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

December 11, 2015

Dr. Joseph Parks, Director
MO HealthNet Division
P.O. Box 1527
Broadway State Office Building
Jefferson City, MO 65102-1527

Dear Dr. Parks:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving a one-year extension of Missouri's Medicaid section 1115 demonstration, "Gateway to Better Health" (No. 11-W-00250/7), in accordance with section 1115(a) of the Social Security Act.

This extension is effective as of the date of this letter through December 31, 2016, upon which date, unless reauthorized, all authorities granted to operate this demonstration will expire. Approval of this demonstration project is subject to the limitations specified in the attached expenditure authorities and Special Terms and Conditions (STCs). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as not applicable to expenditures for the demonstration population in the expenditure authorities.

This extension will allow the state to continue to provide individuals who reside in the St. Louis region who are not eligible for Medicaid and have income at or below 100 percent of the federal poverty level (FPL) with primary care and specialty care benefits provided through a defined provider network. As part of the extension, CMS is approving an amendment submitted on February 19, 2015. The amendment authorizes the state, effective January 1, 2016, to provide coverage of brand name insulin and inhalers which are not available in a generic alternative and make related changes associated with budget neutrality.

The approval is conditioned upon continued compliance with the enclosed STCs defining the nature, character, and extent of anticipated federal involvement in the project. The approval is also subject to our receiving your written acknowledgement of this award and acceptance of the STCs and expenditure authorities within 30 days of the date of this letter.

Your project officer for this demonstration is Lina Gomez Valencia. She is available to answer any questions concerning your section 1115 demonstration renewal. Ms. Gomez Valencia's contact information is as follows:

Centers for Medicare & Medicaid Services
State Demonstrations Group
7500 Security Boulevard, Mailstop S2-01-16
Baltimore, MD 21244-1850

Telephone: (410) 786-4433
Facsimile: (410) 786-8534
E-mail: Lina.gomezvalencia@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Gomez Valencia and to James Scott, Associate Regional Administrator in our Kansas City Regional Office. Mr. Scott's contact information is as follows:

Richard Bolling Federal Building
601 East 12th Street, Room 355
Kansas City, MO 64106-2808
Email: James.Scott1@cms.hhs.gov

If you have questions regarding the terms of this approval, please contact Eliot Fishman, Director, State Demonstrations Group, at (410) 786-9686. We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Vikki Wachino
Director

Enclosures

cc: James Scott, ARA, Region VII

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00250/7**

TITLE: **Gateway to Better Health**

AWARDEE: **Missouri Department of Social Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Missouri for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration extension, beginning the date of the signed approval letter through December 31, 2016, be regarded as expenditures under the state's title XIX plan (except to the extent an earlier expiration date is indicated below).

The following expenditure authorities shall enable Missouri to implement the Gateway to Better Health Medicaid section 1115 demonstration. In addition to the individual limitations on expenditures under each of these authorities, expenditures under all categories below shall not exceed an amount annually that, when added to the amount of payments made for that year to disproportionate share hospital (DSH) providers, as defined under the state plan in accordance with section 1923(f) of the Act, does not exceed the Missouri state-specific disproportionate share hospital payment allotment for that year, as calculated pursuant to section 1923(f) of the Act.

The expenditure authority listed below promotes the objectives of title XIX in the following ways: by increasing overall coverage of low-income individuals in the state and improving health outcomes for low-income populations in the state.

The expenditure authorities below shall apply with respect to operation of the Safety Net Pilot Program:

- **Demonstration Population 1:** Expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between the ages of 19-64 years of age with income up to 100 percent of the FPL to pay for primary care provided by designated primary care providers or designated specialty care providers when referred by a designated primary care provider.

- **Expenditure for Managing the Coverage Model:** Expenditures pursuant to a memorandum of understanding and not to exceed $4,500,000 annually for costs incurred by the St. Louis Regional Health Commission (SLRHC) to activities related to the continued administration of the coverage model during the extension period.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to all demonstration populations.

Statewideness **Section 1902(a)(1)**

To the extent necessary, to allow the state to limit enrollment in the demonstration to persons residing in St. Louis City and St. Louis County.

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary, to enable the state to establish an enrollment target and maintain waiting lists for the demonstration population.

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

To the extent necessary, to permit the state to offer benefits to the demonstration population that differ from the benefits offered under the Medicaid state plan.

Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary, to enable the state to mandatorily enroll the demonstration population into a delivery system that restricts the free choice of provider.

Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary, to enable the state to not provide medical assistance to the demonstration population prior to the date of application for the demonstration benefits.

Payment for Services by Federally Qualified Health Centers (FQHCs) **Section 1902(a)(15)**

To the extent necessary, to enable the state to make payments to participating FQHCs for services provided to the demonstration population using reimbursement methodologies other than those required by section 1902(bb) of the Act due to the limited nature of the benefits.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00250/7**

TITLE: **Gateway to Better Health**

AWARDEE: **Missouri Department of Social Services**

I. PREFACE

The following are the amended special terms and conditions (STCs) for Missouri's Gateway to Better Health section 1115(a) Medicaid demonstration (hereinafter referred to as "demonstration"). The parties to this agreement are the Missouri Department of Social Services ("state") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective date of approval unless otherwise specified, through December 31, 2016

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Primary Care Support
V. Elements of the Safety Net Pilot Program for Participating Providers
VI. Eligibility, Enrollment, and Disenrollment under the Safety Net Pilot Program
VII. Safety Net Pilot Program Benefits
VIII. Cost Sharing Under the Safety Net Pilot Program
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. Evaluation
XIII. Schedule of State Deliverables for the Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

In July 2010, the demonstration was approved to transition the financial payment structure for five safety net providers in the city of St. Louis to a financial model that links expenditures to coverage. Under the demonstration, the state has been authorized to spend up to $30 million (total computable) annually to preserve and improve primary and specialty care in the St. Louis region, in lieu of spending that amount of statutorily authorized funding on payments to disproportionate share hospitals (DSHs). The amount of expenditures under this demonstration, when added to the amount of DSH payments made for the year, shall not exceed the state's DSH allotment calculated in accordance with section 1923 of the Social Security Act (the Act).

The demonstration was amended in June 2012, to implement a pilot program, as described below, whereby it provides health insurance coverage to uninsured individuals residing in St. Louis City and St. Louis County with family income at or below 133 percent of the federal poverty level (FPL). This amendment was effective July 1, 2012.

In addition, under the demonstration, the state has authority to claim as administrative costs limited amounts incurred for functions related to the design and implementation of the demonstration pursuant to the Memorandum of Understanding with the St. Louis Regional Health Commission (SLRHC), which is a non-profit, non-governmental organization whose mission is to 1) increase access to health care for people who are medically uninsured and underinsured; 2) reduce health disparities among populations in the St. Louis City; and 3) improve health outcomes among populations in the St. Louis City, especially among those most at risk.

The state also had authority to claim as administrative costs limited amounts incurred by the SLRHC pursuant to an MOU for functions related to emergency room diversion efforts through the Community Referral Coordinator program (CRC). The CRC expenditure authority ended December 31, 2013.

On December 26, 2012, the state submitted an extension request. On September 27, 2013, the demonstration was extended for one year to cover uninsured individuals who reside in the St. Louis region with incomes between 0 through 100 percent of the FPL.

In March 2014, the state submitted a renewal application for a two-year extension period of the Gateway to Better Health demonstration with no changes. In July 2014, CMS approved a one year extension of the demonstration to continue health care coverage to Gateway beneficiaries.

On December 31, 2014, the state submitted an extension request for a one-year extension of the demonstration. On February 19, 2015, the state submitted an amendment request to offer brand name insulin and inhalers when there is no generic alternative.

In October 2015, CMS approved a one-year extension of the current demonstration and the amendment request to provide brand name insulin and inhalers when there is no generic alternative. The state may begin offering brand name insulin and inhalers starting January 1, 2016, as specified in in STC 26.

Under this demonstration Missouri expects to achieve the following to promote the objectives of title XIX:

- Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act (ACA);
- Connect the uninsured to a primary care home which will enhance coordination, quality, and efficiency of health care through patient and provider involvement; and
- Maintain and enhance quality service delivery strategies to reduce health disparities.

III. GENERAL PROGRAM REQUIREMENTS

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

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

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

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as necessary, to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

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

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

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not

retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

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

    a. An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;

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

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

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

8. **Extension of the Demonstration.** The Gateway to Better Health demonstration is not a comprehensive, statewide demonstration; therefore, it may only be renewed under section 1115(a) of the Act. No later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS notification that it expects to cover individuals under the Medicaid state plan or through some other type of coverage, a demonstration extension request, or a phase-out plan consistent with the requirements of STC 9.

    As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements at 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

    a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter

and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the plan.

c. Phase-out Plan Requirements: The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, state Health Official Letter #10-008.

e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate, subject to adequate public notice, the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

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

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved Medicaid state plan, when any program changes to the demonstration, are proposed by the state.

    a. In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal and/or renewal of this demonstration (42 C.F.R. §431.408(b) (3)).

    c. The state must also comply with the public notice procedures set forth in 42 C.F.R. 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter or as expressly stated within these STCs.

IV. PRIMARY CARE SUPPORT

16. **St. Louis Regional Health Commission (SLRHC)**. The SLRHC may assist the state with the administrative functions of the Gateway demonstration.

    a. **Managing the Coverage Model:** The state may claim as administrative costs for expenditures incurred by the SLRHC in support of activities related to the implementation and maintenance of the coverage model subject to the following:

        i. The administrative costs must be claimed by the state at monthly intervals based on the number of individuals who meet criteria for Population 1 as outlined in STC 20 in this demonstration.

        ii. The state must ensure that all administrative expenditures claimed based on SLRHC expenditures are consistent with the cost principles under Office of Management and Budget guidance documents and CMS administrative guiding principles as outlined in Attachment B.

        iii. A memorandum of understanding (MOU) exists between the state and SLRHC outlining the administrative activities that SLRHC will perform on the behalf of the state.

        iv. The state must submit a copy of the MOU for CMS review whenever changes are made.

        v. Costs are not to exceed the limits, as outlined in the chart below, per demonstration year in which the coverage model is operational.

Demonstration Year (DY)	Expenditure Limit per Demonstration Year
DY 5/ FFY 2014 (10/1/2013-09/30/2014) (12 months)	$4,500,000
DY 6/ FFY 2015 (10/1/2014 – 9/30/2015) (12 months)	$4,500,000
DY 7/ FFY 2016 (10/1/2015-9/30/2016) (12 months)	$4,500,000
DY 8/ FFY 2017 (10/1/2016 – 12/31/2016) (3 months)	$1,125,000

V. ELEMENTS OF THE SAFETY NET PILOT PROGRAM FOR PARTICIPATING PROVIDERS

This section defines the participating providers in the Pilot Program, payment structures, and associated infrastructure development.

17. **Safety Net Pilot Program Providers Defined.**

    For the purposes of this demonstration, the St. Louis providers eligible for reimbursement under these terms and conditions consist of the following clinics:
    a. Myrtle Hilliard Davis Comprehensive Health Centers;
    b. Grace Hill Neighborhood Health Centers;
    c. Betty Jean Kerr People's Health Centers;
    d. Family Health Care Centers; and
    e. St. Louis County Health Centers.

    Clinics are reimbursed by an alternate payment methodology established at a 100 percent of the Medicare rate, which will be accepted as payment in full, for assigned enrollees.

18. **Specialty Voucher Program Parameters.** Demonstration enrollees seen at the facilities listed above who need physician inpatient services or outpatient hospital care, will receive vouchers for such care, as described below and as funding allows. Parameters for the voucher program are as follows:

    a. Utilization managers will not provide vouchers if funding for specialty care services exceeds its estimated annual funding levels.

    b. The providers that participate in the voucher program may include, but are not limited to Barnes-Jewish Hospital, Washington University School of Medicine, St. Louis University School of Medicine, St. Mary's Hospital, Mercy Health System, St. Alexius Hospital, and Eye Associates.

    c. Specialty care providers will be reimbursed at a rate equal to 100 percent of the Medicare rate for each service.

19. **Incentive Payments.** As part of the payment reform efforts to pay for improved health outcomes, the state may use seven-percent of the provider payment as an incentive to improve provider practices. The provider shall have an opportunity to receive the withheld amount upon demonstrating that the provider has been able to meet measurement targets for improving the health of its enrollees. Any remaining amount will be redirected for services and must not be redirected for administrative or infrastructure payments. Details of the incentive protocol are provided in Attachment D.

    a. The protocol outlines performance metrics that the providers must meet, the schedule on which the providers must submit data, and the date that the state via the SLRHC must make the payment. The state must not claim the federal share of the incentive

payments until the actual payments based on provider performance are made.

VI. ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT UNDER THE SAFETY NET PILOT PROGRAM

20. **Eligibility.**
    a. Individuals eligible for the demonstration are described in the table below.

Population Eligible for the Demonstration	
Population 1: Uninsured Individuals receiving both Primary and Specialty Care through the demonstration	This population is limited to those with incomes at or below 100 percent of the FPL. Specialty care services will be provided solely through the specialty voucher program. Individuals are not eligible under the Medicaid state plan, are living in St. Louis City or St. Louis County, and are between the ages of 19-64 years old.

21. **Screening for Eligibility for Medicaid and/or CHIP.** Demonstration applicants for primary care services and specialty care services must be screened for Medicaid or CHIP eligibility before an eligibility determination is made for the demonstration. The state will follow the same enrollment processes as for Medicaid state plan individuals.

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

23. **Enrollment Target.** The state generally may cap enrollment to stay within budget neutrality. The state shall set an enrollment target for participants enrolled in the demonstration at 21,432 individuals and will not restrict enrollment if that target has not been met. If the enrollment target has been reached, the state will enroll individuals from the wait list based on available funding and when the number of enrolled individuals drops to 21,382.

24. **Managing the Enrollment Target.** The state or the SLRHC may employ a waiting list to enroll in this demonstration using a "first come – first served" method.

    a. The state or SLRHC will provide and accept applications for coverage under the demonstration even when enrollment is closed. Applicants will be checked for other categories of Medicaid or CHIP eligibility and will be added to the waiting list if they are not eligible for such other coverage.

    b. The state or SLRHC must provide written notice to CMS at least 60 days prior to changing the enrollment target.

c. The state or SLRHC will be required to provide written notice to CMS at least 30 days prior to re-establishing program enrollment. The notice to CMS, at a minimum, must include:

i. Data on current enrollment levels in the program;

ii. An analysis of the current budget neutrality agreement; and

iii. The projected timeframe for the enrollment target to be in effect or the period for enrollment into Gateway program.

25. **Disenrollment.** Enrollees shall be disenrolled if any of the following circumstances occur: voluntarily withdraw from the program, no longer reside in a city or county participating in the demonstration, obtain other health insurance coverage, become pregnant; attain age 65; or are deceased. The state will follow the same disenrollment processes for the demonstration populations as for individuals eligible under the Medicaid state plan. In the event that a waiting list is implemented, the state shall contact enrollees who have not utilized services in a six months period regarding their eligibility status via mail. If any of the reasons for disenrollment apply, the state must also screen individuals for health coverage through Medicaid or CHIP prior to providing notice of disenrollment. The state will reopen enrollment per STC 24.

VII. SAFETY NET PILOT PROGRAM BENEFITS

26. **Benefits.** All enrollees shall receive the following benefits subject to the applicable limitations noted in the table below:

Benefit	**Notes/Limitations**
Preventive	Internal, family practice, gynecology
Well care	
Dental	diagnostic, periodontal, preventive
Urgent Care	Up to 5 urgent care visits
Durable Medical Equipment	Crutches, walkers, Wound Vac, and supplies for the Wound Vac
Oncology	
Rheumatology	
Cardiology	
Endocrinology	
Ear, Nose, and Throat	
Gastroenterology	
Internal Medicine	
Neurology	
Ophthalmology	
Orthopedics	
Pulmonology	

Pharmacy	Generics provided through the community health center and brand name insulin and inhalers that are not available in a generic alternative. If other brand name drugs are needed, individuals may apply for coverage under the pharmaceutical manufacturers' Prescription Assistance Program. Brand name insulin and inhalers that are not available in a generic alternative will be available January 1, 2016. If the state cannot provide brand name insulin and inhalers, it must notify CMS in writing that it will not offer this benefit prior to January 1, 2016. Such a change will not require an amendment to the demonstration.
Renal	
Urology	
Non-Emergency Transportation	
Outpatient Surgery	
Radiation therapy	
Laboratory/pathology	
Physical, occupational, or speech therapy	Only as medically necessary after a covered surgery.
Radiology (x-ray, MRI, PET/CT)	

a. All enrollees are eligible for services through the specialty care voucher program. If persons seen at the facilities listed above need physician inpatient services or outpatient hospital care, SLRHC will provide vouchers for such care. In order to access voucher services, a demonstration enrollee must have received care and received a referral from a facility listed in STC 17, within the past 12 months from the date of the request. The service request must be deemed medically necessary by the SLHRC Utilization Management process.

27. **Minimum Essential Coverage.** As the Gateway to Better Health demonstration is limited to primary care and specialty care benefits, the demonstration is not recognized as Minimum Essential Coverage, consistent with the guidance set forth in State Health Official Letter #14-002, issued by CMS on November 7, 2014.

VIII. COST SHARING UNDER THE SAFETY NET PILOT PROGRAM

28. **Cost Sharing.** Cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies and be reflected in the State Plan. Cost sharing shall not exceed amounts permitted under the federal regulation at 42 CFR §447. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR 447.56 apply to the demonstration.

IX. GENERAL REPORTING REQUIREMENTS

29. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX set forth in these STCs.

30. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The state must submit any corrected budget neutrality data upon request.

31. **Quarterly Calls.** CMS will schedule quarterly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration.

    Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, the benefit package, cost-sharing, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS will update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

32. **Quarterly Progress Reports.** The state must submit progress reports within 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. Action plans for addressing any policy, administrative, or budget issues identified.

    d. Quarterly enrollment reports for demonstration-eligible, that include the member months and end-of-quarter, point-in-time enrollment for each demonstration population;

    e. Evaluation activities and interim findings;

    f. Updates on enrollment, disenrollment, and the waiting list (if applicable);

g. Updates on provider incentive payments;

h. Updates on any potential amendment requests such as proposed changes to the benefits, voucher program, or delivery system;

i. Update on the effect of offering brand name insulin and inhalers that are not available in the generic alternative; and

j. Other items as requested.

33. **Annual Report.** The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties and solutions in the operation of the demonstration. The state must also include the following information in its draft annual report:

a. Success and challenges of educating and providing outreach to uninsured populations, with an emphasis on young adults aging out of Medicaid;

b. Data and findings of health status of the population served under the demonstration (The state must provide additional detail regarding measuring the health status of the population served under the demonstration in its draft evaluation design as required in STC 48);

c. Data and findings of cost of providing care to persons served under the demonstration;

d. Analysis on enrollment, waiting list, and disenrollment;

e. Analysis on utilization and performance/outcome trends;

f. Analysis on program implementation and operations barriers and action plans to resolve concerns related to eligibility/enrollment, outreach, provider enrollment, and provider reimbursement;

g. Total cost of voucher services provided under the demonstration; and

h. Information on incentive payments.

The state must submit the draft annual report no later than 120 days after the close of the demonstration year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

34. **Final Report.** The state must submit a final report to CMS to describe the impact of the demonstration, including the extent to which the state met the goals of the demonstration. The draft report will be due to CMS, six months after the expiration of

the demonstration. The state must submit a final report for CMS approval within 60 days of receipt of CMS comments.

X. GENERAL FINANCIAL REQUIREMENTS

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

a. The state will run a summary report identifying the total expenditures to be claimed under the demonstration. The documentation in support of the summary report will be the individual claims paid by the state during the quarter. The state will be able to produce the details of the individual claims upon request.

b. The state will produce reports from the State Accounting System (SAMII) as supporting documentation for the state's expenditures. These reports will identify the amount paid from state appropriations (General Revenue equivalent, Federal Reimbursement Allowance Fund, and federal funds) to Gateway providers.

c. The signed certification of expenditures from the City of St. Louis will be the documentation used by the state to support the amount of local expenditures paid by the City.

d. The signed certification of expenditures from St. Louis County will be the documentation used by the state to support the amount of local expenditures paid by the County.

e. The total computable amount will be claimed on the appropriate CMS 64 Waiver forms. The total computable claimed for a quarter will not exceed the aggregate amount paid by the state, the City of St. Louis, and St. Louis County.

f. The documentation will be maintained at the offices of state and will be made available for review by CMS reviewers, as part of the quarterly review of expenditures, or other federal reviewers or auditors.

g. The Certification of Expenditures by the city of St. Louis and St. Louis County meets the Missouri Partnership Plan (MPP) requirement in Attachments C and D of the MPP since the city of St. Louis and St. Louis County are purchasing services rather than providing services. No further approved protocol is necessary. For example:

Total computable expenditures	$7,500,000 (supported by MMIS reports)
Total paid by state	$6,100,000 (supported by MMIS reports)
Total paid by the City of St. Louis	$1,250,000 (supported by MMIS reports)
Total paid by St. Louis County	$150,000 (supported by MMIS reports)
Total	$7,500,000

36. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure limit.** All expenditures to support the administrative costs of the SLRHC (all years of the demonstration) and the Safety Net Provider Network for primary care and specialty care for demonstration participants are subject to the budget neutrality expenditure limit.

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

a. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00250/7) assigned by CMS, including the project number extension, which indicates the DY in which services were rendered.

b. To simplify monitoring of both demonstration expenditures and remaining DSH payments, DYs will be aligned with federal fiscal years (FFYs). DY 1 is defined as the period from July 28, 2010 (date of the original approval letter) through September 30, 2010. DYs 2 through 7 will coincide with FFYs 2011 through 2016. DY 8 will begin October 1, 2016, and end December 31, 2016.

c. DSH Expenditures. To facilitate monitoring of budget neutrality and compliance with the DSH allotment, the rules below will govern reporting of DSH expenditures for the demonstration. All DSH expenditures are subject to the DSH allotments defined in section 1923(f) of the Act.

    i. All DSH expenditures for FFYs 2011 through 2016 are demonstration expenditures subject to the budget neutrality, and must be reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver for the DY corresponding to the FFY.

    ii. Missouri must report DSH expenditures that are subject to FFY 2017 DSH allotment on CMS 64.9 Waiver and CMS-64.9 until such expenditures equal one-quarter of the DSH allotment minus $7.5 million (total computable), which is the amount to be spent on the Expansion Population for that year. For FFY

2017, demonstration expenses and actual DSH expenditures must not exceed the state DSH allotment.

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

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

v. All DSH expenditures are subject to the auditing and reporting requirements under section 1923(j) of the Act.

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

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

f. **Use of Waiver Forms.** The following five (5) waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration and for residual DSH. The expression in quotation marks are the waiver names to be used to designate the waiver form in the MBES/CBES system.

i. "Grace Hill" expenditures
ii. "Myrtle Davis" expenditures
iii. "Contingency Provider Network" expenditures
iv. "Voucher" expenditures
v. "Residual DSH" expenditures

g. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" refers to all title XIX expenditures made to support the providers on behalf of individuals who are enrolled in this demonstration, as defined in STC 20, including all service expenditures net of premium collections and other offsetting collections. DSH expenditures ("Residual DSH") are also subject to the budget neutrality limit. Total expenditures must not exceed the state's annual DSH allotment. All title XIX expenditures that are subject to the budget neutrality expenditure limit are considered demonstration expenditures and must be reported on Forms CMS-64.9Waiver and/or CMS-64.9P Waiver.

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

i. The administrative costs associated with support of the SLRHC program are subject to the budget neutrality limit and must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY for which the administrative services were paid. A separate form must be submitted, using the waiver name **"SLRHC Adm"** to report expenses related to administrative support of the SLRHC.

ii. Administrative costs that are directly attributable to the demonstration that are not described in this STC must be reported under waiver name "Gateway." These expenses are not subject to the budget neutrality limit, but the state must separately track and report administrative costs that are directly attributable to the demonstration. Directly attributable administrative costs for this demonstration include eligibility determinations made by state staff. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

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

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

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

    a. Administrative costs, including those associated with the administration of the demonstration; and

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

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

    a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

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

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

    d. The non-federal share of the total computable expenditures certified as the basis for federal funds are quarterly medical service demonstration expenditures incurred by the city of St. Louis or St. Louis County as documented through the Quarterly Expenditure Reconciliation process and the Certification of Expenditures Statement. The amounts represented on the Certification of Expenditures Statement are expressed in total computable (state and federal) costs incurred by the city of St. Louis or St. Louis County for eligible and paid medical waiver claims reported to the MMIS for the reporting period. The incurred costs represent medical provider demonstration service claims reimbursed at the rates established through the demonstration. One hundred percent of the total computable service rate payments are paid to and retained by eligible demonstration providers. The non-federal share for all other demonstration service claims are satisfied through the state appropriations to the single state Medicaid agency. The source of non-federal share funds utilized shall not include federal funds or revenue from provider taxes or donations that

do not comport with federal requirements at section 1903(w) of the Social Security Act, implementing regulations and applicable policy guidance.

e. On a quarterly basis, the appropriate executive official of the city of St. Louis will sign the certification statement on the Certification of Expenditures (Attachment C) form. The document presents the total computable quarterly service expenditures incurred by the city of St. Louis for eligible paid waiver claims for which the city funds the non-federal match associated with the payments.

f. On a quarterly basis, the appropriate executive official of St. Louis County will sign the certification statement on the Certification of Expenditures (Attachment D) form. The document presents the total computable quarterly service expenditures incurred by St. Louis County for eligible paid waiver claims for which the county funds the non-federal match associated with the payments.

g. As defined in the Quarterly Expenditure Reconciliation, the quarterly calculation of documented waiver claims is derived from MMIS paid claims reports within the quarter.

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

42. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

43. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 37.

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

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

DY	Budget Neutrality Limit
DY 1	¼ of the FFY 2010 DSH allotment
DYs 2 through 7	Corresponding FFY DSH allotment
DY 8	¼ of the FFY 2017 DSH allotment

For purposes of illustration, the annual expenditure authority cap is shown in the table below.

DY/ FFY	Dates	Annual Expenditure Authority Cap (Total Computable)
DY 1/ FFY 2010 (3 months)	07/28/2010 to 09/30/2010	$7.5 million
DY 2/ FFY 2011	10/01/2010 to 09/30/2011	$30 million
DY 3/ FFY 2012	10/01/2011 to 09/30/2012	$30 million
DY 4/ FFY 2013	10/01/2012 to 09/30/2013	$30 million
DY 5/ FFY 2014	10/01/2013 to 9/30/2014	$30 million
DY 6/FFY 2015	10/1/2014 to 9/30/2015	$30 million
DY 7/ FFY 2016	10/1/2015 to 9/30/16	$30 million
DY 8/FFY 2017 (3 months)	10/1/2016 to 12/31/2016	$7.5 million
Cumulative Total		$195 million

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

47. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality on an annual basis. If the state exceeds the annual budget neutrality expenditure limit in any given DY, the state must submit a corrective action plan to CMS for approval and will repay (without deferral or disallowance) the federal share of the amount by which the budget neutrality agreement has been exceeded.

XII. EVALUATION

48. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval, within 120 days from the extension of the demonstration, an amended draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration. The draft design must discuss the outcome measures that shall be used in evaluating the impact of the

demonstration during the period of approval, particularly among the target population. The draft evaluation design shall include items such as new payment methodology, delivery systems, and the population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The state shall ensure that the draft evaluation design will address the following evaluation questions and topics:

a. How has access to care improved for low-income individuals?

b. How successful is the demonstration in expanding coverage to the region's uninsured by 2 percent each year?

c. To what extent has the demonstration improved the health status of the population served in the demonstration? The state must provide a detailed description of how it will evaluate the health status, including specific data elements, in the draft evaluation design. The evaluation shall report on enrollment, financial, utilization, quality and outcomes metrics.

d. Describe provider incentives and activities.

e. Include comparable FQHC population/providers to compare effectiveness of provider payment incentives.

f. What effect does providing access to brand name insulin and inhalers when there is no generic alternative have on beneficiaries?

49. **Interim Evaluation Reports**. In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

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

51. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with

CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date – Specific	Deliverable	STC Reference
120 days after approval ~ 04/11/2016	Submit revised Evaluation Design	Section XII, STC 48
07/01/2017	Submit Draft Final Report	Section IX, STC 34

	Deliverable	STC Reference
Annual	By February 1st - Draft Annual Report	STC 33
Annual	Within 30 days of receipt of CMS comments – Final Annual Report	STC 33
Quarterly	Quarterly Progress Reports	STC 32

Attachment A: Quarterly Reporting Format

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

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

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – State of Missouri (Gateway to Better Health Demonstration 11-W-00250/7)

Title Line Two - Section 1115 Quarterly Report
Demonstration Reporting Period:

Example:
Demonstration Year: 7 (October 1, 2015 – September 30, 2016)

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

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

Please also include disenrollment information and any updates on the waiting list.

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

Demonstration Program	**Current Enrollees** (to date)
Population 1	

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

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter. Include any updates providing brand name insulin and inhalers when there is no generic available.

Attachment A
Quarterly Reporting Format

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify any updates regarding the source of non-federal share. Identify the state's actions to address these issues.

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

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

Evaluation Activities and Interim Findings:
Identify any evaluation activities and interim findings.

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

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

The state may also add additional program headings as applicable.

Date Submitted to CMS:

Attachment B
Administrative Cost Claiming Rules and Protocol

I. Preface

As part of the total amount payable under the demonstration authority granted under section 1115(a)(2) of the Social Security Act (the Act)by the Centers for Medicare and Medicaid Services (CMS) to the Gateway for Better Health (GBH), federal financial participation (FFP) as authorized by 42 Code of federal regulations (CFR) 433.15 is available to GBH at the 50 percent rate for administrative costs required for "proper and efficient" administration of the demonstration subject to the limitations outlined below.

The following guidance and protocols are based on and in response to information submitted in writing or otherwise communicated to CMS and are provided to inform the state and assist the state in its efforts to comply with the rules and protocols regarding claiming for FFP for administrative expenditures incurred by the state and/or its contractors under this demonstration.

a. General Requirements

The state must comply with all federal statute, regulations and guidance for all claims for FFP.

In order for the costs of administrative activities to be claimed as Medicaid administrative expenditures at the 50% FFP rate, the following requirements must be met:

- Costs must be “necessary for the proper and efficient administration of the Medicaid state plan” (Section 1903(a)(7) of the Social Security Act).
- If applicable, costs must be allocated in accordance with the relative benefits received by all programs, not just Medicaid.
- Claims for costs must not duplicate costs that have been, or should have been, paid through another source.
- State or local governmental agency costs must be supported by an allocation methodology under the applicable approved public assistance Cost Allocation Plan (42 CFR 433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility or otherwise include costs of a direct service to beneficiaries (these should be claimed as service costs, not plan administration).
- Costs must not duplicate activities that are already being offered or should be provided by other entities, or through other programs.
- Costs must be supported by adequate source documentation.
- Costs must not be federally-funded or used for any other federal matching purposes.

b. Interagency Agreements/Memorandum of Understanding (MOU)

Because only the state Medicaid agency may submit a claim to CMS to receive FFP for allowable and properly allocated Medicaid costs, every participating entity that is performing administrative activities on behalf of the Medicaid program must be covered, either directly or indirectly, through an interagency agreement. These agreements must be in effect before the

Medicaid agency may claim federal matching funds for any administrative activities conducted by the St. Louis Regional Health Commission (SLRHC) as detailed in the agreement with the Medicaid agency.

In order to provide a basis for FFP to be claimed, the agreement must describe and define the relationships between the state Medicaid agency and the SLRHC and must document the scope of the activities being performed by the SLRHC. The interagency agreement must include:

- Mutual objectives of the agreement;
- Responsibilities of all the parties to the agreement;
- Activities or services each party to the agreement offers and under what circumstances;
- Cooperative and collaborative relationships at the state and local levels;
- Specific administrative claiming time study activity codes which have been approved by CMS, by reference or inclusion;
- Specific methodology which has been approved by CMS for computation of the claim, by reference or inclusion;
- Methods for reimbursement, exchange of reports and documentation, and liaison between the parties, including designation of state and local liaison staff.

The interagency agreement should address the Medicaid administrative claiming process, identify the services the state Medicaid agency will provide for the local entity, including any related reimbursement and funding mechanisms, and define oversight and monitoring activities and the responsibilities of all parties. All participation requirements the state Medicaid agency determines to be mandatory for ensuring a valid process should be detailed in the agreement. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are all important elements of the interagency agreement. Also, the specific methodologies, which may include a standardized claim form, the mechanism for filing the claim, and the approved allocation methodology that may include use of a time study by the local entity, are valid agreement elements.

Many interagency agreements require the governmental agency that performs the administrative activities to provide the required state match for Medicaid administrative claiming. As always, the non-federal share of the Medicaid payments must be derived from permissible sources (e.g., appropriations, Intergovernmental transfers, certified public expenditures, provider taxes) and must comply with federal regulations and policy.

c. Identification, Documentation and Allocation of Costs

All administrative costs (direct and indirect) are normally charged to federal grant awards such as Medicaid through the state's public assistance Cost Allocation Plan (CAP). Federal regulations (42 CFR 433.34) require that under the Medicaid state plan, the single state agency have an approved public assistance cost allocation plan (CAP) on file with the Division of Cost Allocation in the U.S. Department of Health and Human Services that meets certain regulatory requirements, which are specified at Subpart E of 45 CFR part 95 and referenced in OMB Circular A-87. There are certain items that must be in the public assistance CAP which a state Medicaid agency must submit before providing FFP for administrative claiming. The public

assistance CAP must make explicit reference to the methodologies, claiming mechanisms, interagency agreements, and other relevant issues pertinent to the allocation of costs and submission of claims by the participating entities.

Documentation for administrative activities must clearly demonstrate that the activities directly support the administration of the Medicaid program. In accordance with the statute, the regulations, and the Medicaid state plan, the state is required to maintain/retain adequate source documentation to support Medicaid payments. The basis for this requirement can be found in statute and regulations. See section 1902(a)(4) of the Act and 42 CFR 431.17; see also 45 CFR 92.20(b) and 42 CFR 433.32(a) (requiring source documentation to support accounting records) and 45 CFR 92.42 and 42 CFR 433.32(b and c) (retention period for records). The records must be made available for review by state and federal staff upon request during normal working hours (section 1902(a) (4) of the Act, implemented at 42 CFR 431.17).

When states submit claims for FFP for Medicaid administration, only costs directly related to Medicaid administration are allowable and these costs must be allocated according to accepted cost principles. Since most administrative activities are provided both to Medicaid and non-Medicaid eligible individuals, the costs applicable to these activities must be allocated to both groups.

d. Administrative FFP for Skilled Professional Medical Personnel

In addition to the 50 percent federal Medicaid administrative matching rate, Section 1903(a)(2) of the Act provides for FFP at 75 percent for expenditures attributable to the compensation and training of skilled professional medical personnel (SPMP) of the state agency (See also 42 CFR 432.2, 432.45, 432.50 and 433.15.)

The state has not identified to CMS any activities under this demonstration that are reimbursable at the enhanced 75 percent SPMP matching rate.

Note: Administrative costs incurred that are an integral part of, or an extension of, the provision of services by medical providers , are to be included in the rate paid by the state or its fiscal agent for the medical service There is no additional FFP available.

II. General Conditions

Under the Gateway to Better Health, the state must:

1. Obtain prior approval from CMS for any changes to the methodology used to capture or claim FFP for administrative costs associated with the demonstration
2. Describe how it will offset other revenue sources for administrative expenditures associated with the demonstration, if applicable.
3. Detail the oversight and monitoring protocol to oversee administrative claiming for the demonstration.
4. Obtain prior approval for any new categories of administrative expenditures to be claimed under the demonstration.

5. Agree to permit CMS to review any forms and/or documents that are subsequently developed for use by this program, prior to modification or execution.
6. Submit all necessary changes to the Medicaid administrative claiming plan to CMS for review and approval prior to implementation.

Attachment C

Certification of Expenditures
By St. Louis City
For the Missouri Gateway to Better Health Waiver

I certify that:

1. I am the executive officer of St. Louis City or his/her designate authorized by the City to submit this form.

2. This certification only includes expenditures that are allowable in accordance with the approved Gateway to Better Health waiver.

3. The expenditures included in this report are based on actual recorded expenditures for the period _____ through _____, and are not based on estimates.

4. The city funds in the amount of $_____were paid for primary or specialty care and were used to match the allowable waiver expenditures for the same time period referenced above, and were in accordance with all applicable federal requirements for the non-federal share of expenditures.

5. The information shown above is correct to the best of my knowledge and belief.

_____

Name Title

_____

Signature Date

Attachment D

Certification of Expenditures
By the County of St. Louis
For the Missouri Gateway to Better Health Waiver

I certify that:

1. I am the executive officer of the county of St. Louis or his/her designate authorized by the county to submit this form.

2. This certification only includes expenditures that are allowable in accordance with the approved Gateway to Better Health waiver.

3. The expenditures included in this report are based on actual recorded expenditures for the period _____ through _____, and are not based on estimates.

4. The county funds in the amount of $_____were paid for primary or specialty care and were used to match the allowable waiver expenditures for the same time period referenced above, and were in accordance with all applicable federal requirements for the non-federal share of expenditures.

5. The information shown above is correct to the best of my knowledge and belief.

_____

Name Title

_____

Signature Date

Attachment E
Incentive Payment Protocol

Incentive Payments

The state will withhold 7% from payments made to the primary care health centers (PCHC) through December 31, 2016, and the amount withheld will be tracked on a monthly basis. The SLRHC will be responsible for monitoring the PCHC performance against the pay-for-performance metrics outlined below.

Pay-for-performance incentive payments will be paid out at six-month intervals of the Pilot Program based on performance during the reporting period. The state must not claim the federal share of the incentive payments until the actual payments based on provider performance are made.

Reporting Periods:

- July 1, 2012 – December 31, 2012
- January 1, 2013 – June 30, 2013
- July 1, 2013 – December 31, 2013
- January 1, 2014 – June 30, 2014
- July 1, 2014 –December 1, 2014
- January 1, 2015 – June 30, 2015
- July 1, 2015 – December 31, 2015
- January 1, 2016 – June 30, 2016
- July 1, 2016 - December 31, 2016

SLRHC will calculate the funds due to the providers based on the criteria and methodologies described below and report the results to the state. The state will disburse funds within the first quarter following the end of the reporting period. PCHC are required to provide self-reported data within 30 days of the end of the reporting period.

Primary Care Health Center Pay-for-Performance Incentive Eligibility
Below are the criteria for the PCHC first incentive payments to be paid within the first quarter following the end of the reporting period:

TABLE 1

Pay-for-Performance Incentive Criteria	**Threshold**	**Weighting**	**Source**
All Newly Enrolled Patients Minimum of at least 1 office visit within 1 year (6 months before/after enrollment date)	80%	20%	EHR data
Patients with Diabetes, Hypertension, CHF or COPD – Minimum of at least 2 office visits within 1 year (6 months before/after reporting period start date)	80%	20%	EHR Data
Patients with Diabetes – Have one HgbA1c test within 6 months of reporting period start date	85%	20%	EHR data

Patients with Diabetes – Have a HgbA1c less than or equal to 9% on most recent HgbA1c test within the reporting period	60%	20%	EHR Data
Hospitalized Patients - Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days after hospital discharge.	50%	20%	Self-reported by health centers and AHS Call Center Data
TOTAL POSSIBLE SCORE		**100%**	

Objective measures may be changed for the subsequent reporting period. Any changes or additions will be approved by the Pilot Program Planning Team managed by the SLRHC at least 60 days in advance of going into effect. At no time will changes to the measures go into effect for a reporting period that has already commenced. (Note: the health centers and state are represented on the Pilot Program Planning Team.) Any changes to the measures will be included in an updated protocol and subject to CMS review.

Any remaining funds will be disbursed based on the criteria summarized below and will be paid within the first quarter following the end of the reporting period:

TABLE 2

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
Rate of Referral to Specialist among Demonstration Enrollees	680/1,000 analysis	100%	Referral data

The primary care providers will be eligible for the remaining funds based on the percentage of Demonstration Population 1 individuals enrolled at their health centers. For example, if Grace Hill has 60% of the primary care patients and Myrtle Hilliard Davis 40%, they would each qualify up to that percentage of the remaining funds. Payments will not be redirected for administrative or infrastructure payments.

Within the first quarter following the end of the reporting period, the state will issue incentive payments to the health centers. Incentive payments will be calculated based on the data received and the methodology described below.

Primary Care Health Center (PCHC) Calculations

Step 1: Calculate the PCHC Incentive Pool (IP) for each PCHC.

- IP = PCHC Payments Earned x 7%

Step 2: Calculate the Incentive Pool Earned Payment (IPEP) that will be paid to each PCHC.

- Identify which performance metrics were achieved
- Determine the total Incentive Pool Weights (IPW) by adding the weights of each performance metric achieved
- *Example:* If the PCHC achieves 3 of the 5 performance metrics, then: IPW = 20% + 20% + 20% = 60%
- IPEP = IP x IPW

Step 3: Calculate the Remaining Primary Care Incentive Funds (RPCIF) that are available for performance metrics not achieved.

- Add the IP for each PCHC to derive the Total IP
- Add the IPEP for each PCHC to derive the Total IPEP
- RPCIF = Total IP – Total IPEP

Step 4: Calculate member months (MM) per reporting period for each PCHC (CMM) and in total (TMM).

- CMM = Total payments earned by **each** PCHC during the reporting period / Rate
- TMM = Total payments earned by **all** PCHC during the reporting period / Rate

Step 5: Calculate the Proportionate Share (PS) of the RPCIF that is available to each PCHC.

- PS = RPCIF x (CMM/TMM)

Step 6: Calculate the Remaining Primary Care Incentive Fund Payment (RPCIFP) for each PCHC.

Example: If the PCHC achieves both the emergency room utilization and specialty referral performance metrics, then:

IPW = 30% + 70% = 100% (effective 07/01/2012 through 12/31/2013)
IPW = 100% (effective 01/01/2014 through 12/31/2016)

- RPCIFP = PS x IPW

The following scenarios illustrate the calculations for Step 3 through Step 6 explained above as well as the final amounts withheld and paid to each PCHC based on the assumptions of these scenarios. These scenarios are provided for illustrative purposes only and are not a prediction of what may actually occur.

SCENARIO 1

Key assumptions:

- $40,000 remains in the primary care incentive pool after the first round of disbursements based on the criteria listed in Table 1.
- Each PCHC met both performance metrics for emergency room and specialty referrals based on the criteria listed in Table 2.

Table 1A - Identifies the remaining incentive funds to be disbursed to PCHC.

STEP 3

	7% Withheld	Earned	Remaining (Unearned)
Grace Hill	$ 200,000	$200,000	$ -
Myrtle Hilliard	$ 100,000	$ 75,000	$ 25,000
Family Care	$ 20,000	$ 20,000	$ -
BJK People's	$ 50,000	$ 40,000	$ 10,000
St. Louis County	$ 50,000	$ 45,000	$ 5,000
Total	$ 420,000	$380,000	**$ 40,000**

Remaining Primary Care Incentive Funds

Table 1B - Identifies each PCHC proportionate share of the remaining incentive funds.

STEP 4 ***STEP 5***

	Gross Earnings	# of Member Months	% of Member Months	PCHC Proportionate Share
Grace Hill	$ 2,857,143	54,966	48%	$ 19,200
Myrtle Hilliard	$ 1,428,571	27,483	24%	$ 9,600
Family Care	$ 285,714	5,497	4%	$ 1,600
BJK People's	$ 714,286	13,742	12%	$ 4,800
St. Louis County	$ 714,286	13,742	12%	$ 4,800
Total	**$ 6,000,000**	**115,430**	100%	**$ 40,000**

Table 1C - Computes the remaining primary care incentive fund payment (RPCIFP) for each PCHC assuming the performance metrics for both emergency department utilization and specialty referral metrics are met (Table 2).

Step 6

	PCHC Proportionate Share	IPW	RPCIFP
Grace Hill	$ 19,200	100%	$ 19,200
Myrtle Hilliard	$ 9,600	100%	$ 9,600
Family Care	$ 1,600	100%	$ 1,600
BJK People's	$ 4,800	100%	$ 4,800
St. Louis County	$ 4,800	100%	$ 4,800
Total	**$ 40,000**		**$ 40,000**

Table 1D - Shows the total withheld, earned and paid for each PCHC.

	7% Withheld	Earned	RPCIFP	Total Paid
Grace Hill	$ 200,000	$200,000	$ 19,200	$ 219,200
Myrtle Hilliard	$ 100,000	$ 75,000	$ 9,600	$ 84,600
Family Care	$ 20,000	$ 20,000	$ 1,600	$ 21,600
BJK People's	$ 50,000	$ 40,000	$ 4,800	$ 44,800
St. Louis County	$ 50,000	$ 45,000	$ 4,800	$ 49,800
Total	$ 420,000	$380,000	$ 40,000	**$ 420,000**

SCENARIO 2

Key assumptions:

- $40,000 remains in the primary care incentive pool after the first round of disbursements based on the criteria listed in Table 1.
- Some PCHC do not meet both performance metrics for emergency room and specialty referrals based on the criteria listed in Table 2.

Table 2A - Identifies the remaining incentive funds to be disbursed to PCHC.

STEP 3

	7% Withheld	Earned	Remaining (Unearned)
Grace Hill	$ 200,000	$200,000	$ -
Myrtle Hilliard	$ 100,000	$ 75,000	$ 25,000
Family Care	$ 20,000	$ 20,000	$ -
BJK People's	$ 50,000	$ 40,000	$ 10,000
St. Louis County	$ 50,000	$ 45,000	$ 5,000
Total	$ 420,000	$380,000	**$ 40,000**

Remaining Primary Care Incentive Funds

Table 2B - Identifies each PCHC proportionate share of the remaining incentive funds.

STEP 4 ***STEP 5***

	Gross Earnings	# of Member Months	% of Member Months	PCHC Proportionate Share
Grace Hill	$ 2,857,143	54,966	48%	$ 19,200
Myrtle Hilliard	$ 1,428,571	27,483	24%	$ 9,600
Family Care	$ 285,714	5,497	4%	$ 1,600
BJK People's	$ 714,286	13,742	12%	$ 4,800
St. Louis County	$ 714,286	13,742	12%	$ 4,800
Total	**$ 6,000,000**	**115,430**	100%	**$ 40,000**

Table 2C - Computes the remaining primary care incentive fund payment (RPCIFP) for each PCHC assuming that some providers did not meet both performance metrics for emergency department utilization and/or specialty referrals.

Step 6

	PCHC Proportionate Share	IPW	RPCIFP	Unused Funding for Medical Services
Grace Hill	$ 19,200	100%	$ 19,200	$ -
Myrtle Hilliard	$ 9,600	70%	$ 6,720	$ 2,880
Family Care	$ 1,600	100%	$ 1,600	$ -
BJK People's	$ 4,800	30%	$ 1,440	$ 3,360
St. Louis County	$ 4,800	0%	$ -	$ 4,800
Total	**$ 40,000**		**$ 28,960**	**$ 11,040**

Table 2D - Shows the total withheld, earned and paid for each PCHC.

	7% Withheld	Earned	RPCIFP	Total Paid
Grace Hill	$ 200,000	$200,000	$ 19,200	$ 219,200
Myrtle Hilliard	$ 100,000	$ 75,000	$ 6,720	$ 81,720
Family Care	$ 20,000	$ 20,000	$ 1,600	$ 21,600
BJK People's	$ 50,000	$ 40,000	$ 1,440	$ 41,440
St. Louis County	$ 50,000	$ 45,000	$ -	$ 45,000
Total	$ 420,000	$380,000	**$ 28,960**	**$ 408,960**

The state will determine with the SLRHC where the demand exists in the Pilot Program (primary care or specialty care) to determine where to apply the remaining funds. Payments will not be redirected for administrative or infrastructure payments.