$3,665,315	103,274	$35.49	14,080	$260.32
February	$1,033,955.55	30,263	5,015	4,017	$34.17	$257.39	$4,699,270	133,537	$35.19	18,097	$259.67
March	$1,224,053.58	31,973	5,828	4,599	$38.28	$266.16	$5,923,324	165,510	$35.79	22,696	$260.99
April	$1,169,222.86	33,346	5,597	4,445	$35.06	$263.04	$7,092,547	198,856	$35.67	27,141	$261.32
May	$1,367,222.07	34,769	6,485	5,150	$39.32	$265.48	$8,459,769	233,625	$36.21	32,291	$261.99
June	$1,128,523.38	36,012	5,305	4,250	$31.34	$265.53	$9,588,292	269,637	$35.56	36,541	$262.40
July	$1,149,503.02	37,312	5,393	4,405	$30.81	$260.95	$10,737,795	306,949	$34.98	40,946	$262.24
August	$966,240.54	38,239	4,573	3,821	$25.27	$252.88	$11,704,036	345,188	$33.91	44,767	$261.44
Sept	$1,010,476.74	39,132	4,732	3,981	$25.82	$253.82	$12,714,513	384,320	$33.08	48,748	$260.82
Total	**$12,714,512.57**		**60,472**	**48,748**							

DATA AND FINDINGS OF HEALTH STATUS OF THE POPULATION SERVED

Findings on health status of the population served by the GNOCHC Demonstration are not available at this time, as such an undertaking requires substantial coordination with a third-party contracted to track Healthcare Effectiveness Data and Information Set (HEDIS) measures for the State and/or the amendment of existing contracts. Demonstration encounter data analysis is ongoing, and DHH will report its progress on health status findings in future reports to CMS.

PROGRAM OPERATIONS

FINALIZATION OF KEY ELEMENTS OF DEMONSTRATION STCS

During Demonstration Year 1, DHH substantially completed program start up, paving the way for routine program operations in Demonstration Year 2. Completion of the *remaining* program start-up activities required CMS approval of key elements of the Demonstration terms and conditions central to program operations. These elements include:

- STC Attachment B – Evaluation Design;
- STC Attachment D – Administrative Cost Claiming Protocol;
- STC Attachment E – Accounting and Audit Protocol; and
- An Evolution Plan to preserve health care access restored by PCASG and to facilitate financial sustainability through diverse means of financing beginning January 1, 2012.

Below is a summary of the State's progress toward CMS approval of these attachments during Demonstration Year 2.

EVALUATION DESIGN

On April 1, 2011, DHH submitted to CMS a first draft of the evaluation design. It prioritized funding protocol negotiations and deferred attention to the evaluation design pending CMS approval of the funding protocol. Upon approval of the funding protocol on June 27, 2011, the State resumed active pursuit of CMS approval of the evaluation design. Negotiations continued through the Demonstration year's end; CMS approved the evaluation design on December 7, 2011.

ADMINISTRATIVE COST CLAIMING PROTOCOL

On February 11, 2011, DHH submitted to CMS a first draft of the administrative cost claiming protocol. It prioritized funding protocol negotiations and deferred attention to the administrative cost claiming pending CMS approval of the funding protocol. Upon approval of the funding protocol on June 27, 2011, the State resumed active pursuit of CMS approval of the administrative cost claiming protocol. Negotiations continued through the Demonstration year's end; after lengthy negotiations, the November 16, 2011 revision of the administrative cost claiming protocol was approved by CMS on January 10, 2012.

Due to the timing of the protocol's approval, no administrative costs for Demonstration Year 1 were claimed during that period; all Demonstration Year 1 administrative costs, totaling $548,567.97, have been claimed retrospectively as prior period adjustments. Administrative costs for Demonstration Year 2, totaling $334,879.91, have been reported in the quarterly CMS-64 reports throughout DY2.

Accounting and Audit Protocol

On March 1, 2011, DHH submitted to CMS a first draft of the accounting and audit protocol to CMS. It prioritized funding protocol negotiations and deferred attention to the accounting and audit protocol pending CMS approval of the funding protocol. Upon approval of the funding protocol on June 27, 2011, the State resumed active pursuit of CMS approval of the accounting and audit protocol. Final revisions were submitted to CMS on February 1, 2012 and were approved by CMS on August 9, 2012.

Evolution plan / Inter-Pregnancy Care Coordination (IPC)

On June 29, 2011, DHH submitted to CMS a plan to evolve primary and behavioral health care access restored by PCASG and preserved by the Demonstration and to facilitate financial sustainability through diverse means of financing, including but not limited to Medicaid, CHIP, and other payer sources as the revenue base. It actively pursued approval of the plan through the end of Demonstration Year 1; however, many proposals included in the original evolution plan were reconsidered or withdrawn by DHH during the course of these negotiations, given both program operations during DY1 and changes to the State's broader health care reform initiatives.

In the second quarter of DY2, it was agreed by both CMS and the State that the state's inter-pregnancy care (IPC) coordination proposal would, upon its approval, substitute for the evolution plan, as it was the only remaining component of the original plan.

CMS approved the IPC proposal/Evolution Plan on June 22, 2012 and implementation of the IPC service began on July 1, 2012. Through the IPC component of the Demonstration, the State aims to reduce the incidence of subsequent adverse pregnancy outcomes among women who have previously had a low or very low birth weight baby, preterm birth, fetal death, or infant death. Evaluation of the IPC component of the Demonstration will assess the extent to which the intervention succeeds in meeting its objectives. The evaluation will provide valuable data on the efficiency and effectiveness of the model. If successful, this evidence base will provide further support for a social case management approach as a viable, scalable life course intervention to improve pregnancy outcomes not only in the New Orleans region but throughout Louisiana and the nation.

Amendment Process

In the second quarter of Demonstration Year 2 (DY2), the State began active discussions with the policy advisors for the City of New Orleans Health Department as well as with other GNOCHC providers regarding a proposed change to the approved payment methodology. Providers stated that they had serious concerns, based on the payment issues they experienced during Demonstration Year 1 (DY1) and expectations of higher volume of GNOCHC enrollment and

utilization in DY2, regarding the availability of steady cash-flows and their ability to provide medical services at current or expanded levels if payment/reimbursement trends remained unchanged.

The most significant issue driving these discussions was the result of DY1 reconciliation completed on March 14, 2012, by which it became evident that providers earned only a fraction of the allowable funding throughout the year. Providers were awarded $21M of the $30M available for DY1 via a supplemental payment to their approved encounter claims after the Demonstration Year had already ended. If this trend were to continue, some providers stated that they would necessarily have to cut back on service availability or, in some extreme cases, consider closing their operations. Neither of these potential outcomes would promote the goals of the waiver program.

To address a variety of concerns, a multi-faceted approach was utilized, building upon the approved payment methodology in place. The goal of this approach was to allow providers additional billable activities by which to receive financial support throughout the year to promote revenue stability, service capacity, and prevent another payment windfall at the end of Demonstration Year 2.

On June 7, 2012, the State and the GNOCHC providers submitted a joint proposal to CMS that included:

- Shared Services – Funding would be awarded, in a manner similar to Infrastructure Investments awards, for activities and services from which all participating providers would benefit, such as a city-wide enrollment outreach initiative, shared training programs, and a computerized referral system to enhance specialty care utilization.

- Core Payments – These payments would be made to each provider based on two components: 1) population serviced; and 2) expected quality of care. The population component was proposed due to the lack of a State-instituted primary care provider linkage for those enrolled in the waiver. The quality component would financially support those participating providers who are still working towards achieving NCQA Primary Care Medical Home (PCMH) recognition, as well as providing lump sum assistance to those already recognized by NCQA; funding would be based solely on existing PCMH recognition as opposed to the current method, which is based on a count of approved claims in the previous quarter.

- Modification of Infrastructure Investment Guidelines – By expanding the definition of Infrastructure Investments, other operational needs such as professional services (MD and RN salary) could be funded to further the activities required to meet the goals of a PCMH.

Negotiations between CMS, the State, and GNOCHC providers continued throughout the third and fourth quarters of Demonstration Year 1, and at the end of the year, these negotiations were concluding. During final negotiations, CMS advised that the requested Core Payments could not be considered. Also during these final negotiations, DHH made the decision to rescind seeking approval to add primary care CPT codes 99201 and 98967, as these CPT codes designate a brief interaction between a patient and a healthcare provider and are therefore not suitable to the

comprehensive care that the GNOCHC program intends to deliver. In addition, the primary care encounter rate did not take these types of claims into consideration and would necessarily result in the reduction of the flat rate paid to participating providers in order to maintain budget neutrality.

CMS finally approved the payment methodology amendment on October 26, 2012, after the conclusion of Demonstration Year 2.

Patient Centered Medical Home Linkages

Initially, GNOCHC Patient Centered Medical Home (PCMH) linkages were planned to go live in January 2012, concurrent with linkages for recipients of the Medicaid Coordinated Care Network (also known as BayouHealth) residing in the Greater New Orleans area. Subsequently, in the first quarter of DY2, as planning efforts intensified program staff and contractors recognized risks to both programs posed by concurrent implementation as initially planned, the decision was made to defer BayouHealth linkages to February 2012 and GNOCHC linkages to May 2012.

In the second quarter of Demonstration Year 2, the State indefinitely deferred planning for the implementation of PCMH linkages for GNOCHC recipients. The decision was based on a cost-benefit analysis considering multiple factors, including estimates of the population eligible for Demonstration coverage; the rate and timeline of enrollment growth under the Demonstration; the cost of encounter rate payments for enrollees; and, payments for contracted enrollment broker (linkage) services.

The decision reflects the State's prioritization of coverage for eligible individuals and payments for eligible providers over professional services contracts. Additionally, it reflects the State's recognition that PCMH linkage implementation as it relates to provider payments would likely require changes to the funding protocol, and that the timeline for CMS approval and subsequent State operationalization would likely make the linkages and payment changes effective sufficiently late in the Demonstration term that they would be more disruptive than beneficial.

Behavioral Health Benefits Coordination

During Demonstration Year 1, the State began to coordinate with the Office of Behavioral Health and MEDS and MMIS staff toward implementation of a new Medicaid 1915i behavioral health benefit known as the Louisiana Behavioral Health Partnership (LBHP).

This coordination was necessary as it was expected that nearly all GNOCHC enrollees who meet clinical criteria for basic behavioral health care or serious mental illness behavioral health care services under the Demonstration would become "otherwise Medicaid eligible" for the Medicaid 1915i benefit. That is, clinical eligibility criteria for the Medicaid 1915i benefit – diagnosed with a major mental disorder or meeting the federal definition of serious mental illness – is identical to those for the GNOCHC basic behavioral health care or serious mental illness behavioral health care services. Furthermore, income eligibility criteria for the Medicaid 1915i benefit is 150% FPL, and 86% of all GNOCHC enrollees have income up to 133% FPL.

While LBHP implementation began as scheduled on March 1, 2012 for Medicaid-eligible individuals under the approved 1915i, coordination of GNOCHC benefits and LBHP benefits has not been accomplished as desired. GNOCHC enrollees remain outside of the service benefit package of the LBHP at this time; however, further discussions regarding the transition of current enrollees to the LBHP and BayouHealth will occur in Demonstration Year 3 as the State, in preparation for the waiver's termination at the end of 2013, continues the development and modification of its ACA Transition Plan, as required under STC V.37.

FINANCIAL

CMS 64 REPORTING

As noted in the Demonstration Year 1 report, two noteworthy administrative difficulties in the initial submission of the CMS-64 quarterly reports were the classification of enrolled eligible individuals by Medicaid Eligibility Group (MEG) and the classification of enrolled eligible providers by Type of Service. Both of these issues were resolved in DY1 and CMS-64 reporting in Demonstration Year 2 was submitted quarterly as required. Additionally, the delay in approval of the Administrative Cost Claiming Protocol until the second quarter of DY2 resulted in the retrospective submission of administrative costs by prior period adjustment; subsequent quarterly CMS-64 reports included administrative costs as required by the approved Administrative Cost Claiming Protocol.

CONSUMER ISSUES

Not unexpectedly, the number and severity of issues identified by consumers in Demonstration Year 2 was greatly reduced from those encountered during initial program implementation in Demonstration Year 1. Of note are the two issues outlined below.

ENROLLMENT OF ELIGIBLE INDIVIDUALS

In the first quarter of Demonstration Year 2, the State notified CMS in writing that it would institute an enrollment limit in order to remain under the budget neutrality limit approved by CMS for the Demonstration. Enrollment was frozen effective December 28, 2011 at 38,364. Mechanisms were established to generate a reservation list and notify applicants of their placement on the list on a monthly batch cycle, with the first notices planned for early February.

However, a January analysis of Demonstration Year 1 and Demonstration Year 2 claims data and expenditure projections developed on the basis of enrollment growth, service utilization, and provider payment patterns to date indicated that the State could afford to resume enrollment within the Demonstration expenditure limit.

As such, effective January 12, 2012, the State lifted the enrollment cap and resumed determining eligibility for and enrolling eligible individuals into the GNOCHC program as before.

The State automatically reconsidered for GNOCHC eligibility any applications received while the cap was in effect (12/28/11 – 1/11/12), with no action required on the part of the applicant.

Furthermore, the State enrolled eligible individuals based on application date rather than processing date, so no coverage time was lost due to the cap having been in effect.

COVERED SERVICES

As outlined in section IV.17. of the STCs and the GNOCHC Provider Manual, all participating GNOCHC providers are required to provide access to specialty physician, laboratory, and radiology services, either directly or by referral, to all enrolled recipients seeking such services. In order to track the ***actual*** costs incurred by providers for the provision of these specialty care services, which are not directly reimbursed but were included in the computation of the bundled encounter rate, the State submitted draft instructions for the reporting of specialty care services to both providers and CMS in late January 2012. On July 20, 2012 after months of consultation with and technical assistance from CMS, the State disseminated its final Specialty Care reporting instructions to providers. Due to the delays in establishing this reporting protocol, providers were asked to report specialty care expenditures for dates of service beginning on October 1, 2011 or later.

Given that some providers have remarked on a believed disparity between actual costs and the reimbursements received for specialty, the forthcoming analysis of this data is eagerly anticipated.

PROVIDER SUSTAINABILITY

As required by the STCs, all participating GNOCHC providers are required to submit semi-annual Sustainability Progress reports, describing their organization's strategic plan to become a self-sustaining organizational entity, capable of permanently providing primary care or behavioral health care services to residents in the Greater New Orleans region, by the Demonstration's end on December 31, 2013. Providers were challenged to carefully evaluate their current GNOCHC utilization, and, based on a data-driven analysis of expenditures, future utilization, and estimated revenue projections through 2013, to develop realistic strategies for future financial sustainability and to provide a clear vision of an organization moving decisively toward self-sufficiency at the Demonstration's close.

While all providers minimally met the requirement for submission of the Sustainability Progress reports, the quality of the reports received by the State has varied greatly, as individual data collections and reporting systems are at differing levels of completion and maturity within our provider group. Larger providers who are affiliated with regional and/or national health care network were more likely to have the resources to conduct financial feasibility studies and provided more thorough statistical reports and more reliable estimates of future utilization than those organizations whose fiscal infrastructure is less robust. Additionally, the larger provider organizations reported more diverse revenues sources – a higher mix of private payors, significantly larger grant awards, and the utilization of endowments/foundation funding – than smaller providers who rely more heavily on GNOCHC, Medicaid, and Medicare payments in addition to small grants and donations secured through both public and private sources.

In brief, findings from the Sustainability Progress Reports show:

- All providers expressed concerns regarding the uncertainty of future revenue sources to support the patient population currently served through GNOCHC funding, as they had anticipated that this previously uninsured population would transition to the Medicaid expansion population in 2014, as outlined in the Affordable Care Act (ACA); most had expected improved financial stability and viability as a result of the expansion and so urged reconsideration of the State's decision or the exploration of alternative funding strategies.
- Providers are also concerned about the impact of state budget cuts to the regular Medicaid population, as Medicaid revenues are critical to the long-term viability of all GNOCHC providers. In addition to the adverse effects budget cuts could have upon cash flows, some providers also noted concern about the potential for increased utilization at community clinics if MCLNO/Interim LSU Public Hospital, the safety-net hospital for residents of the greater New Orleans area, is forced to reduce hours or access to their outpatient clinics.
- Provider organizations are focusing on income diversification in preparation for termination of the waiver in 2014, but with few exceptions, most still rely very heavily on Medicaid, given the population they serve. As noted above, Medicaid reimbursements are likely to decrease in the future as the State continues to experience economic insecurity.
- Several providers in Orleans and Jefferson parishes – Common Ground, Daughters of Charity, EXCELth, MCLNO, MQVN, Community Development, New Orleans' Musicians Assistance Foundation, St. Thomas, and Tulane – reported ongoing or planned participation in affiliation agreements and other types of partnerships with their fellow GNOCHC providers to expand service offerings, increase patient access to needed health care services, and improve future sustainability.
- 6 provider organizations (33.3%) report that GNOCHC is <30% of their total revenues; 10 provider organizations (55.6%) report that GNOCHC is =>30% of their total revenues; and 4 provider organizations (22.2%) report that GNOCHC is =>50% of their total revenues.
- 3 provider organizations (16.7%) report that GNOCHC and Medicaid are <30% of their total revenues; 13 provider organizations (72.2%) report that GNOCHC and Medicaid are =>30% of their total revenues; and 6 provider organizations (33.3%) report that GNOCHC and Medicaid are >50% of their total revenues.
- 6 provider organizations (33.3%) are FQHCs and receive HRSA funding. 2 provider organizations are FQHC Look-Alikes; 1 provider organizations is seeking full-FQHC status.

EVALUATION DESIGN

As noted earlier in this report, the draft Evaluation Design was submitted to CMS for approval in April, 2011, and final approval was received in December, 2011. Following approval of the design, the State worked to develop and refine reports to gather needed data from MMIS. In the final quarter of DY2, the State finalized its internal MMIS data reports and, also utilizing data reported by

providers in their semi-annual Sustainability Progress Reports, aggregated and reviewed evaluation data for DY2.

Unfortunately, there were significant reporting gaps from some providers, whether due to claims processing lag or issues with their individual data collection and reporting systems, and preliminary analysis of the self-reported measures, particularly as related to age-based utilization figures, clearly indicated that revision/resubmission of some data would be required. Given the State's need to prioritize the DY2 reconciliation and supplemental payment, however, the data remains incomplete at this time. The State will work with providers to improve their reporting and ensure the accuracy and reliability of the data submitted.

Briefly, analysis of the available data indicates:

- The Demonstration has been successful in preserving access to primary and behavioral care, as the percentage of eligible, participating providers who participated in the Primary Care Access Stabilization Grant (PCASG) and who continue to participate in GNOCHC has remained at over 80% (18 organizations) throughout the year. By year's end, the number of enrolled sites increased from 62.9% to 66.1% – indicative of the growth from 39 sites in quarter one to 41 sites in quarter 4.
- The rate of GNOCHC enrollees who accessed primary care services in DY2 ranged from a high of 12.1% in quarter two to a low of 9.0% in quarter four. For behavioral health care services, the rate of access also peaked in quarter two at 2.5% and dipped to its low rate, 0.9%, in quarter four.
- The percentage of participating provider sites with NCQA decreased from 61.5% at the beginning of DY2 to only 28.6% at year's end. This was due to the expiration of certifications for 17 sites early in 2012; by September 30, 2012, five sites had regained their recognition and renewal applications were pending for 10 sites.
- 2,658 recipients had both a primary care and behavioral health encounter in Demonstration Year, at an average of 222 recipients per month or 0.5% of all enrollees. Of those recipients, an average of 13.4% received those services on the same date of service.
- As previously noted, enrollment is heavily skewed toward the lower income eligibility group, with 86% of GNOCHC enrollees earning less than 133% FPL.
- Evaluation measures that track utilization of behavioral health services by enrollee sub-population indicate that the average payment for behavioral health care for childless enrollees is $160 per month, which is 13.5% higher than payment for enrollees with a child in the home, which average $141 per month. Also, the average payment per month for enrollees with incomes of 133% FPL or less was $158 per month, which is 18.8% higher than the average of $133 per month for enrollees earning 134-200% FPL.

EVALUATION DATA as of September 30, 2012

	FFY12 Q1		FFY12 Q2		FFY12 Q3		FFY12 Q4	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
GOAL 1: *Preserve Primary and Behavioral Health Care Access*								
1.1 Number and Percentage of Eligible Provider Organizations Enrolled	19	86.4% as of Dec. 31, 2011	18	81.8% as of Dec. 31, 2011	18	81.8% as of June 30, 2012	18	81.8% as of Sept. 30, 2012
1.2 Number and Percentage of Eligible Provider Sites Enrolled	39	62.9% as of Dec. 31, 2011	39	62.9% as of Dec. 31, 2011	41	66.1% as of June 30, 2012	41	66.1% as of Sept. 30, 2012
1.3 Rate of Primary Care Access		11.2% Avg rate per month		12.1% Avg rate per month		11.7% Avg rate per month		9.0% Avg rate per month
1.4 Rate of Behavioral Health Care Access		2.2% Avg rate per month		2.5% Avg rate per month		1.6% Avg rate per month		0.9% Avg rate per month
Goal 1 Notes: 22 provider organizations participated in the Primary Care Access Stabilization Grant (PCASG), with 62 service locations throughout the New Orleans metro area. Performance measures 1.1 and 1.2 compare participation in PCASG and GNOCH								
GOAL 2: *Sustain and Advance Medical Home Model*								
2.1 Attain NCQA PCMH Recognition								
2.1.1 Number and Percentage of Enrolled Provider Sites Applying for NCQA PCMH Recognition	N/A	N/A as of Dec. 31, 2011	7	17.9% as of Mar. 31, 2012	N/A	N/A as of June 30, 2012	10	24.4% as of Sept. 30, 2012
2.1.2 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Recognition (Levels 1, 2, and 3)	24	61.5% as of Dec. 31, 2011	7	17.9% as of Mar. 31, 2012	10	24.4% as of June 30, 2012	12	29.3% as of Sept. 30, 2012
2.1.3 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 1 Recognition	12	30.8% as of Dec. 31, 2011	4	10.3% as of Mar. 31, 2012	4	9.8% as of June 30, 2012	4	9.8% as of Sept. 30, 2012
2.1.4 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 2 Recognition	1	2.6% as of Dec. 31, 2011	1	2.6% as of Mar. 31, 2012	2	4.9% as of June 30, 2012	2	4.9% as of Sept. 30, 2012
2.1.5 Number and Percentage of Enrolled Provider Sites with NCQA PCMH Level 3 Recognition	11	28.2% as of Dec. 31, 2011	2	5.1% as of Mar. 31, 2012	4	9.8% as of June 30, 2012	6	14.6% as of Sept. 30, 2012
~~2.2 Provide Enrollees with a Medical Home~~								
~~2.2.1 Number/Percentage of Enrollees Linked to Patient Centered Medical Home (PCMH) effective July 2012~~	N/A - No PCMH Linkages in GNOCHC		N/A - No PCMH Linkages in GNOCHC		N/A - No PCMH Linkages in GNOCHC		N/A - No PCMH Linkages in GNOCHC	
~~2.2.2 Number/Percentage of Primary Care Encounter Claims Submitted by Enrolled Providers and Denied for No PCMH L~~	N/A - No PCMH Linkages in GNOCHC		N/A - No PCMH Linkages in GNOCHC		N/A - No PCMH Linkages in GNOCHC		N/A - No PCMH Linkages in GNOCHC	
2.3 Provide Care Coordination Services								
2.3 Number and Percentage of Primary Care Encounter Claims with Care Coordination Services Billed	0	0.0%	0	0.0%	0	0.0%	0	0.0%
2.4 Integrate Primary and Behavioral Health Care Services								
2.4.1 Number and Percentage of Enrollees with Both Primary Care and Behavioral Health Encounters	652	0.6%	872	0.7%	720	0.5%	414	0.3%
2.4.2 Number and Percentage of Enrollees with Both Primary Care & Behavioral Health Encounters on the Same Date of Service	62	9.4%	96	11.0%	110	15.5%	72	17.6%
GOAL 3: *Evolve Grant-Funded Model to Financial Sustainability Through Diverse Means of Financing*								
3.1 Number and Percentage of Enrolled Provider Sites Certified as Medicaid Application Center	37	94.9%	37	94.9%	39	95.1%	39	95.1%
3.2 Number and Percentage of Patients Enrolled in the Demonstration	6,049	21.7%	6,790	23.2%	4,631	26.3%	4,193	25.9% Q3, Q4 incomplete from some providers.
3.3 Number and Percentage of Uninsured, Non-Elderly Adult Patients	1,376	26.4%	1,278	22.1%	580	16.4%	484	16.1% Q3, Q4 incomplete from some providers.
3.4 Amount and Percentage of Paid Claims for Services Provided to Enrollees	$1,089,833.58	48.0%	$1,347,086.24	56.6%	$484,265.40	35.4%	$476,512.85	28.6% Data incomplete from some providers.
Goal 3 Notes: This information is self-reported by providers in their semi-annual Sustainability Progress Reports. Performance measures 3.2, 3.3, and 3.4 provide information on GNOCHC enrollees as compared to the total population served by GNOCHC providers. Data for Q3 and Q4 are incomplete for some provide due to claims processing lag.								
GOAL 4: *Increase Access to Health Care Coverage*								
4.1 Increase Access to Health Care Coverage to Populations Eligible for the Demonstration								
4.1.1 Total Enrollment	38,413	as of Dec. 31, 2011	44,298	as of Mar. 31, 2012	49,712	as of June 30, 2012	53,565	as of Sept. 30, 2012
4.1.2 Number and Percentage of Enrollment in MEG 1 (0-133% FPL)	33,142	86.3% as of Dec. 31, 2011	37,957	85.7% as of Mar. 31, 2012	42,348	85.2% as of June 30, 2012	45,943	85.8% as of Sept. 30, 2012
4.1.3 Number and Percentage of Enrollment in MEG 2 (134-200% FPL)	5,271	13.7% as of Dec. 31, 2011	6,341	14.3% as of Mar. 31, 2012	7,364	14.8% as of June 30, 2012	7,622	14.2% as of Sept. 30, 2012
4.2 Reduce rate of Uninsured Children								
4.2.1 Number and Percentage of Uninsured Patients Under Age 19	169	2.4%	113	0.9%	115	0.8%	155	1.1% Data incomplete for most providers.
4.2.2 Number and Percentage of Patients under Age 19 Enrolled in Medicaid or CHIP	1047	14.8%	1045	8.7%	1146	8.2%	1131	8.2% Data incomplete for most providers.
Goal 4 Notes: Data for performance measures 4.2.1 and 4.2.2 are self-reported by providers in their semi-annual Sustainability Progess Reports. Reporting was incomplete for most providers, as many cannot readily track age-related information in their internal databases								
GOAL 5: *Assess Behavioral Health Care Needs of Enrollee Sub-Populations*								
5.1 Assess Service Utilization and Cost by Parent Population								
5.1.1 Average Number of Behavioral Health Care Encounters Per Enrollee with a Child in the Home	1.5	Avg per recipient per month in Q1	1.2	Avg per recipient per month in Q2	1.3	Avg per recipient per month in Q3	1.3	Avg per recipient per month in Q4
5.1.2 Average Payment for Behavioral Health Care Per Enrollee with a Child in the Home	$159.38	Avg per recipient per month in Q1	$127.81	Avg per recipient per month in Q2	$138.93	Avg per recipient per month in Q3	$136.82	Avg per recipient per month in Q4
5.2 Assess Service Utilization and Cost by Childless Population								
5.2.1 Average Number of Behavioral Health Care Encounters Per Enrollee without a Child in the Home	1.6	Avg per recipient per month in Q1	1.5	Avg per recipient per month in Q2	1.6	Avg per recipient per month in Q3	1.5	Avg per recipient per month in Q4
5.2.2 Average Payment for Behavioral Health Care Per Enrollee without a Child in the Home	$163.02	Avg per recipient per month in Q1	$160.28	Avg per recipient per month in Q2	$164.88	Avg per recipient per month in Q3	$152.65	Avg per recipient per month in Q4
5.3 Assess Service Utilization and Cost by Medicaid Expansion Population								
5.3.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	1.5	Avg per recipient per month in Q1	1.5	Avg per recipient per month in Q2	1.6	Avg per recipient per month in Q3	1.5	Avg per recipient per month in Q4
5.3.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 0-133% FPL	$160.36	Avg per recipient per month in Q1	$158.21	Avg per recipient per month in Q2	$163.92	Avg per recipient per month in Q3	$152.84	Avg per recipient per month in Q4
5.4 Assess Service Utilization and Cost by Exchange Population								
5.4.1 Average Number of Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	1.3	Avg per recipient per month in Q1	1.3	Avg per recipient per month in Q2	1.3	Avg per recipient per month in Q3	1.2	Avg per recipient per month in Q4
5.4.2 Average Payment for Behavioral Health Care Encounters Per Enrollee with Income 134-200% FPL	$134.85	Avg per recipient per month in Q1	$134.30	Avg per recipient per month in Q2	$136.18	Avg per recipient per month in Q3	$129.04	Avg per recipient per month in Q4

CONCLUSION

During Demonstration Year 2, the State successfully met the schedule established in the STCs by CMS for deliverables during the period and continued to make significant process toward accomplishments its overall program goals. Most notably:

- For a second year, the State enrolled tens of thousands of eligible, low-income uninsured adults into basic health care coverage.
- GNOCHC staff finalized remaining STC protocol requirements, resulting in more clearly-defined reporting requirements and billing procedures, and moreover, the establishment and maintenance of routine program operations.
- Working throughout the Demonstration Year with providers, internal DHH partners, and Medicaid's fiscal intermediary, the State normalized payments through timely claims processing and amendment of the Funding & Reimbursement Protocol, promoting improved financial stability for GNOCHC providers and helping move them toward the goal of self-sustainability at the waiver's end in December 2013.

GNOCHC Annual Report

FFY13

State of Louisiana Greater New Orleans
Community Health Connection Demonstration
11-W-00252/6

Submitted to CMS
December 30, 2013

INTRODUCTION

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00252/6, Section 1115(a) Demonstration, 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 Greater New Orleans Community Health Connection (GNOCHC) Annual Report for Demonstration Year 3 (October 1, 2012 through September 30, 2013). Due to be submitted to CMS by November 30, 2013, but submitted on December 31, 2013 under an extension granted to the State, this document satisfies the requirements of STC V. 38 – Annual Report.

This draft documents accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration during Year 3. It also contains:

- Updates on the financial sustainability of the GNOCHC providers;
- Data and findings of health status of the population served under the Demonstration;
- The number of persons served and the allocation of funds per GNOCHC provider under the Demonstration;
- Data and findings of cost of providing care to persons served under the Demonstration;
- Updates on the State's success in meeting the milestones listed in section VIII; and
- The progress and outcome of any GNOCHC program receiving FFP.

BACKGROUND

Through the Greater New Orleans Community Health Connection program, Louisiana will:

- Preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with Primary Care Access and Stabilization Grant (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.
    - Phase 2 spans Demonstration months 16-51 (January 2012 – December 31, 2014) and focuses on Evolution plan implementation and assessment, successful transition to Medicaid and the State Health Benefits Exchange, and Demonstration phase-down. The period for Phase 2 continues for another calendar year because CMS approved a 12-month extension of the GNOCHC Demonstration Waiver on September 29, 2013.

YEAR IN REVIEW

During Demonstration Year 3, the State successfully met the schedule established in the STCs by CMS for the following deliverables during the period. The State:

- Actively participated in the monthly calls as described in V. 35.
- Submitted timely the quarterly reports as described in V. 36, including the budget neutrality reporting described in VI. 42.
- Provided quarterly expenditure reports (Form CMS-64) as described in VI. 40.
- Submitted quarterly encounter data to MSIS as described in IV. 26.
- Ensured providers submitted sustainability plans & progress reports as described in IV. 20.
- Ensured providers submitted quarterly infrastructure investment expenditure reports as described in Attachment C – Funding and Reimbursement Protocol.

In addition to the deliverables above, the State also:

- Secured approval from CMS of an amendment to the payment methodology allowing for reimbursement of shared services expenditures.
- Received approval from CMS of a 12-month extension for the GNOCHC Demonstration Waiver and changes to the program eligibility criteria and reimbursement methodology for 2014.
- Submitted to CMS a transition plan (per STC V. 37) for enrollees who will no longer be eligible for GNOCHC under the new eligibility guidelines as of January 1, 2014 into the Affordable Care Act Exchange or Medicaid.

ACCOMPLISHMENTS

In Demonstration Year 1, the State accomplished its Phase 1 goals by enrolling thousands of eligible, low-income, uninsured adults into basic health care coverage; transforming PCASG awardees into coverage model-driven health care providers with routine Medicaid enrollment and billing processes and encounter rate payments; and substantially completing program start up, paving the way for routine program operations in Demonstration Year 2.

In Demonstration Year 2, as it entered into Phase 2 of the waiver, the State continued to enroll thousands of eligible adults into the Waiver; finalized the remaining key elements of the terms and conditions of the Demonstration; and established and maintained routine operations to enable providers to move toward the goal of self-sustainability at the waiver's end in December 2013.

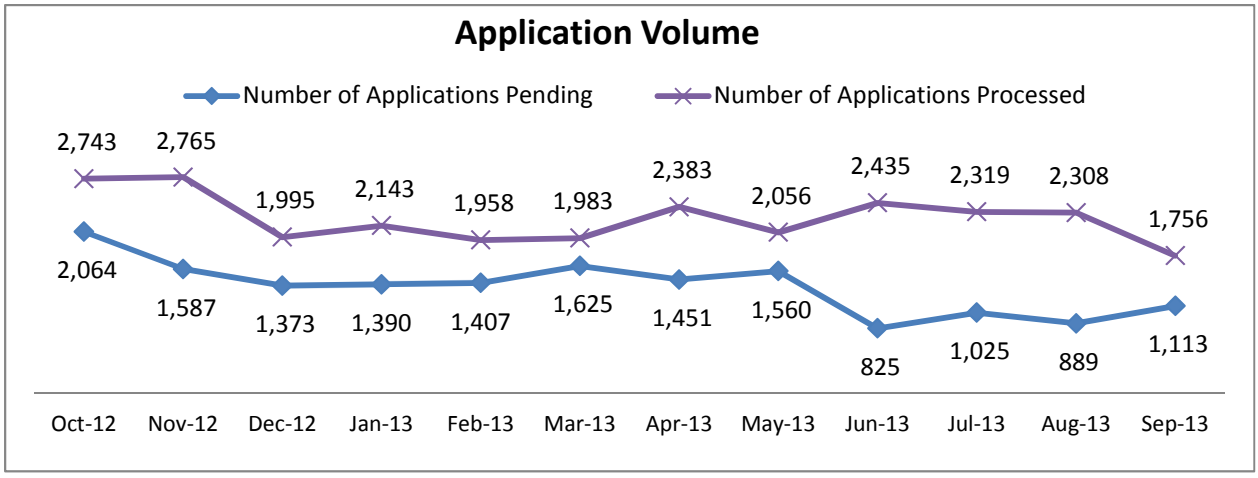
In DemonstrationYear3, the State continued routine operations, and as a result of the CMS-approved extension, the waiver will continue through December 31, 2014.

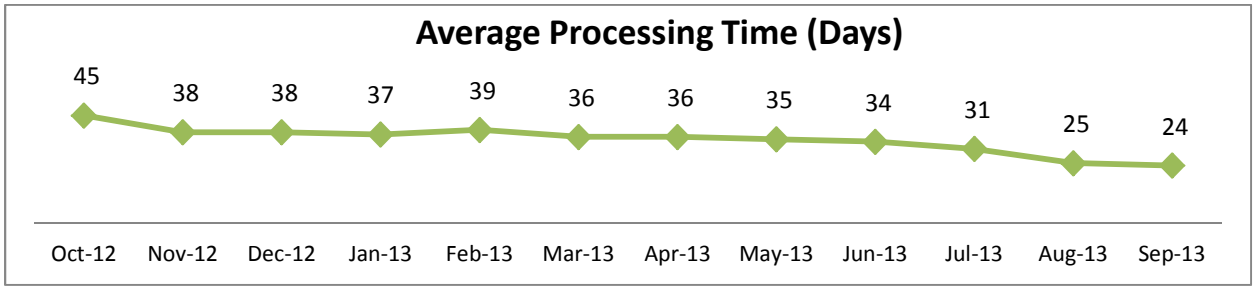
The following sections detail the State's accomplishments.

ENROLLMENT OF ELIGIBLE INDIVIDUALS

In the last quarter of Demonstration Year 2 (DY2), both application volume and application processing times shifted dramatically. In July, 2,827 applications were approved, slightly less than the average of 3,000+ applications per month as seen throughout the first three quarters of the year. However, in August, only 937 applications were approved, and in September, 2,200 were approved. Processing time also increased to an average of 18 days in July to 32 days in August and 42 days in September. This shift was due to two factors: staffing issues in the Region 1 (Orleans) Medicaid office, which typically approves 40-50% of GNOCHC applications, and the impact of Hurricane Isaac, which made landfall in southern Louisiana on August 28, 2012, resulting in statewide office closures and, for several weeks thereafter, reassignments of eligibility staff to support recovery efforts. Similar increases for application approvals and processing times were seen in all other Medicaid programs.

For the first month of Demonstration Year 3 (DY3), processing time continued to be high (45 days) as a result of the application backlog. There was a significant improvement for November (38 days), and processing time steadily decreased each month thereafter, except for the short month of February. At the end of DY3, processing time was down to an average of 24 days, similar to the rate seen in Demonstration Year 1. The average number of applications processed each month fluctuated over the year from a high of 2,765 in November 2012 to 1,756 in the last month of DY3. Overall, the average number of applications processed monthly is lower than in both DY1 and DY2, and conversely, the average number of applications pending remains higher than in previous Demonstration years.

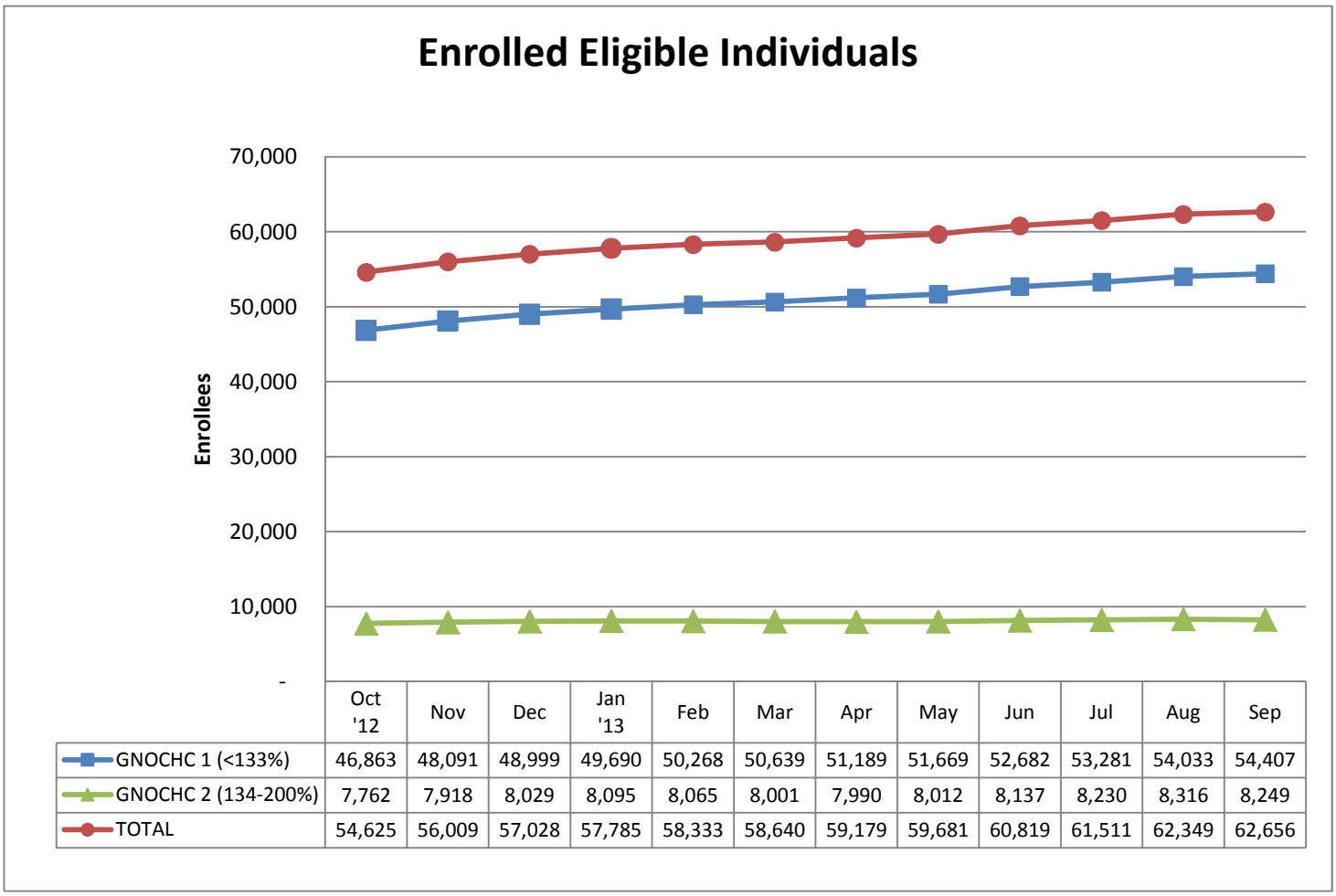




Enrollment at the beginning of Demonstration Year 3 was 54,625 and grew to 62,656 by the end of the year. Enrollment gains over the course of the year averaged 1.3% per month, with peaks of 2% growth in October and 2.5% growth in November, the same months of highest growth as in Demonstration Year 2.

As in Demonstration Year 1 and Year 2, enrollment continues to be biased heavily toward the low end of the income spectrum, with 87% of enrollees with income below 133% of the Federal Poverty Level (FPL).

It is important to note that about 75% of current GNOCHC enrollees have income below 100% of the FPL and will continue to be eligible for GNOCHC when the income standard is lowered to 100% effective January 1, 2014.



	Oct '12	Nov	Dec	Jan '13	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
GNOCHC 1 (<133%)	46,863	48,091	48,999	49,690	50,268	50,639	51,189	51,669	52,682	53,281	54,033	54,407
GNOCHC 2 (134-200%)	7,762	7,918	8,029	8,095	8,065	8,001	7,990	8,012	8,137	8,230	8,316	8,249
TOTAL	54,625	56,009	57,028	57,785	58,333	58,640	59,179	59,681	60,819	61,511	62,349	62,656

PROVIDER ENROLLMENT

At the beginning of Demonstration Year 3, there were 18 organizations with 41 service sites actively participating in the GNOCHC program.

Over the course of the year, only one type of change in provider enrollment occurred: a site ownership transfer.

SITE OWNERSHIP TRANSFERS

- In March 2013, Ruth U. Fertel/Tulane Community Health Center changed ownership from the Administrators of the Tulane Educational Fund to Access Health Louisiana.

At year's end, 18 organizations, including 41 service sites, remained active participants in the GNOCHC program.

GNOCHC Enrolled Providers

Organization	Service Site Name	Service Site Location
Administrators of the Tulane Educational Fund	Tulane Community Health On The Move	***Mobile site*** / 1430 Tulane Ave, New Orleans
	New Orleans Children's Health Project	***Mobile site*** / 1430 Tulane Ave, New Orleans
	Drop In Center	1428 N Rampart St, New Orleans
	Walter L. Cohen School Based Health Clinic	3520 Dryades St, New Orleans
	Adolescent Drop-In Clinic	611 N Rampart St, New Orleans
City of New Orleans Health Department	Health Care for the Homeless	2222 Simon Boliver Ave Fl 2, New Orleans
Common Ground Health Clinic	Common Ground Health Clinic	1400 Teche St, New Orleans
Daughters of Charity Services of New Orleans / Marillac Community Health Centers	Carrollton	3201 S Carrollton, New Orleans
	Metairie	111 N Causeway, Metairie
	St. Cecilia	1030 Lesseps St, New Orleans
	New Orleans East	5640 Read Blvd, Ste 550, New Orleans
EXCELth, Incorporated	Gentilly	2050 Caton St, New Orleans
	Algiers	4422 General Meyer Ave/Ste 103, New Orleans
Jefferson Community Health Care Centers	Avondale	4028 US Hwy 90, Avondale
	Marrero	1855 Ames Blvd, Marrero
	River Ridge	11312 Jefferson Hwy, River Ridge
Jefferson Parish Human Service Authority	West Jefferson	5001 Westbank Expy, Marrero
	East Jefferson	2400 Edenborn Ave, Metairie
Louisiana State University School of Medicine	LSU Healthcare Network Behavioral Health	3450 Chestnut St, New Orleans
Medical Center of Louisiana at New Orleans	Interim LSU Public Hospital – LB Landry Community Clinic	1200 L B Landry Ave, New Orleans
	Interim LSU Public Hospital – HIV OP Program	2235 Poydras St., New Orleans

GNOCHC Enrolled Providers

Organization	Service Site Name	Service Site Location
	Interim LSU Public Hospital – Medical Home Care	1400 Poydras St, New Orleans
	University Medical Office Building	2025 Gravier St, New Orleans
Metropolitan Human Services District	Algiers	4422 Gen Meyer Ave, Ste. 201, New Orleans
	St Bernard	7407 St Bernard Ave, Ste. A, Arabi
	New Orleans East	5552 Read Blvd, New Orleans
	Central City	2221 Philip St, New Orleans
	Chartres-Pontchartrain	719 Elysian Fields Ave, New Orleans
Mary Queen of Vietnam Community Development Corporation	NOELA	4626 Alcee Fortier Blvd, Ste. D, New Orleans
New Orleans Musicians Assistance Foundation	New Orleans Musicians Assistance Clinic	3700 St. Charles Ave, New Orleans
NO/AIDS Task Force	NO/AIDS Task Force	2601 Tulane Ave, New Orleans
Odyssey House Inc Louisiana	Odyssey House	1125 N Tonti St, New Orleans
Plaquemines Primary Care	Plaquemines Primary Care, Inc	26851 Hwy 23, Ste. A, Port Sulphur
Sisters of Mercy Ministries	Mercy Family Center	110 Veterans Memorial Blvd, Ste. 425, Metairie
St. Charles Community Health Center / Access Health Louisiana	St Bernard Community Health Center	7718 W Judge Perez Dr., Arabi
	St Charles Community Health Center	200 W Esplanade Ave., Kenner
	Belle Chasse Community Health	8200 Hwy 23, Belle Chasse
	Ruth U. Fertel Community Health Center	*711 N Broad St, New Orleans*
St Thomas Community Health Center	St Thomas Community Health Center	1020 St Andrew St., New Orleans
	St Thomas Community Health Center	2405 Jackson Ave., New Orleans
	St Thomas Community Health Center	1936 Magazine St., New Orleans

PROVIDER PAYMENTS

PAYMENT METHOD OVERVIEW

The Funding Protocol approved on June 28, 2011 provides for three reimbursement methodologies in Demonstration Year 3 (DY3): 1) targeted payments, 2) incentive payments, and 3) encounter rate payments.

Additionally, the payment methodology approved by CMS on October 26, 2013 allows for reimbursement of various Shared Services expenditures, such as media campaign expenses, translation services, and pharmaceutical assistance programs, as well as administrative costs for managing these shared services. It also allows for "incubator" payments for those clinics who have not obtained recognition from the National Center for Quality Assurance (NCQA) as a Patient-Centered Medical Home (PCMH).

Of these newly allowable DY3 costs, the Shared Services pharmaceutical assistance program and NCQA Incubator program are considered infrastructure costs, while the rest are considered administrative costs.

1) Targeted payments

The protocol provides for one type of targeted payment in DY3: infrastructure investment payments. There are three subcategories of infrastructure investment payments: infrastructure investment awards, Shared Services, and NCQA Incubator payments. The combined total of all infrastructure investment payments cannot exceed ten percent of total computable expenditures.

INFRASTRUCTURE INVESTMENT AWARD PAYMENTS support providers' delivery of services, billing for services, financial accountability, and encounter/quality reporting. Payments are based on award applications from participating providers and the State's assessment of the extent to which a provider's application meets designated criteria for targeted infrastructure investment. They do not cover costs for the acquisition, construction or renovation of bricks and mortar.

SHARED SERVICES PAYMENTS reimburse providers for purchase of services that are available to ***all*** GNOCHC providers to improve care for patient populations. Allowable Shared Services which are to be considered infrastructure investments include the Cenla Medication Access Program (CMAP), Surescripts, GNOHIE Analytics, Interfaces and EMR upgrades, and Specialty Care Services System.

NCQA INCUBATOR PAYMENTS are incentive payments made to sites which are on the path to attain NCQA PCMH recognition. Payments are made to a site as it achieves each established milestone in progress towards NCQA PCMH recognition.

2) Incentive payments

The protocol provides for quarterly *NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) PATIENT CENTERED MEDICAL HOME (PCMH) RECOGNITION INCENTIVE PAYMENTS*, not to exceed ten percent of total computable expenditures. The amount of a provider's quarterly 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 number of enrollee encounters for the prior quarter.

3) Encounter rate payments

The protocol defines encounter rates as payments made on a per visit/encounter basis to eligible providers for covered services received by enrolled eligible individuals from qualified practitioners. Three types of encounters are payable under GNOCHC: primary care, basic behavioral health care, and Serious Mental Illness (SMI) behavioral health care. Each encounter type has its own rate which is fixed for all providers. All encounter rates cover a bundle of services.

The *PRIMARY CARE ENCOUNTER RATE* covers 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 and radiology services that are routinely available in a primary care setting or through contracted services.

The *BASIC BEHAVIORAL HEALTH CARE ENCOUNTER RATE* covers 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). Basic 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 do not include primary care services. All providers are eligible for the basic behavioral health care encounter rate.

The *SMI BEHAVIORAL HEALTH CARE ENCOUNTER RATE* covers services provided to enrollees who meet the federal SMI definition, including those who also have a co-occurring addictive disorder. SMI behavioral health care services include mental health and/or substance abuse screening, assessment, counseling, medication management, follow-up and community support services. Only two providers are eligible for the SMI behavioral health care encounter rate. SMI payments may not exceed ten percent of total computable expenditures.

The protocol also provides for a year-end adjustment consisting of *SUPPLEMENTAL ENCOUNTER RATE PAYMENTS*. For each Demonstration Year, the State will subtract the sum of all payments made under the Demonstration for that year, including payments for State administrative costs and targeted payments, incentive payments and encounter rate payments for dates of service during the year, from the limit of total computable expenditures allowed under the Demonstration.

If the sum of all payments made is less than the limit of total computable expenditures allowed 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 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. To be considered in the year-end adjustment, encounter reports for dates of service during Demonstration year must be submitted not later than 45 days after the end of the Demonstration year as specified in the GNOCHC Provider Manual.

4) Inter-Pregnancy Care Coordination (IPC) Payments

The *INTER-PREGNANCY COORDINATION (IPC) SERVICE* provides care coordination/case management services for women who have previously had a low or very low birth weight baby, preterm birth, fetal death, or infant death in order to reduce the incidence of subsequent adverse pregnancy outcomes. IPC payments are made on a per unit (15 minute) basis and limited to 28 units per month per enrollee. The IPC unit rate is based on the independent rate model in use by Louisiana Medicaid for case management, support coordination, and targeted case management services.

EXPENDITURE TRACKING & RECONCILIATION

The Demonstration Year 3 (DY3) Expenditure Tracking & Reconciliation Workbook provides a complete accounting of all encounter rate payments, targeted payments, and incentive payments made to GNOCHC providers in DY3. It also contains calculations for each provider's year-end supplemental payment.

Calculations are organized by worksheet, as named and described below:

- ***Rates*** contains the calculation of the supplemental encounter rate.
- ***Site Summary*** contains all site-level reconciliation calculations and references the data worksheets.
- ***Organization Summary*** aggregates site-level reconciliation calculations to the organization level.

Supporting data are also organized by worksheet:

- ***Encounters*** contains site-level summary data for primary care, basic behavioral health care, and SMI behavioral health care encounter claims, including paid and denied counts and payments for encounter claims with DY3 dates of service submitted on Form CMS-1500 to the fiscal intermediary.
- ***NCQA*** contains site-specific data on the level and period of NCQA PCMH recognition.
- ***Infrastructure*** contains site-specific summary data on the amount of State-approved infrastructure investment expenditures reported by quarter and year.
- ***Administrative Costs*** identifies the total State administrative costs claimed for the year, including personnel and professional services contract costs.
- ***Rates*** contains the primary care, basic behavioral health care, and serious mental illness behavioral health care encounter rates; the NCQA PCMH Recognition Levels 1, 2, and 3 rates; and the supplemental encounter rate.

For purposes of communicating to each provider organization its individual reconciliation outcomes, the workbook includes a worksheet with a standard reporting format:

- ***Site-specific provider*** is a summary report template with a drop down menu listing the names of all participating provider sites; select a site name in the drop down menu and the worksheet automatically populates the template with summary data specific to the selected site, including encounter rate payments, NCQA PCMH incentive payments, infrastructure investment payments, supplemental payments, and total DY3 payment amounts.

Targeted Payments

In DY3, providers received a total of $1,299,392.60 in targeted payments for approved infrastructure investments, shared services, and NCQA Incubator milestone payments.

Infrastructure Investment Awards

Infrastructure investment awards are site-specific based on outcomes of the 2013 GNOCHC Infrastructure Investment Payments application cycle and DHH-approved expenditures reported by providers for DY3.

2013 Application Cycle

On January 18, 2013, DHH released to providers the Demonstration Year 3 Application for GNOCHC Infrastructure Investment Payments. Applications were due to DHH by May 31, 2013, and applicants were notified of DHH funding decisions by June 30, 2013.

Funding decisions were based on DHH's assessment of the extent to which the application targets select criteria for infrastructure investments:

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

Applications were assessed on both the extent to which they target infrastructure investment criteria and:

- Detail the work plan for the project and an achievable timeline
- Demonstrate provider capacity to manage the infrastructure project
- Demonstrate cost effectiveness of the investment (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 for health information technology (HIT))
- Provide detailed documentation and a reasonable basis for cost estimates included in the application (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

Through the 2013 GNOCHC Infrastructure Investment Payments application cycle:

- 13 applications were received from 9 provider organizations;
- All but one application were funded;
- 4 applications were fully funded
- A total of $943,388.85 in funding was awarded for the period October 1, 2012 through September 30, 2013.

DHH-Approved Infrastructure Investment Awards

Provider Organization	*Investment*	*Amount*
Administrators of the Tulane Educational Fund	Consultant fees; working with Access Health Louisiana Management on process improvements and billing support; NCQA Coordinator; staff training; HIT training	$91,129.46
Common Ground	Allscripts billing software and server installation; consultant fees; staff training; conferences; travel	$52,546.30
Interim LSU Hospital	SAS Visual Analytics Software and server to implement and promote analytical exploration of patient care outcomes	$55,689.16
Jefferson Community Health Care	Software and equipment for telemedicine consults and mobile service	$50,061.02
MQVN Community Development	Staff training and development; conference; travel	$62,162.00
New Orleans Musicians Assistance Foundation	Acquire, install, and train staff to operate practice management, billing, financial and data collection system; costs to gain NCQA PCMH recognition; contractors to create and distribute a Hispanic Patient Community Health Needs Assessment	$60,736.00
NO/AIDS Task Force	Add functionality to existing practice management and electronic health record system software; staff training; Datix Incident patient safety software	$219,904.91
Odyssey House	Technical support and the application process to gain Federally Qualified Health Center (FQHC) Look-Alike status, including staff training, consultants, and travel; Allscripts billing software, installation, and training; equipment	$191,160.00
St. Thomas Community Health Center	Additional electronic health record/practice management software licenses; staff training	$160,000
TOTAL		**$943,388.85**

Approved Expenditures Reported

For Demonstration Year 3, $943,388.85 in funding was awarded, but providers were reimbursed for $880,143.97 or 93% of the original award amount.

Infrastructure investment award payments made for DY3 are summarized below at the provider organization level.

For site-level detail, see the DY3 Expenditure Tracking & Reconciliation Workbook.

Infrastructure Investment Award Payments Per Provider

Provider Organization	*Payment Amount*
Administrators of the Tulane Educational Fund	$91,129.46
City of New Orleans Health Department	$0.00
Common Ground Health Clinic	$34,125.14
Daughters of Charity / Marillac CHC	$0.00
EXCELth, Incorporated	$0.00
Jefferson Community Health Care	$50,061.02
Jefferson Parish Human Service Authority	$0.00
Louisiana State University School of Medicine	$0.00
Medical Center of Louisiana at New Orleans	$55,689.16
Metropolitan Human Services District	$0.00
MQVN Community Development	$37,713.07
New Orleans Musicians Assistance Foundation	$60,736.00
NO/AIDS Task Force	$207,782.00
Odyssey House Inc. Louisiana	$182,908.12
Plaquemines Primary Care	$0.00
Sisters of Mercy Ministries	$0.00
St. Charles Community Health Center / Access Health Louisiana	$0.00
St. Thomas Community Health Center	$160,000.00
TOTAL	**$880,143.97**

Shared Services

The payment methodology amendment approved by CMS in October 2012 allowed for reimbursement for "shared" services that would be available to all GNOCHC providers to support enrollment efforts and improved care for patient populations. These newly allowable Shared Services expenses could be utilized for specific, pre-approved services including a media campaign, translation services, and eligibility software purchases, which along with a pool of funding for management of contracts for these shared services would be considered administrative expenses. Other approved Shared Services expenditures included pharmacy assistance and distribution services, data analytics and information exchange services, and specialty care scheduling and billing software; this second group of expenditures would be considered infrastructure investments.

After review and approval of supporting documentation, $172,940.17 in reimbursements were made in DY3 to Access Health Louisiana, the provider organization serving as the single administrative entity for all shared service contracts. Of the total amount, $49,248.63 was reported as infrastructure expenses and $123,691.54 was reported as administrative expenses, in accordance with the STCs.

Shared Services Expenditures

Organization	Description	Admin Expenses	Infrastructure Expenses	Total
Access Health Louisiana	Administration & Coordination	$63,128.20		$63,128.20
Access Health Louisiana	Media Campaign	$59,859.52		$59,859.52
Access Health Louisiana	Translation Services	$703.82		$703.82
Access Health Louisiana	Pharmacy Assistance Program		$49,248.63	$49,248.63
TOTAL		**$123,691.54**	**$49,248.63**	**$172,940.17**

NCQA Incubator

In DY3, NCQA Incubator payments totaling $370,000 were made to participating provider organizations who met various milestones in accordance with specified program deadlines.

Of the 10 sites initially identified for participation in the Incubator program, one site was deemed ineligible for PCMH recognition by NCQA because of its status as a school-based health clinic (Tulane - Walter Cohen), and another site did not participate after determining it could not meet the final deadline established for the program (Plaquemines Primary Care). A third site failed to respond to requests to participate in the program (AHL – Belle Chasse Community Health Center).

Seven sites, then, submitted signed attestation forms to participate in the program and provided documentation of the achievement of Milestone #1 – use of Electronic Medical Records – by the

January 2013 deadline. Of those seven sites, five sites subsequently reached Milestone #7, submission of a PCMH application, by September 30, 2013. Three of the five sites achieved Level 3 PCMH status (DCSNO – NOE, STCHC-Jackson Ave, and STCHC- Magazine St), one site achieved Level 2 status (MCLNO-UMOB), and as of the time of this report, one site (NOMAF) is awaiting results from NCQA.

Milestones achieved and payments made are as shown in the table below.

NCQA Incubator Milestones and Payments

Organization & Service Location	Milestone #1 EMR (due 1/1)	Milestone #2 Same-Day Appts (due 3/1)	Milestone #3 Patient Reminders (due 4/1)	Milestone #4 Written Plan of Care (due 6/1)	Milestone #5 Chronic Disease Mgmt (due 7/1)	Milestone #6 Data Sharing (due 8/1)	Milestone #7 NCQA Submit (due 9/1)	Milestone #8 NCQA Award (NLT 12/31)	Total
City of New Orleans Health Department	$5,000								$5,000
Daughters of Charity of New Orleans - New Orleans East	$5,000	$5,000	$5,000	$5,000	$10,000	$5,000	$10,000	$35,000	$80,000
Medical Center of Louisiana at New Orleans (MCLNO) – Univ. Medical Office Bldg	$5,000	$5,000	$5,000	$5,000	$10,000	$5,000	$10,000	$25,000	$70,000
New Orleans Musicians Assistance Foundation	$5,000	$5,000	$5,000	$5,000	$10,000	$5,000	$10,000	***Pending****	$45,000
Odyssey House	$5,000	$5,000							
St Thomas CHC – Jackson Ave	$5,000	$5,000	$5,000	$5,000	$10,000	$5,000	$10,000	$35,000	$80,000
St Thomas CHC - Magazine St.	$5,000	$5,000	$5,000	$5,000	$10,000	$5,000	$10,000	$35,000	$80,000
TOTAL	**$35,000**	**$30,000**	**$25,000**	**$25,000**	**$50,000**	**$25,000**	**$50,000**	**$135,000**	**$370,000**

*Note: For the purposes of calculating supplemental payments for all providers, the Reconciliation Workbook *includes* the maximum allowable Milestone #8 payment of $35,000 to NOMAF, even though recognition is still pending.

Incentive Payments

In Demonstration Year 3, providers earned a total of $1,516,044.29 in incentive payments for NCQA PCMH Recognition.

NCQA PCMH incentive payments are site- and quarter-specific. The table below notes the number of sites at each recognition level (1, 2 or 3), and it summarizes site-specific payments at the organization level.

For additional detail, see the DY3 Expenditure Tracking & Reconciliation Workbook.

Incentive Payments Per Provider

Provider Organization	*Recognition Level*	*Payment*
Administrators of the Tulane Educational Fund	3 sites, Level 1; 1 site Level 3	$55,594.37
Common Ground Health Clinic	1 site, Level 2	$94,924.67
Daughters of Charity Services of New Orleans /Marillac CHC	3 sites, Level 3	$371,043.33
EXCELth, Incorporated	1 site, Level 2; 1 site, Level 3	$143,593.68
Jefferson Community Health Care	3 sites, Level 1 for 1 quarter: Level 3 for 3 quarters	$294,101.88
Jefferson Parish Human Service Authority	N/A	-
Louisiana State University School of Medicine	N/A	-
Medical Center of Louisiana at New Orleans	N/A	-
Metropolitan Human Services District	N/A	-
MQVN Community Development	1 site, Level 1 for 1 quarter; Level 2 for 2 quarters, Level 3 for 3 quarters	$84,891.00
New Orleans Musicians Assistance Foundation	N/A	-
NO/AIDS Task Force	1 site, Level 3	$140,471.11
Odyssey House	N/A	-
Plaquemines Primary Care	N/A	-
Sisters of Mercy Ministries	N/A	-
St. Charles Community Health Center / Access Health Louisiana	1 site, for 3 quarters	$87,916.67
St. Thomas Community Health Center	3 sites, 1 site, Level 2; 2 sites, Level 3	$243,507.58
TOTAL		**$1,516,044.29**

Encounter Rate Payments

In Demonstration Year 3, providers were paid a total of $20,795,468.51for encounter claims.

Primary Care Encounters

Analysis of encounter data reported for DY3 show that primary care encounters drove both encounter volume and encounter rate payments for the period. Primary care encounters account for 85.1% of the total number of encounters approved for DY3 (82,382 of 96,753). Primary care encounter payments account for 92.8% of all encounter rate payments.

Behavioral Health Care Encounters

Behavioral health care encounters account for 14.9% of encounters approved for DY3, with 8.5% (8,266) being basic behavioral health care encounters and 6.3% (6,105) being Serious Mental Illness (SMI) behavioral health care encounters. Behavioral health care encounter payments account for 7.2% of all encounter rate payments, with 4% being basic behavioral health care encounter rate payments and 3.2% being SMI behavioral health care encounter rate payments.

The following table provides the number of primary and behavioral health care encounters approved for payment and the amount of primary and behavioral health care encounter rate payments per provider organization. For site-level detail, see the DY3 Expenditure Tracking & Reconciliation Workbook.

Primary Care and Behavioral Health Encounter Rate Payments Per Provider

Provider Organization	Number of Primary Care Encounters	Primary Care Encounter Rate Payments	Number of Basic BH Encounters	Basic BH Payments	Number of SMI Encounters	SMI Payments	Total Number of Encounters	Total Encounter Rate Payments
Administrators of the Tulane Educational Fund	2,361	$554,794.71	406	$41,212.55	0	$0.00	2,767	$596,007.26
City of New Orleans Health Department	489	$61,278.65	0	$0.00	0	$0.00	489	$61,278.65
Common Ground Health Clinic	2,227	$523,278.16	0	$0.00	0	$0.00	2,227	$523,278.16
Daughters of Charity Services of New Orleans / Marillac CHC	18,454	$4,341,939.00	303	$30,821.16	0	$0.00	18,757	$4,372,760.16
EXCELth, Inc.	8,232	$1,919,873.58	648	$65,638.06	0	$0.00	8,880	$1,985,511.64
Jefferson Community Health	12,825	$3,013,639.31	278	$28,278.16	0	$0.00	13,103	$3,041,917.47
Jefferson Parish Human Service Authority	0	$0.00	2,768	$281,428.38	59	$6,343.68	2,827	$287,772.06
LSU School of Medicine	0	$0.00	318	$32,346.96	0	$0.00	318	$32,346.96
Medical Center of Louisiana at New Orleans	15,731	$3,702,786.55	566	$57,573.52	0	$0.00	16,297	$3,760,360.07
Metropolitan Human Services District	0	$0.00	0	$0.00	6,046	$649,770.94	6,046	$649,770.94
Mary Queen of Vietnam Community Development	1,997	$469,926.18	42	$4,272.24	0	$0.00	2,039	$474,198.42
New Orleans Musicians Assistance Foundation	912	$214,549.61	8	$813.76	0	$0.00	920	$215,363.37
NO/AIDS Task Force	228	$52,047.71	135	$12,918.44	0	$0.00	363	$64,966.15
Odyssey House Inc.	1,763	$414,708.25	2,029	$206,389.88	0	$0.00	3,792	$621,098.13
Plaquemines Primary Care	256	$60,290.56	0	$0.00	0	$0.00	256	$60,290.56
Sisters of Mercy Ministries	0	$0.00	70	$7,048.68	0	$0.00	70	$7,048.68
St. Charles Community Health / Access Health Louisiana	9,179	$2,153,195.52	274	$27,871.27	0	$0.00	9,453	$2,181,066.79
St. Thomas Community Health	7,728	$1,817,608.92	421	$42,824.12	0	$0.00	8,149	$1,860,433.04
TOTAL	**82,382**	**$19,299,916.71**	**8,266**	**$839,437.18**	**6,105**	**$656,114.62**	**96,753**	**$20,795,468.51**

Supplemental Encounter Rate Payments

Based on calculations in the DY3 Expenditure Tracking & Reconciliation Workbook, providers are due a total of $4,066, 408.91 in supplemental encounter rate payments. These payments are site-specific, and summarized below at the provider organization level. See the DY3 Expenditure Tracking & Reconciliation Workbook for site-level details.

Supplemental Encounter Rate Payments Per Provider

Provider Organization	*Payment Amount*
Administrators of the Tulane Educational Fund	$116,293.59
City of New Orleans Health Department	$20,552.07
Common Ground Health Clinic	$96,598.06
Daughters of Charity Services of New Orleans / Marillac CHC	$788,333.51
EXCELth, Incorporated	$373,215.41
Jefferson Community Health	$550,702.89
Jefferson Parish Human Service Authority	$118,815.32
LSU School of Medicine	$13,365.15
Medical Center of Louisiana at New Orleans	$684,942.74
Metropolitan Human Services District	$254,105.90
Mary Queen of Vietnam Community Development	$85,696.65
New Orleans Musicians Assistance Foundation	$38,666.46
NO/AIDS Task Force	$15,256.44
Odyssey House Inc.	$159,373.07
Plaquemines Primary Care	$10,759.36
Sisters of Mercy Ministries	$2,942.01
St. Charles Community Health Center / Access Health Louisiana	$397,297.90
St. Thomas Community Health Center	$342,492.38
TOTAL	**$4,066,408.91**

Inter-Pregnancy Care Coordination (IPC) Payments

Through the IPC component of the Demonstration, the State aims to reduce the incidence of subsequent adverse pregnancy outcomes among women who have previously had a low or very low birth weight baby, preterm birth, fetal death, or infant death. IPC payments are made on a per unit (15 minute) basis and limited to 28 units per month per enrollee. The IPC unit rate is based on the independent rate model in use by Louisiana Medicaid for case management, support coordination, and targeted case management services.

In DY3, only one provider, Healthy Start, was eligible for reimbursement for IPC services. Due to low enrollee interest and participation in the IPC program, only 6 claims (31 units of service) were submitted for reimbursement for a total payment of $314.65.

Total DY3 Payments

In sum, according to the DY3 Expenditure Tracking & Reconciliation Workbook:

- A total of $20.8 million in encounter payments were made to 18 provider organizations.
- Incentive payments for NCQA PCHM recognition program totaled $1.5 million.
- Targeted payments for infrastructure investments totaled $1.3 million.
- Providers were due a total of $4.1 million in supplemental encounter rate payments.
- Payments for IPC services totaled $314.65.
- Total DY3 payments to providers totaled $27.7 million.

The following table summarizes DY3 payments at the provider organization level.

Summary of All DY3 Payments by Participating Provider Organization

Provider Organization	Total NCQA Incentive Payments	Total Infrastructure Investment Payments	Total Encounter Rate Payments	Total Supplemental Payment	Total IPC Payments	Total DY3 Payments
Administrators of the Tulane Educational Fund	$55,594.37	$91,129.46	$596,007.26	$116,293.59	$0.00	$859,024.68
City of New Orleans Health Dept.	$0.00	$5,000.00	$61,278.65	$20,552.07	$314.65	$87,145.37
Common Ground Health Clinic	$94,924.67	$34,125.14	$523,278.16	$96,598.06	$0.00	$745,926.03
Daughters of Charity / Marillac CHC	$371,043.33	$80,000.00	$4,372,760.16	$788,333.51	$0.00	$5,612,137.00
EXCELth, Incorporated	$143,593.68	$0.00	$1,985,511.64	$373,215.41	$0.00	$2,502,320.73
Jefferson Community Health Care	$294,101.88	$50,061.02	$3,041,917.47	$550,702.89	$0.00	$3,936,783.26
Jefferson Parish Human Service Authority	$0.00	$0.00	$287,772.06	$118,815.32	$0.00	$406,587.38
Louisiana State University School of Medicine	$0.00	$0.00	$32,346.96	$13,365.15	$0.00	$45,712.11
Medical Center of Louisiana at New Orleans	$0.00	$125,689.16	$3,760,360.07	$684,942.74	$0.00	$4,570,991.97
Metropolitan Human Services District	$0.00	$0.00	$649,770.94	$254,105.90	$0.00	$903,876.84
MQVN Community Development	$84,891.00	$37,713.07	$474,198.42	$85,696.65	$0.00	$682,499.14
New Orleans Musicians Assistance Foundation	$0.00	$105,736.00	$215,363.37	$38,666.46	$0.00	$394,765.83
NO/AIDS Task Force	$140,471.11	$207,782.00	$64,966.15	$15,256.44	$0.00	$428,475.70
Odyssey House Inc.	$0.00	$192,908.12	$621,098.13	$159,373.07	$0.00	$973,379.32
Plaquemines Primary Care	$0.00	$0.00	$60,290.56	$10,759.36	$0.00	$71,049.92
Sisters of Mercy Ministries	$0.00	$0.00	$7,048.68	$2,942.01	$0.00	$9,990.69
St Charles Community Health Center / Access Health Louisiana	$87,916.67	$49,248.63	$2,181,066.79	$397,297.90	$0.00	$2,715,529.99
St Thomas Community Health Center	$243,507.58	$320,000.00	$1,860,433.04	$342,492.38	$0.00	$2,766,433.00
TOTAL	**$1,516,044.29**	**$1,299,392.60**	**$20,795,468.51**	**$4,066,408.91**	**$314.65**	**$27,677,628.96**

ENCOUNTER DATA FINDINGS

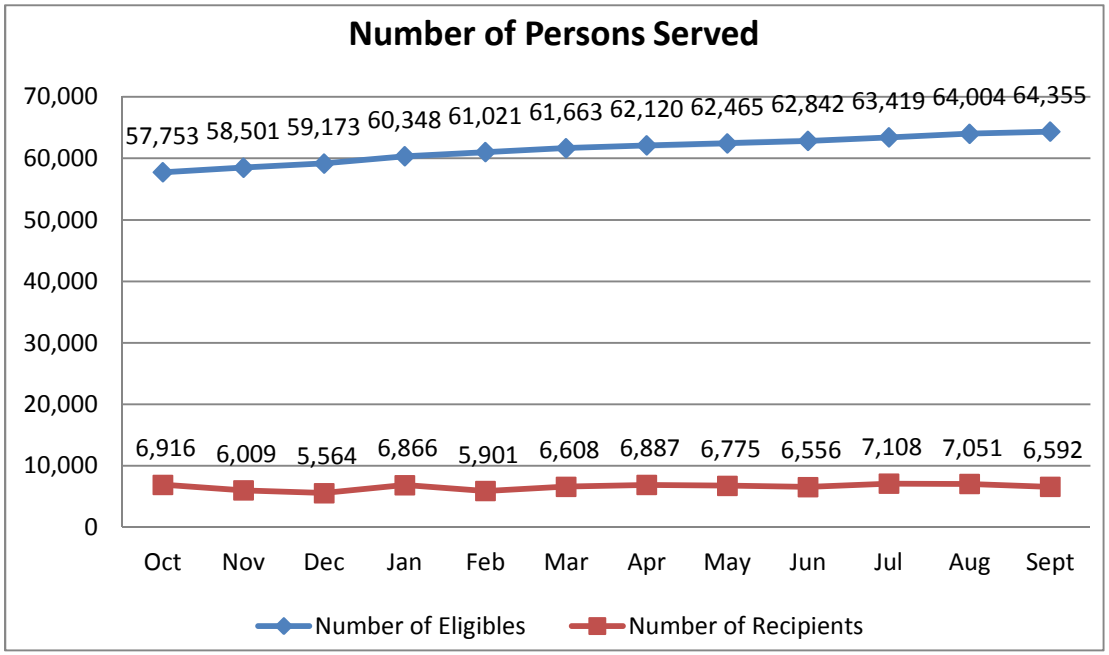
Encounter data analyses of enrollee encounter data reported for Demonstration Year 3 provide the following information about the number of persons served and the cost of providing care to persons served under the Demonstration.

NUMBER OF PERSONS SERVED

Over the course of Demonstration Year 3, enrollment has slowly increased. At year's end, there has been a slow rate of growth in enrollment. Most enrollees are childless adults (70%). Utilization of services is low. The primary care utilization rate is 10.5% per month, and the behavioral health care access averages 1 .7% per month.

As described in previous reports, all applications (GNOCHC or any other program-specific application or a general Medicaid application) received from any source (online or paper, direct from the applicant or via Medicaid Application Center) are considered for GNOCHC eligibility when the applicants reside in one of the four GNOCHC-participating parishes. When determining eligibility, Medicaid eligibility staff "roll down" through the full benefit programs first; if an applicant is not eligible, staff explore eligibility in limited benefit programs like GNOCHC. This roll down procedure applies to renewals as well.

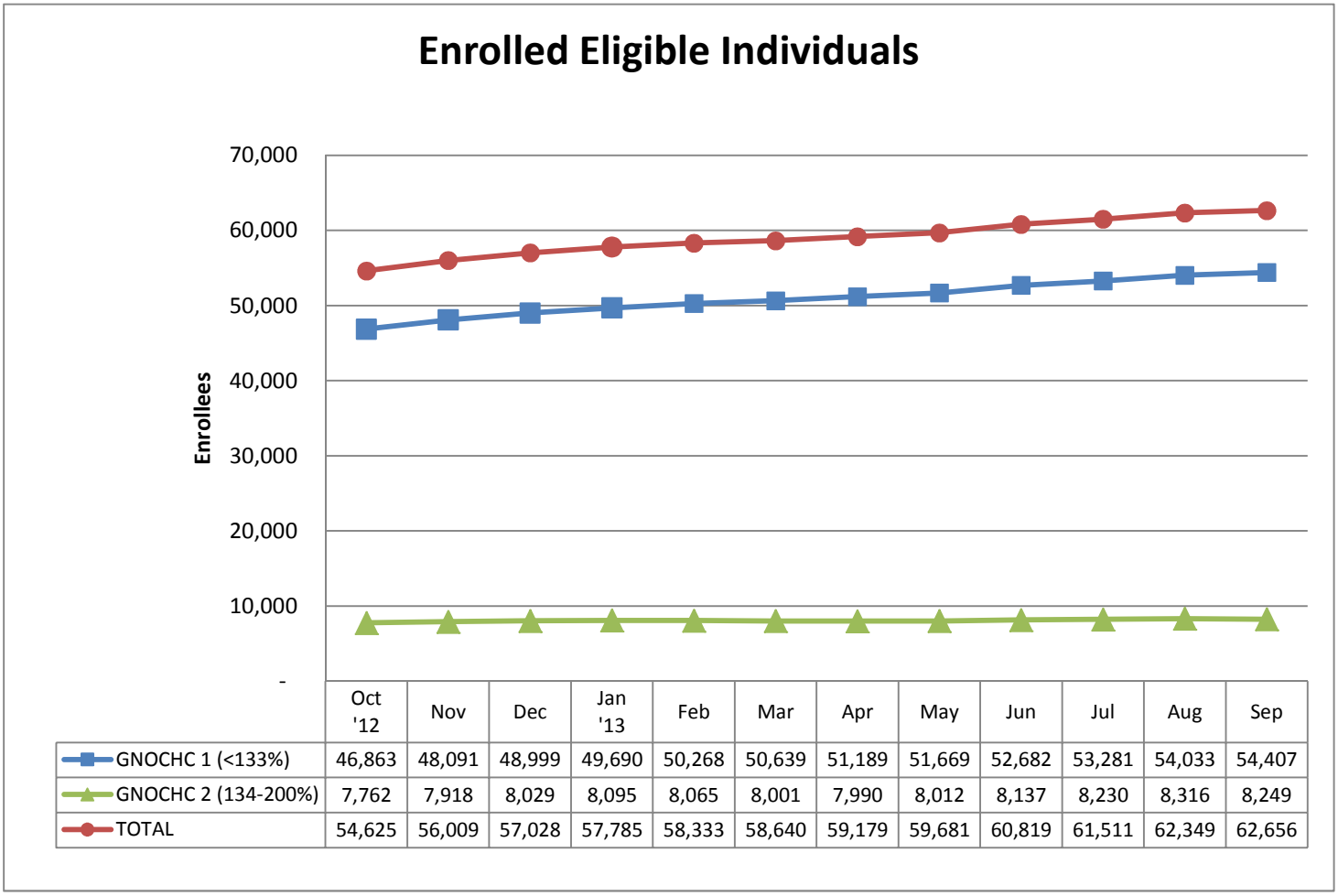
Enrollment tracking shows that, on average, 70% of applications are approved. About 30% of applications are received from a Medicaid Application Center, but most applications are received from another source such as directly from the applicant or local Medicaid office. About 17% are newly certified from the renewal process, meaning the enrollee was no longer eligible in a full benefit program and was "rolled down" to the GNOCHC program. For annual GNOCHC renewals, most enrollees remain eligible in the program (71%). The closure rate is low (0.05%).



Cost of Providing Care

The driver of the cost of providing care to Demonstration enrollees is the primary care encounter. It is the most utilized service, and the primary care encounter rate payments account for the vast majority of encounter rate payments. Of the total number of encounter claims approved for DY3, 85.1% (82,382 of 96,753) were primary care encounters. Total encounter payments for primary care and behavioral health were $20,795,468.51 ($19,299,916.71 for primary care and $1,495,551.80 for behavioral health). (Reference DY3 Reconciliation)

In consideration of child-related status, childless adults drive the cost of providing care by both enrollment volume and service utilization. Childless adults (without minor children in the home) account for 86.8% of total enrollment and 76.4% of all encounter rate payments, while parents (adults with minor children in the home) account for 13.2% of total enrollment and 2% of all encounter rate payments.



	Oct '12	Nov	Dec	Jan '13	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
GNOCHC 1 (<133%)	46,863	48,091	48,999	49,690	50,268	50,639	51,189	51,669	52,682	53,281	54,033	54,407
GNOCHC 2 (134-200%)	7,762	7,918	8,029	8,095	8,065	8,001	7,990	8,012	8,137	8,230	8,316	8,249
TOTAL	54,625	56,009	57,028	57,785	58,333	58,640	59,179	59,681	60,819	61,511	62,349	62,656

Service Utilization by and Cost of Providing Care to All Demonstration Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$1,822,078.60	57,753	8,495	6,916	$31.55	$263.46	$1,822,079	57,753	$31.55	6,916	$263.46
November	$1,548,936.31	58,501	7,172	6,009	$26.48	$257.77	$3,371,015	116,254	$29.00	12,925	$260.81
December	$1,420,451.15	59,173	6,642	5,564	$24.01	$255.29	$4,791,466	175,427	$27.31	18,489	$259.15
January	$1,800,650.31	60,348	8,371	6,866	$29.84	$262.26	$6,592,116	235,775	$27.96	25,355	$259.99
February	$1,519,422.76	61,021	7,056	5,901	$24.90	$257.49	$8,111,539	296,796	$27.33	31,256	$259.52
March	$1,718,792.78	61,663	7,988	6,608	$27.87	$260.11	$9,830,332	358,459	$27.42	37,864	$259.62
April	$1,834,541.86	62,120	8,553	6,887	$29.53	$266.38	$11,664,874	420,579	$27.74	44,751	$260.66
May	$1,821,258.23	62,465	8,446	6,775	$29.16	$268.82	$13,486,132	483,044	$27.92	51,526	$261.73
June	$1,719,779.62	62,842	8,015	6,556	$27.37	$262.32	$15,205,912	545,886	$27.86	58,082	$261.80
July	$1,929,559.25	63,419	8,911	7,108	$30.43	$271.46	$17,135,471	609,305	$28.12	65,190	$262.85
August	$1,921,418.82	64,004	8,957	7,051	$30.02	$272.50	$19,056,890	673,309	$28.30	72,241	$263.80
Sept	$1,741,103.76	64,355	8,155	6,592	$27.05	$264.12	$20,797,993	737,664	$28.19	78,833	$263.82
Total	**$20,797,993.45**	**737,664**	**96,761**	**78,833**							

Service Utilization by and Cost of Providing Care to Parent Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$432,212.93	17,343	1,934	1,578	$24.92	$273.90	$432,213	17,343	$24.92	1,578	$273.90
November	$356,777.31	17,565	1,578	1,344	$20.31	$265.46	$788,990	34,908	$22.60	2,922	$270.02
December	$344,495.56	17,862	1,534	1,315	$19.29	$261.97	$1,133,486	52,770	$21.48	4,237	$267.52
January	$417,956.32	18,116	1,858	1,554	$23.07	$268.96	$1,551,442	70,886	$21.89	5,791	$267.91
February	$342,801.57	18,312	1,529	1,323	$18.72	$259.11	$1,894,244	89,198	$21.24	7,114	$266.27
March	$413,303.18	18,495	1,833	1,547	$22.35	$267.16	$2,307,547	107,693	$21.43	8,661	$266.43
April	$440,913.17	18,648	1,981	1,632	$23.64	$270.17	$2,748,460	126,341	$21.75	10,293	$267.02
May	$444,580.52	18,727	1,966	1,607	$23.74	$276.65	$3,193,041	145,068	$22.01	11,900	$268.32
June	$411,626.54	18,831	1,837	1,533	$21.86	$268.51	$3,604,667	163,899	$21.99	13,433	$268.34
July	$451,512.86	18,910	1,998	1,662	$23.88	$271.67	$4,056,180	182,809	$22.19	15,095	$268.71
August	$442,973.84	18,991	1,954	1,636	$23.33	$270.77	$4,499,154	201,800	$22.30	16,731	$268.91
Septembe	$414,672.71	18,967	1,821	1,566	$21.86	$264.80	$4,913,827	220,767	$22.26	18,297	$268.56
Total	**$421,796.42**	**220,767**	**1,834**	**1,575**							

Service Utilization by and Cost of Providing Care to Childless Adult Enrollees

Month	Payment (based on date of service)	Number of Enrollees	Number of Encounters	Number of Recipients	Per Enrollee Per Month	Per Recipient Per Month	Cumulative Payment	Cumulative Enrollees	Cumulative PEPM	Cumulative Recipients	Cumulative PRPM
October	$1,389,865.67	40,411	6,571	5,338	$34.39	$260.37	$1,389,866	40,411	$34.39	5,338	$260.37
November	$1,192,159.00	40,936	5,594	4,665	$29.12	$255.55	$2,582,025	81,347	$31.74	10,003	$258.13
December	$1,075,955.59	41,312	5,108	4,249	$26.04	$253.23	$3,657,980	122,659	$29.82	14,252	$256.66
January	$1,382,693.99	42,232	6,513	5,312	$32.74	$260.30	$5,040,674	164,891	$30.57	19,564	$257.65
February	$1,176,621.19	42,711	5,527	4,578	$27.55	$257.02	$6,217,295	207,602	$29.95	24,142	$257.53
March	$1,305,489.60	43,171	6,155	5.061	$30.24	$257.95	$7,522,785	250,773	$30.00	29,203	$257.60
April	$1,393,628.69	43,474	6,572	5,255	$32.06	$265.20	$8,916,414	294,247	$30.30	34,458	$258.76
May	$1,376,677.71	43,740	6,480	5,168	$31.47	$266.39	$10,293,091	337,987	$30.45	39,626	$259.76
June	$1,308,153.08	44,012	6,178	5,023	$29.72	$260.43	$11,601,245	381,999	$30.37	44,649	$259.83
July	$1,478,046.39	44,509	6,913	5,446	$33.21	$271.40	$13,079,291	426,508	$30.67	50,095	$261.09
August	$1,478,444.98	45,013	7,033	5,415	$32.84	$273.03	$14,557,736	471,521	$30.87	55,510	$262.25
Sept	$1,326,431.05	45,389	6,334	5,026	$29.22	$263.91	$15,884,167	516,910	$30.73	60,536	$262.39
Total	**$15,884,166.94**	**516,910**	**74,938**	**60,536**							

DATA AND FINDINGS OF HEALTH STATUS OF THE POPULATION SERVED

Findings on health status of the population served by the GNOCHC Demonstration are not available at this time, as such an undertaking requires substantial coordination with a third-party contracted to track Healthcare Effectiveness Data and Information Set (HEDIS) measures for the State and/or the amendment of existing contracts. Demonstration encounter data analysis is ongoing, and DHH will report its progress on health status findings in future reports to CMS.

PROGRAM OPERATIONS

PAYMENT METHODOLOGY AMENDMENT

In the second quarter of DY2, the State began active discussions with the policy advisors for the City of New Orleans Health Department as well as with other GNOCHC providers regarding a proposed change to the approved payment methodology. Providers stated that they had serious concerns, based on the payment issues they experienced during DY1 and expectations of higher volume of GNOCHC enrollment and utilization in DY2, regarding the availability of steady cash-flows and their ability to provide medical services at current or expanded levels if payment/reimbursement trends remained unchanged.

The most significant issue driving these discussions was the result of DY1 reconciliation completed on March 14, 2012, by which it became evident that providers earned only a fraction of the allowable funding throughout the year. Providers were awarded $21M of the $30M available for DY1 via a supplemental payment to their approved encounter claims after the Demonstration Year had already ended. If this trend were to continue, some providers stated that they would necessarily have to cut back on service availability or, in some extreme cases, consider closing their operations. Neither of these potential outcomes would promote the goals of the waiver program.

To address a variety of concerns, a multi-faceted approach was utilized, building upon the approved payment methodology in place. The goal of this approach was to allow providers additional billable activities by which to receive financial support throughout the year to promote revenue stability, service capacity, and prevent another payment windfall at the end of DY2.

On June 7, 2012, the State and the GNOCHC providers submitted a joint proposal to CMS that included:

- Shared Services – Funding would be awarded, in a manner similar to Infrastructure Investments awards, for activities and services from which all participating providers would benefit, such as a city-wide enrollment outreach initiative, shared training programs, and a computerized referral system to enhance specialty care utilization.

- Core Payments – These payments would be made to each provider based on two components: 1) population serviced; and 2) expected quality of care. The population component was proposed due to the lack of a State-instituted primary care provider linkage

for those enrolled in the waiver. The quality component would financially support those participating providers who are still working towards achieving NCQA Primary Care Medical Home (PCMH) recognition, as well as providing lump sum assistance to those already recognized by NCQA; funding would be based solely on existing PCMH recognition as opposed to the current method, which is based on a count of approved claims in the previous quarter.

- Modification of Infrastructure Investment Guidelines – By expanding the definition of Infrastructure Investments, other operational needs such as professional services (MD and RN salary) could be funded to further the activities required to meet the goals of a PCMH.

Negotiations between CMS, the State, and GNOCHC providers continued throughout the third and fourth quarters of DY2, and at the end of the year, these negotiations were concluding. During final negotiations, CMS advised that the requested Core Payments could not be considered. Also during these final negotiations, DHH made the decision to rescind seeking approval to add primary care CPT codes 99201 and 98967, as these CPT codes designate a brief interaction between a patient and a healthcare provider and are therefore not suitable to the comprehensive care that the GNOCHC program intends to deliver. In addition, the primary care encounter rate did not take these types of claims into consideration and would necessarily result in the reduction of the flat rate paid to participating providers in order to maintain budget neutrality.

CMS finally approved the payment methodology amendment on October 26, 2012.

WAIVER EXTENSION

The State did not implement the Medicaid expansion, but instead on July 22, 2013 requested a 12-month extension of the Waiver until December 31, 2014. Due to a limited amount of available matching funds, the State proposed changes to program eligibility criteria (reducing the income eligibility standards from 200% to 100% of the FPL) and reimbursement methodology (reduce the bundled payment rate for primary care encounters, eliminate infrastructure investment payments, and eliminate year-end supplemental payments to providers), effective January 1, 2014, that will allow the State to continue the Waiver for a full 12-months. The source of state match used to fund the waiver is a Community Development Block Grant. CMS approved the extension and program changes on September 29, 2013. Details of the waiver extension changes in reimbursement methodology follow.

- Primary care encounter rate reduced from $235.51 to $205.
- Elimination of infrastructure investment payments, currently capped at $3M or 10% of annual waiver budget.
- Elimination of year-end supplemental payments, which proportionately redistribute any remaining balance of the annual $30M program budget amongst all providers, based on claims volume.

Transition Plan

As described in STC V. 37., the State is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (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 Affordable Care Act, including a simplified, streamlined process for transitioning eligible enrollees from the Demonstration to Medicaid or the Exchange in 2014.

Per the STCs, the State was required to submit a draft plan to CMS by July 1, 2012, implement the plan by January 1, 2013, and include updates on the implementation or revision of the plan in each quarterly report required by STC IV. 36. In light, however, of the June 28, 2012 Supreme Court ruling on the Patient Protection and Affordable Care Act, specifically as it relates to the Medicaid expansion, and the State's need to carefully review the Court's decision in its entirety, the State requested an extension of the July 1st deadline for the draft Transition Plan. The Transition Plan (per STC V. 37) for current GNOCHC enrollees who will no longer be eligible for GNOCHC as a result of the change in income limit requirements taking place on January 1, 2014 was submitted to CMS on October 31, 2013. The transition plan includes actions that the State will take to help guide those no longer eligible into the Affordable Care Act Marketplace.

Financial

CMS 64 Reporting

In the last quarter of Demonstration Year 2, numerous errors were discovered in the CMS 64 reporting for GNOCHC expenditures for FFY11 and FFY12. In particular, DHH Fiscal staff had misreported GNOCHC expenditures as "State Plan DSH" and struggled to accurately report expenditures by both Medicaid Eligibility Groups (i.e. - GNOCHC 1 for individuals with <133% FPL and GNOCHC 2 for individuals 134-200% FPL) and Demonstration Year as required. Unfortunately, these reporting errors continued into the first quarter of FFY13 and, to a lesser extent, the second quarter of FFY13.

GNOCHC staff worked closely with DHH Fiscal staff and with CMS Regional Financial staff to address the issues noted above and to verify the accuracy of all data reported for FFY11, FFY12, and FFY13. All noted deficiencies were corrected by the fourth quarter FFY13 reporting.

Consumer Issues

No notable consumer issues were identified in Demonstration Year 3.

Provider Sustainability

As required by the STCs, all participating GNOCHC providers are required to submit semi-annual Sustainability Progress reports, describing their organization's strategic plan to become a self-sustaining organizational entity, capable of permanently providing primary care or behavioral health care services to residents in the Greater New Orleans region, by the Demonstration's end on

December 31, 2014. Providers were challenged to carefully evaluate their current GNOCHC utilization, and, based on a data-driven analysis of expenditures, future utilization, and estimated revenue projections through 2014, to develop realistic strategies for future financial sustainability and to provide a clear vision of an organization moving decisively toward self-sufficiency at the Demonstration's close.

While all providers minimally met the requirement for submission of the Sustainability Progress reports, the quality of the reports received by the State has varied greatly, as individual data collections and reporting systems are at differing levels of completion and maturity within our provider group. Larger providers who are affiliated with regional and/or national health care network were more likely to have the resources to conduct financial feasibility studies and provided more thorough statistical reports and more reliable estimates of future utilization than those organizations whose fiscal infrastructure is less robust. Additionally, the larger provider organizations reported more diverse revenues sources – a higher mix of private payors, significantly larger grant awards, and the utilization of endowments/foundation funding – than smaller providers who rely more heavily on GNOCHC, Medicaid, and Medicare payments in addition to small grants and donations secured through both public and private sources.

In brief, findings from the Sustainability Progress Reports show:

- Most GNOCHC providers receive funding from federal and non-federal grants.
- Other sources of revenue are private contributions, payment from non-GNOCHC Medicaid recipient claims, fund raising community events, enhanced reimbursement from Medicaid and Medicare as a result of becoming a FQHC network, and private insurance. All continue to search for more funding opportunities.
- Smaller clinics continue to have funding issues (the New Orleans Musicians Assistance Foundation no longer sends birthday cards to patients to receive free wellness visits and have terminated 3 outreach staff).
- Providers have engaged in outreach to diversify their patient base to include non-GNOCHC Medicaid patients and patients with private insurance.
- Funding from GNOCHC has helped many providers attain NCQA PCMH recognition or they are on the path to attain recognition.
- Six provider organizations have reported that GNOCHC patients are more than 50% of their patient base; at the low end of the spectrum are those clinics who are specialized such as NO/AIDS Task Force and Louisiana State University School of Medicine who only offers behavioral health services.
- Some have hired consultants to assist with outreach, marketing, identify funding opportunities, train staff, apply for grants, and assist with sustainability and forecasting.
- With the advent of managed care in Louisiana Medicaid, most GNOCHC providers accept all Bayou Health managed care plans which increases their non-GNOCHC patient count and provides another source of revenue. Most have increased staff to allow for a rise in the number of patients.
- Some are now outsourcing billing to improve effectiveness; some have expressed that billing is a challenge due to various sources of payment and the Bayou Health program.

- Some have expanded the size of their clinic or hope to add another clinic.
- Most screen patients at check-in and have trained staff to take Medicaid applications for uninsured patients.
- Some have contracted with other medical entities such as LSU to offer specialty care like mammography and endocrinology services.
- Clinics are working together to offer more services (EXCELth has a MOU with Common Ground to provide behavioral health to Common Ground patients via telehealth).
- All are looking forward to the changes the Affordable Care Act will bring such as more private insurance payments and more patients.
- Most have made improvements/upgrades to billing/claims systems and have (or will) transitioned to a new EMR/ billing system; GNOCHC funding has provided computer equipment, servers, funds for training, etc.
- Some have attended conferences to stay up to date on the latest developments in the medical industry.

In conclusion, the common concern reported by the clinics is continued funding, but most are optimistic about the changes the Affordable Care Act will bring. GNOCHC has provided greatly needed revenue which has allowed most clinics to expand and improve for continued sustainability after the Program ends.

EVALUATION DESIGN

As noted in the DY2 annual report, there were significant reporting gaps from some providers, whether due to claims processing lag or issues with their individual data collection and reporting systems, and preliminary analysis of the self-reported measures, particularly as related to age-based utilization figures, clearly indicated that revision/resubmission of some data would be required. The State continues to work with providers to improve their reporting and ensure the accuracy and reliability of the data submitted.

Briefly, analysis of the available data indicates:

- The Demonstration has been successful in preserving access to primary and behavioral care, as the percentage of eligible, participating providers who participated in the Primary Care Access Stabilization Grant (PCASG) and who continue to participate in GNOCHC has remained at over 80% (18 organizations) throughout the year. The number of enrolled sites remains at 41, but FFY14 will show an increase due to planned clinic expansions.
- The rate of GNOCHC enrollees who accessed primary care services in DY3 ranged from a high of 11% in quarter three to a low of 7% in quarter four. For behavioral health care services, the rate of access peaked in quarters two and three at 1.9% and dipped to its low rate, 1.4%, in quarter four.
- The percentage of participating provider sites with NCQA PCMH recognition is at 34.1% (14 sites). 12 of the 14 sites are at Level 3. By year's end, 3 additional sites were actively pursuing recognition.

- 39 sites are certified Medicaid application centers.
- 4,252 recipients had both a primary care and behavioral health encounter in Demonstration Year, an average of 0.6% of all enrollees. Of those recipients, an average of 21% received those services on the same date of service.
- As previously noted, enrollment is heavily skewed toward the lower income eligibility group, with 87% of GNOCHC enrollees earning less than 133% FPL.
- Evaluation measures that track utilization of behavioral health services by enrollee sub-population indicate that the average payment for behavioral health care for childless enrollees is $147 per month, which is 12.2% higher than payment for enrollees with a child in the home, which average $131 per month. Also, the average payment per month for enrollees with incomes of 133% FPL or less was $145 per month, which is 9.8% higher than the average of $132 per month for enrollees earning 134-200% FPL.

CONCLUSION

During Demonstration Year 3, the State successfully met the schedule established in the STCs by CMS for deliverables during the period except for the Transition Plan and continued to make significant process toward accomplishments of its overall program goals. Most notably:

- For a third year, the State enrolled new eligibles and/or eligibility was renewed for tens of thousands of low-income uninsured adults.
- The GNOCHC clinics continue to be a "medical home" and the provider of choice for area underserved residents.
- GNOCHC clinics have become an important part of the community. They sponsor community events and collaborate with faith based organizations and non-profits to raise funds and support the community.
- The Waiver Extension was approved, continuing the program through 2014. This is notable because GNOCHC clinics are vital to the community offering a variety of services in addition to primary and behavioral health care, care such as allergy testing, asthma management, obstetrical, surgical consultations, optometry, and dental, thereby being a one stop shop for patients regardless of their ability to pay. Infrastructure and supplemental payments from the GNOCHC program has made it possible for the expansion of the services offered and continued sustainability of the clinics.
- Working throughout the Demonstration Year with providers, internal DHH partners, and Medicaid's fiscal intermediary, the State normalized payments through timely claims processing and amendment of the Funding & Reimbursement Protocol, promoting improved financial stability for GNOCHC providers and helping move them toward the goal of self-sustainability at the waiver's end in December 2014.

BUDGET NEUTRALITY

Federal Funds With and Without Waiver

WITHOUT WAIVER	Historical Data					Base Year	Demonstration Period				
	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY2013	FFY2015**	FFY2016	FFY2017	FFY2018**	Total Demo.
DSH Allotment	$ 731,960,000	$ 750,259,000	$ 769,015,475	$ 731,960,000	$ 731,960,000	$ 731,960,000	$ 548,970,000	$ 731,960,000	$ 731,960,000	$ 182,990,000	$ 2,195,880,000
Total	$ 731,960,000	$ 750,259,000	$ 769,015,475	$ 731,960,000	$ 731,960,000	$ 731,960,000	$ 548,970,000	$ 731,960,000	$ 731,960,000	$ 182,990,000	$ 2,195,880,000

WITH WAIVER* **	Historical Data					Base Year	Demonstration Period				
	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY2013	FFY2015	FFY2016	FFY2017	FFY2018	Total Demo.
MEG 1 Payments (0-133% FPL)*	$ -	$ -	$ -	$ 20,474,902	$ 17,186,995	$ 14,635,854.92	$ 11,166,130	$ 16,482,598	$ 17,243,527	$ 4,330,003	$ 49,222,258
MEG 2 Payments (134% - 200% FPL)	$ -	$ -	$ -	$ 3,088,091	$ 2,443,141	$ 2,360,906.11	$ -	$ -		$ -	$ -
DSH Expenditures	$ 701,980,533	$ 700,619,833	$ 602,246,807	$ 506,045,957	$ 523,318,057	$ 491,768,427	$ 537,803,870	$ 715,477,402	$ 714,716,473	$ 178,659,997	$ 2,146,657,742
Total	$ 701,980,533	$ 700,619,833	$ 602,246,807	$ 529,608,950	$ 542,948,193	$ 508,765,188	$ 548,970,000	$ 731,960,000	$ 731,960,000	$ 182,990,000	$ 2,195,880,000
Savings Under Waiver							$0	$0	$0	$0	$0

*Note 1 - MEG 1 Redefined as 0-100% FPL effective January 1, 2014.
**Note 2 - Demonstration Year 1 begins January 1, 2015, therefore only nine months are included in FFY2015. Similarly, the last year of the demonstration ends December 31, 2017, therefore only three months are in FFY2018.
***Note 3 - Note that with waiver expenditures include medical expenditures at the services matching rate as well as administrative expenditures at the 50% administrative mathcing rate, per the terms and conditions of the previously approved waiver.

BUDGET NEUTRALITY

Total Computable Funds With and Without Waiver

WITHOUT WAIVER	Historical Data					Base Year	Demonstration Period				
	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY2013	FFY2015	FFY2016	FFY2017	FFY2018	Total Demo.
DSH Allotment	$ 1,010,017,938	$ 1,052,109,101	$ 1,137,428,598	$ 1,150,699,576	$ 1,198,166,639	$ 1,117,325,599	$ 883,867,332	$ 1,178,489,776	$ 1,178,489,776	$ 294,622,444	$ 3,535,469,329
Subtotal	$ 1,010,017,938	$ 1,052,109,101	$ 1,137,428,598	$ 1,150,699,576	$ 1,198,166,639	$ 1,117,325,599	$ 883,867,332	$ 1,178,489,776	$ 1,178,489,776	$ 294,622,444	$ 3,535,469,329

WITH WAIVER	Historical Data						Demonstration Period				
	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY2013	FFY2015	FFY2016	FFY2017	FFY2018	Total Demo.
MEG 1 Payments (0-133% FPL)*	$ -	$ -	$ -	$ 26,698,073	$ 24,725,697	$ 22,393,571	$ 18,003,581	$ 26,571,873	$ 27,797,005	$ 6,980,037	$ 79,352,496
MEG 2 Payments (134% - 200% FPL)	$ -	$ -	$ -	$ 4,035,018	$ 3,501,288	$ 3,603,968	$ -	$ -		$ -	$ -
DSH Expenditures	$ 968,649,831	$ 982,498,715	$ 890,765,869	$ 795,544,658	$ 854,015,086	$ 801,383,901	$ 865,863,751	$ 1,151,917,903	$ 1,150,692,772	$ 287,642,407	$ 3,456,116,833
Subtotal	$ 968,649,831	$ 982,498,715	$ 890,765,869	$ 826,277,749	$ 882,242,071	$ 827,381,440	$ 883,867,332	$ 1,178,489,776	$ 1,178,489,776	$ 294,622,444	$ 3,535,469,329

Savings Under the Waiver					$0	$0	$0	$0	$0

*Note 1 - MEG 1 Redefined as 0-100% FPL effective January 1, 2014.

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

May 15, 2014

Karen Matthews, Health Director
Chitimacha Health Clinic
3231 Chitimacha Trail
Jeanerette, LA 70544

Angela Martin
Chitimacha Tribe of Louisiana
P. O. Box 640
Jeanerette, LA 70544

Anita Molo
Chitimacha Tribe of Louisiana
P. O. Box 640
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Marshall Pierite, Chairman
Misty Hutchby, Health Director
Tunica-Biloxi Tribe of Louisiana
P. O. Box 1589
Marksville, LA 71351-1589

Lovelin Poncho, Chairman
Paula Manuel, Health Director
Coushatta Tribe of Louisiana
P. O. Box 818
Elton, LA 70532

Chief Beverly Cheryl Smith
Holly Vanhoozen, Health Director
The Jena Band of Choctaw Indians
P. O. Box 14
Jena, LA 71342

Dear Louisiana Tribal Contact:

RE: Notification of Louisiana GNOCHC Waiver Renewal

In compliance with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, the Department of Health and Hospitals, Bureau of Health Services Financing is taking the opportunity to notify you of our intent to submit a request to renew a waiver that may have an impact on your tribe.

The Department intends to submit a request to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), in order to renew its Section 1115 Medicaid Demonstration Waiver called the Greater New Orleans Community Health Connection (GNOCHC) Waiver. This renewal request shall be for a period not to exceed three years.

The GNOCHC Waiver, which is set to expire on December 31, 2014, provides limited primary and behavioral health care services to low-income, uninsured residents of Jefferson, Orleans, Plaquemines, and St. Bernard Parishes.

Submission of a renewal request to CMS by the June 30, 2014 deadline is contingent upon the identification of matching funds which are required to continue the GNOCHC Waiver. Renewal of the waiver is contingent upon CMS approval.

Please provide any comments you may have by June 20, 2014 to Ms. Darlene Adams via email to Darlene.Adams@la.gov or by postal mail to:

Department of Health and Hospitals
Bureau of Health Services Financing
Medicaid Policy and Compliance
P.O. Box 91030
Baton Rouge, LA 70821-9030

Should you have additional questions about Medicaid policy, Ms. Adams will be glad to assist you. You may reach her hy email or by phone at (225) 342-3881. Thanks for your continued support of the tribal consultation process.

Sincerely,

Darlene M. Adams

for J. Ruth Kennedy
Medicaid Director

RK/DA/KB

c: Janice Arceneaux
Ford J. Blunt, III
Jeanne Levelle

Public Notice

Department of Health and Hospitals
Bureau of Health Services Financing

Greater New Orleans
Community Health Connection
1115 Demonstration Waiver

Background

The Louisiana Department of Health and Hospitals (DHH) was awarded a $100 million Primary Care Access Stabilization Grant (PCASG) for July 2007 through September 2010 for the Greater New Orleans area in the aftermath of Hurricanes Katrina and Rita to restore and expand access to primary care, mental health, and dental services without regard to a patient's ability to pay. In 2010, DHH submitted a proposal to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for a Medicaid section 1115 demonstration to continue funding of the PCASG provider organizations, propose a reduction in discretionary disproportionate share hospital (DSH) funding, and increase support for primary care medical homes (PCMH). The CMS approved the Greater New Orleans Community Health Connection (GNOCHC) 1115 demonstration effective October 1, 2010 through December 31, 2013. In September 2013, CMS approved a 12-month extension of the program to December 31, 2014 and changes to the eligibility criteria and reimbursement methodology.

DHH plans to submit a proposal to CMS to renew the GNOCHC demonstration waiver for three more years. An extension of this waiver program continues access to medical care to the Greater New Orleans area comprised of Orleans, Jefferson, St. Bernard, and Plaquemines parishes. This area is one of the largest

population centers in the state and is home to over 800,000 individuals, representing roughly 20 percent of the state's population. According to the 2012 U.S. Census Bureau's American Community Survey estimate for the GNOCHC service area, 16.5 percent of the residents aged 18-64 had incomes below poverty, nearly 20 percent of that age group who were employed were uninsured, 53 percent of the unemployed were uninsured, and 22.5 percent of those not in the labor force were uninsured. According to the Louisiana Health Insurance Survey, 124,904 individuals in the GNOCHC service area are under 100 percent of the Federal Poverty Level (FPL). Continuation of the waiver program is expected to reduce reliance on costlier emergency room care to meet primary care needs.

Submission of the renewal request to CMS is contingent upon the identification of State matching funds. Implementation of the provisions in this Public Notice is contingent upon the approval of CMS.

Proposed Changes

The goal of the renewal is to increase access to care in the Greater New Orleans area. **The proposed changes to the program are to remove the requirement that eligible individuals be uninsured for at least 6 months, remove the requirement that**

participating providers have been PCASG funded, and change the provider reimbursement methodology. Details of these proposed changes follow.

Eligibility

For this renewal, DHH proposes to remove the requirement that eligible individuals be uninsured for at least 6 months.

All other eligibility requirements remain unchanged:

- Live in Jefferson, Orleans, St. Bernard or Plaquemines parish;
- Not be pregnant;
- Be uninsured;
- Have family income up to 100 percent of the FPL;
- Meet U.S. citizenship requirements under the Deficit Reduction Act of 2008 and the Children's Health Insurance Program Reauthorization Act of 2009.
- Be age 19 through 64 years old;
- Not be eligible for Medicaid, Children's Health Insurance Program (CHIP) or Medicare. Applicants will continue to be pre-screened to determine possible eligibility in a full benefit program prior to determining eligibility for GNOCHC, a limited benefit program. Applicants may still

qualify for the Tuberculosis Infected Program or the TAKE CHARGE Family Planning Waiver or succeeding State Plan Family Planning services. Retroactive coverage still does not apply.

Recipients will continue to undergo an eligibility redetermination at least once every 12 months. Each redetermination shall include a review of the individual's eligibility for coverage in other Medicaid or CHIP programs.

Services

DHH proposes no changes to covered services. The following services paid for and provided directly or indirectly by referral by a participating GNOCHC provider would continue to be covered:

- care coordination;
- immunizations and influenza vaccines;
- laboratory and radiology;
- behavioral health care;
- primary health care;
- preventive health care;
- substance abuse; and

- specialty care (as provided by the GNOCHC provider or as referred by the GNOCHC provider).

Currently, there is no cost sharing for recipients, but DHH is preserving the option to propose cost sharing. The recipient's share of the cost will be restricted to a 5 percent aggregate limit per family.

Participating Providers

Currently, there are 42 GNOCHC participating providers in the 4-parish area. Providers are disproportionately located in Orleans parish, while Plaquemines, St. Bernard, and even Jefferson parish are relatively underserved. **To increase access to care, DHH proposes to remove the requirement that participating providers have received PCASG funding. All other participating requirements would remain unchanged.**

- Be a GNOCHC enrolled provider;
- Be operational on or after January 1, 2015;
- Be a public or private not-for-profit entity that meets the following conditions:
    - the entity must not be an individual practitioner in private solo or group practice;

    - the provider shall be currently licensed, if applicable;
    - either the provider or its licensed practitioners shall be currently enrolled in the Medicaid Program; and
    - all health care practitioners affiliated with the provider that provide health care treatment, behavioral health counseling, or any other type of clinical health care services to patients shall hold a current, unrestricted license to practice in Louisiana within the scope of that licensure.
- Provide full disclosure of ownership and control, including but not limited to any relative contractual agreements, partnerships, etc.;
- Have a statutory, regulatory or formally established policy commitment (e.g. through corporate bylaws) to serve all people, including patients without insurance, at every income level regardless of their ability to pay for services, and be willing to accept and serve new publicly insured and uninsured individuals;
- Maintain one or more health care access points or service delivery sites for the provision of health care services which may include medical care, behavioral health care and

substance abuse services, either directly on-site or through established contractual arrangements;

- Continue to collect all data on services rendered and maintain such data at the provider level; and
- Continue to submit required reports on patient population and revenue. **DHH is proposing that providers report on outcomes for new incentive payments.**

Reimbursement

Federal funding for GNOCHC is limited and DHH will request a maximum of $15 million in federal funding per year for the demonstration renewal term. The federal share of expenditures for payments to GNOCHC providers shall continue to be calculated based upon the applicable federal medical assistance percentage rate for the year in which the expenditures were incurred. The non-federal source of funding is expected to be a U.S. Department of Housing and Urban Development Community Development Block Grant award to DHH via an Interagency Transfer from the Division of Administration. Within that budget, DHH proposes providers will be reimbursed. Providers shall ensure that reimbursement for services covered under the GNOCHC waiver is requested only for those individuals who meet the program criteria.

Ensuring Expenditures Do Not Exceed Funding

DHH will continue to have discretion to remain under budget. Upon CMS approval, **DHH proposes to keep the following measures, which may be taken to manage eligibility** to ensure that expenditures do not exceed funding allocations. DHH may:

- Employ a first come, first served reservation list to manage the number of applications received;
- Limit the number of applications provided to potential recipients;
- Impose enrollment limits; or
- Reduce encounter rates and/or modify other payments.

Currently, enrollment totals 51,006, and is expected to grow at a rate of 2 percent per year under the renewal, consistent with 2013 enrollment growth for GNOCHC eligible individuals under 100 percent of the FPL. Annual expenditures for the most recent calendar year (2013) totaled $27,827,737. It is anticipated that total annual expenditures under the renewal would not exceed historic annual expenditures due to 1) the income eligibility limit of 100 percent of the FPL effective January 1, 2014, 2)

the proposed changes to the reimbursement methodology, and 3) the limited availability of State matching funds.

DHH proposes that the expenditure authority currently in place remain unchanged.

Reimbursement Methodology

DHH proposed to change the reimbursement methodology for GNOCHC providers. Currently, providers receive encounter rates unique to the demonstration. **DHH proposes to instead reimburse GNOCHC providers for GNOCHC covered services based on the Medicaid rate payable for the service according to the GNOCHC provider's Medicaid provider type (FQHC, physician group, or behavioral health clinic)**.

In addition, **DHH proposes to replace the current quarterly payments for National Committee for Quality Assurance (NCQA) Patient Centered Medical Homes (PCMH) recognition with an alternative, incentive payment for changes to business operations that help increase access to care.** Incentive payments (not to exceed a total of $500,000 per quarter) will be potentially available to all GNOCHC providers. These incentives will be outcome based and shall be awarded to providers successfully meeting certain standards, for example:

- Extended business hours such as weekends, early morning, and evening hours; and
- Same day appointment scheduling.

Evaluation of Program

DHH is proposing changes to the evaluation design. The evaluation will continue to include state-conducted evaluations of participant and applicant experiences and the overall effectiveness of the program. **DHH is seeking input on other ways to demonstrate the impact that the program has had on providers and recipients. Hypotheses and research should incorporate the goals of this renewal proposal which are increasing access to care. The evaluation should also include the original goals and objectives of the program when it was first implemented which are to preserve primary and behavioral health care access, advance and sustain the medical home model, and demonstrate how the providers have become financially sustainable.**

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030. She is responsible for responding to inquiries regarding this public notice. Comments may also be submitted via the DHH's website, http://www.dhh.louisiana.gov/index.cfm/page/1708. Two public

hearings are scheduled for this public notice. Both hearings will also be broadcast over the web and via teleconference.

Hearing #1: May 28, 2014 at 1:00 p.m., at LSU's School of Allied Health and Nursing Building, Tiger Room #138, 1900 Gravier Street, New Orleans, LA, 70112.

Web: https://www4.gotomeeting.com/register/258568263

Teleconference: 1-888-636-3807, then access code 1133472

Hearing #2: June 2, 2014 at 7:00 p.m., at the Joseph S. Yenni Building, EB Council Chambers room, 1221 Elmwood Park Boulevard, Jefferson, LA, 70123.

Web: https://www4.gotomeeting.com/register/203849447

Teleconference: 1-888-636-3807, then access code 1133472

At that time, all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is June 20, 2014 by 4:30 p.m.

County: Orleans
Printed In: The Times-Picayune
Printed On: 2014/05/21

PUBLIC NOTICE Department of Health and Hospitals Bureau of Health Services Financing Greater New Orleans Community Health Connection Waiver Renewal The Department of Health and Hospitals, Bureau of Health Services Financing currently provides limited primary and behavioral health care services to low-income, uninsured residents of Jefferson, Orleans, Plaquemines and St. Bernard Parishes under the authority of a Section 1115 Medicaid Demonstration Waiver, called the Greater New Orleans Community Health Connection (GNOCHC). The GNOCHC Waiver is set to expire on December 31, 2014. The department hereby gives public notice of its intent to submit a request to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to renew the GNOCHC Waiver for a period not to exceed three years. Submission of the renewal request to CMS by the June 30, 2014 deadline is contingent upon the identification of matching funds required to continue the GNOCHC Waiver. Renewal of the waiver is contingent upon CMS approval. Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 She is responsible for responding to inquiries regarding this public notice. Comments may also be submitted via the Department's website, http://www.dhh.louisiana.gov/index.cfm/page/1708. Two public hearings are scheduled for this public notice. Both hearings will also be broadcast over the web and via teleconference. (1) May 28, 2014 at 1:00 p.m., at LSU's School of Allied Health and Nursing Building, Tiger Room #138, 1900 Gravier Street, New Orleans, LA, 70112. Web: https://www4.gotomeeting.com/register/258568263. Teleconference: 1-888-636-3807 then access code 1133472. (2) June 2, 2014 at 7:00 p.m., at the Joseph S. Yenni Building, EB Council Chambers room, 1221 Elmwood Park Boulevard, Jefferson, LA, 70123. Web: https://www4.gotomeeting.com/register/203849447. Teleconference: 1-888-636-3807 then access code 1133472. At these hearings all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is June 20, 2014 by 4:30 p.m. Kathy H. Klieber Secretary

Public Notice ID: 2136814

County: Lafayette
Printed In: The Advertiser
Printed On: 2014/05/21

1864829 PUBLIC NOTICE Department of Health and Hospitals Bureau of Health Services Financing Greater New Orleans Community Health Connection Waiver Renewal The Department of Health and Hospitals, Bureau of Health Services Financing currently provides limited primary and behavioral health care services to low-income, uninsured residents of Jefferson, Orleans, Plaquemines and St. Bernard Parishes under the authority of a Section 1115 Medicaid Demonstration Waiver, called the Greater New Orleans Community Health Connection (GNOCHC). The GNOCHC Waiver is set to expire on December 31, 2014. The department hereby gives public notice of its intent to submit a request to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to renew the GNOCHC Waiver for a period not to exceed three years. Submission of the renewal request to CMS by the June 30, 2014 deadline is contingent upon the identification of matching funds required to continue the GNOCHC Waiver. Renewal of the waiver is contingent upon CMS approval. Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this public notice. Comments may also be submitted via the Department's website, http://www. dhh.louisiana.gov/index.cfm/page/1708. Two public hearings are scheduled for this public notice. Both hearings will also be broadcast over the web and via teleconference. (1) May 28, 2014 at 1:00 p.m., at LSU's School of Allied Health and Nursing Building, Tiger Room #138, 1900 Gravier Street, New Orleans, LA, 70112. Web: https://www4. gotomeeting.com/register/258568263. Teleconference: 1-888-636-3807 then access code 1133472. (2) June 2, 2014 at 7:00 p.m., at the Joseph S. Yenni Building, EB Council Chambers room, 1221 Elmwood Park Boulevard, Jefferson, LA, 70123. Web: https://www4. gotomeeting.com/register/203849447. Teleconference: 1-888-636-3807 then access code 1133472. At these hearings all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is June 20, 2014 by 4:30 p.m. Kathy H. Kliebert Secretary

Public Notice ID: 2136705

Public Hearing

Greater New Orleans Community Health Connection (GNOCHC) Medicaid Section 1115 Waiver

DEPARTMENT OF HEALTH
AND HOSPITALS

Purpose of Today's Hearing

- Report on **current** status of GNOCHC program
- Opportunities for public comment are required to renew the GNOCHC waiver
- Get feedback for inclusion in waiver renewal application
  - What is working well and needs to be retained?
  - What are the gaps/opportunities for improvement that might be addressed?

DEPARTMENT OF HEALTH AND HOSPITALS

Public Hearing Requirements for Medicaid 1115 Waivers

- Intent of CMS is greater transparency and public awareness about a state's request for a Medicaid waiver
- Required in 2010 ACA law and became effective 4/27/12
- Held at least 20 days prior to submission of renewal application to CMS
- Two public hearings on separate dates at separate locations
- Telephonic or web conference participation must be option for at least one of the two required public hearings to ensure maximum accessibility

DEPARTMENT OF HEALTH
AND HOSPITALS

History of the GNOCHC Program

- Successor to $100M PCASG which CMS funded from 2006 to 2010 to preserve access to primary and behavioral health care services in Greater New Orleans after Hurricane Katrina
- Provides limited health coverage to uninsured adults ages 19 – 64 who live Orleans, Jefferson, St. Bernard or Plaquemines parish
- Medicaid Section 1115 Demonstration Waiver approved by CMS on October 1, 2010 through December 31, 2013
- Extended (not renewed) another year through December 31, 2014
- State match comes from Community Development Block Grant funds
- 18 current GNOCHC provider organizations all "grandfathered" from PCASG program; 42 provider clinics

DEPARTMENT OF HEALTH
AND HOSPITALS

GNOCHC Program Participation - 2013

- 31,431 **or 40%** of 78,017 GNOCHC enrollees received at least one GNOCHC service
- 41 GNOCHC clinics provided 96,753 patient visits or encounters
- Over $21 million in claims payments
- $5.4 million in incentive payments to providers
- $1.5 million in NCQA PCMH incentive payments to providers

DEPARTMENT OF HEALTH
AND HOSPITALS

Current Eligibility Requirements for GNOCHC

- Uninsured for at least 6 months
- Adults age 19 – 64
- Income up to 100% FPL (1 person $958, family of 4 $1963)
- Not pregnant
- U.S. citizens or meet citizenship requirements for federal Medicaid program
- Residents of Orleans, Jefferson, St. Bernard, and Plaquemines parishes
- Not eligible for any "full benefit" Medicaid program

DEPARTMENT OF HEALTH
AND HOSPITALS

GNOCHC Services

Covered	Not Covered
Primary care	Pharmacy
Lab and radiology	Inpatient and outpatient hospital
Care coordination	Residential behavioral health services
Behavioral health	Emergency room care
Preventive health	Dental care
Substance abuse	Services received from a provider who is not a GNOCHC provider unless there is a referral from the GNOCHC provider
Immunizations and flu vaccine	
Specialty care (must have referral from GNOCHC provider)	

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GNOCHC Continuation Until 12/31/14

- DHH has approval from CMS to operate GNOCHC through 12/31/14
- DHH **does not** have approval from CMS to draw down more than $18.7 million in federal match in FFY 2014/2015 (Oct 2013 – Dec 2014)
- Claims are currently averaging $1.2 million/month and federal match will be exhausted in Sept 2014
- Current state budget (HB 1) includes $4 million in state match to fund GNOCHC
- By 6/9/14, we will request amendment to the current waiver from CMS to increase budget authority (secure matching federal funding for Sept 2014 – Dec 2014)
- No assurances that CMS will approve the amendment

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Renewal of GNOCHC and Potential Improvements for 2015 and Beyond

GNOCHC Continuation Beyond 12/31/14

- DHH must obtain CMS approval of application for renewal of waiver before 12/31/14 – will request for three years which is maximum
- Full waiver renewal "package" must be submitted no later than 6 months before waiver ends (6/30/14)
- Renewal package must include updated budget neutrality calculations and evaluation of existing waiver
- CMS will post application on their website and allow a 30 day public comment period during which written comments can be submitted
- CMS may request modifications to application or direct an additional 30 day federal comment period
- If approved, CMS sends award letter to state, terms and conditions, and budget neutrality agreement

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What Might CMS Be Looking for in Renewal Application?

- GNOCHC was originally approved in 2010 as a "bridge" to Medicaid expansion in 2014
- Subsequent 2012 Supreme Court decision made Medicaid expansion optional for states and Louisiana has not expanded Medicaid
- Expectation of maturity from 8 years of investment in infrastructure?
- What are we researching and attempting to demonstrate 8 years post-Katrina?
- Current CMS areas of focus that should impact our thinking:
  - Outcome – rather than process-based quality measures
  - Establishment of Adult Quality Measures
  - Integration of physical and behavioral health
  - Investments to achieve meaningful use of electronic medical records

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Remove Requirement to Be Uninsured 6 Months?

- ACA reduced maximum length of waiting periods in CHIP
- We have already reduced income cap from 200% to 100% of poverty
- Revise requirement to be uninsured at point of enrollment in GNOCHC?
- No longer have to wait 6 months to apply and get the services you need?

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Remove PCASG Participation Requirement for GNOCHC Providers?

- Now, only provider organizations who participated in original PCASG grant can be a GNOCHC provider - "grandfathered" in
- More providers would result in increased access to care
- All other participating provider requirements would remain the same or other changes?

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Replace NCQA PCMH Payment with Outcome Measures?

- Now, any provider who has NCQA PCMH recognition receives a quarterly payment based on level (1-$12,500, 2- $25,000, or 3- $37,500)
- "Process" rather than "outcome" measure
- NCQA recognition does not necessarily result in practice reform such as same day appointments, extended hours, meaningful use of electronic records
- Discontinue NCQA PCMH payments and replace with measures that reflect access to care, health outcomes, and/or patient satisfaction?
- What measures should DHH propose to CMS for incentive payments?

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Changes to Reimbursement for Services/Rates?

- Now, providers are paid per encounter unlike other Medicaid programs ($205 primary care, $101.72 basic behavioral health, $107.52 serious mental illness behavioral health)
- Should we reimburse providers for GNOCHC covered services like other Medicaid providers -- based on the Medicaid rate payable for the service according to the type of Medicaid provider (FQHC, physician group, or behavioral health clinic) they are?

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Change the Way We Evaluate the Program?

- Provider surveys
- Recipient surveys
- Data collection
- Factors to evaluate

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