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 amended STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The amended STCs are effective date of approval unless otherwise specified, through December 31, 2014.

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
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XI. Monitoring Budget Neutrality for the Demonstration
XII. Milestones
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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. In addition to the expenditures to the five safety net providers, the demonstration covered expenditures for the administrative support of the demonstration by the St. Louis Regional Health Commission (SLRHC) and expenditures for the use of community referral coordinators. 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). This authority will terminate on June 30, 2012 as the state works to implement other strategies to ensure coverage through the area's safety net providers. Under this authority, payment may be made for otherwise uncompensated ambulatory care at specific facilities for the approved demonstration period, to the extent that the state reduces DSH payments below statutorily authorized levels. These entities include:

St. Louis ConnectCare;
Grace Hill Neighborhood Health Center; and
Myrtle Hilliard Davis Health Center.

By July 1, 2012, the state must implement a pilot program, as described below, whereby it will provide 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).

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 has 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.

The demonstration was amended in June 2012 to provide for the Safety Net Pilot Program to be implemented by July 1, 2012 as a bridge to coverage expansion under the Affordable Care Act. The amendment proposed to expand eligibility under the demonstration to include individuals with incomes between 134-200 percent of the (FPL) for specialty care services; allow an individual to be eligible for an 18-month period; implement a new performance and incentive structure for the primary care and specialty care providers; and track health outcomes in the demonstration.

Under this demonstration, as amended in June 2012, 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.
- Maintain and enhance quality service delivery strategies to reduce health disparities.
- Have the affiliation partners provide health care services to an additional 2 percent of uninsured individuals over the current services levels by July 1, 2012.
- Transition the affiliation partner community to a coverage model, as opposed to a direct payment model, by July 1, 2012.

The following changes are effective the date of the accompanying approval letter through December 31, 2014 except as otherwise noted.

- Effective through December 31, 2013, expenditures are authorized for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between 19 and 64 years of age with income up to 133 percent of the FPL to pay for primary care provided by a designated primary care provider or specialty care provided by either Connect Care or other specialty provider when referred by a designated primary care provider. Effective January 1, 2014, expenditures are only authorized for such individuals with incomes up to 100 percent of the FPL effective January 1, 2014 through December 31, 2014;
- Effective through December 31, 2013, expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between 19 and 64 years of age with income up to 133 percent of the FPL to pay for specialty care services provided by ConnectCare or other specialty care provider when referred by any non-designated primary care provider under this demonstration. This expenditure authority expires December 31, 2013; and
- Effective through December 31, 2013, expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between 19 and 64 years of age with income between 134 through 200 percent of the FPL to pay for specialty care services provided by ConnectCare or other specialty care provider when referred by any participating primary care provider in this demonstration. This expenditure authority expires on December 31, 2013.

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 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 public notice requirements outlined in STC 14, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project; reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met, as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

   b. STCs: The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time. Consistent with federal law, CMS reserves the right to deny approval for a requested extension 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.

   c. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

d. Quality: The state must provide summaries of External Quality Review Organization reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e. Compliance with the Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up-to-date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

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 and the tribal consultation

requirements contained in the state's approved Medicaid state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

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)).

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)).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.

16. **Transition Plan**. The state is required to submit a draft and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act 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 without interruption in coverage to the maximum extent possible. This plan is due to CMS by June 30, 2014. In addition, the plan will include a schedule of implementation activities that the state will use to operationalize the transition plan.

    a. Seamless Transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The state must determine eligibility for all Medicaid eligible for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

    b. Progress Updates: After submitting the initial Transition Plan for CMS approval, the state must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

    c. The state shall provide additional information as needed.

IV. PRIMARY CARE SUPPORT:

17. **Temporary Support for Uncompensated Ambulatory Care:** Through June 30, 2012, amounts not to exceed $30 million (total computable) annually may be paid for otherwise uncompensated ambulatory care at St. Louis ConnectCare, Myrtle Hilliard Davis Comprehensive Health Centers, and Grace Hill Neighborhood Health Centers to further the goal of transitioning the St. Louis health care delivery system for persons with low-income to a viable, self-sustaining model.

    a. **St. Louis Regional Health Commission (SLRHC).** Effective through December 31, 2013, the state may claim administrative costs for expenditures incurred by the SLRHC to assess benefits provided under the demonstration and to direct payments from the state to the safety net providers.

        i. Allowable SLRHC administrative costs for each year of the demonstration (DY) are the lesser of:

Demonstration Year	% of Admin	Annual Expenditure Cap
DY 1/FFY10 (3 months)	1 percent	$75,000
DY 2/FFY 2011	1 percent	$300,000
DY 3/FFY 2012	1 percent	$300,000
DY 4/FFY 2013	1 percent	$300,000
DY 5/FFY 2014 (3 months)	1 percent	$75,000

        ii. If the state is unable to meet the enrollment target as outlined in STC 27 by the end of the DY 4, no SLRHC administrative costs will be allowable in demonstration (DY5).

    b. **Managing the Coverage Model:** Effective through December 31, 2014, 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. Beginning July 1, 2012, the administrative costs shall be claimed by the state at monthly intervals based on the number of individuals who meet criteria for Population 1 as outlined in STC 23 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.

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	Expenditure Limit per Demonstration Year
DY 3/FFY 2012 (7/1/2-12-9/30/2012)	$1,075,000
DY 4/FFY 2013	$4,350,000
DY 5/FFY 2014 (10/1/2013-12/31/2013)	$1,075,000
DY5/FFY 2014 (1/1/2014-9/30/2014))	3,375,000
DY 6/FFY 2015 (10/1/2014-12/31/2014 months)	$1,125,000

c. **Community Referral Coordinator (CRC) Program Overview.** Effective through December 31, 2013, the CRCs are case workers who educate uninsured individuals that present at emergency rooms on available resources for primary/non-emergent care, to schedule follow-up appointments with primary care providers, and arrange transportation to appointments.

These services are coordinated with individuals while they are in the emergency room.

In addition, the CRCs work with health coaches in the primary care clinics to make sure all information has been gathered and arrangements have been made to facilitate an individual's transition to a primary care site. CRC Personnel may work in the following hospitals: Barnes-Jewish Medical Center; St. Louis University Medical Center; and the St. Mary's Medical Center.

The CRC Program may expand to the following hospitals:

- DePaul Medical Center;
- Christian Northeast Medical Center;
- St. Louis Children's Hospital; and
- Cardinal Glennon Children's Hospital.

For one quarter in demonstration years 1 and 5, the state may provide up to $175,000 (total computable) each year to support administrative expenses of the CRC Program. For demonstration years 2-4, the state may provide up to $700,000 (total computable). The goal of the program is to ensure that access to community health centers are enhanced and that emergency departments are utilized for true emergencies. The expenditures are subject to the following:

i. The expenditures are claimable as administrative claiming activities, and reimbursable at the general 50 percent FFP rate for administrative expenditures, insofar as they are necessary for the proper and efficient administration of the demonstration, as described at section 1903(a)(7) of the Act and federal regulations at 42 CFR 433.15.

ii. The state must ensure that all administrative expenditures claimed based on CRC program expenditures are consistent with the cost principles under Office of Management and Budget guidance documents.

iii. A memorandum of understanding (MOU) must be established between the state and CRC program outlining the administrative activities that CRC program will perform on the behalf of the state.

iv. The state must submit a copy of the MOU for CMS review.

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

Effective July 1, 2012, this section defines the participating providers in the Pilot Program, payment structures, and associated infrastructure development through December 31, 2014 unless otherwise indicated.

18. **Safety Net Provider Pilot Program.** By July 1, 2012, the state must implement a pilot program, as described below, which would provide health insurance coverage for demonstration enrollees described in section VI. The state must meet the additional milestones described in STC 56 to ensure successful implementation of the pilot program. The goal of the pilot program is to serve as a bridge to Affordable Care Act coverage. The elements of the pilot program with respect to eligibility, benefits, cost-sharing, and delivery systems are addressed in Sections VI-VIII of these STCs.

19. **Safety Net Pilot Program Providers Defined.** The state will provide financial support via the SLRHC to pay for otherwise uncompensated ambulatory care at providers associated with the St. Louis Safety Net Provider Network.

    For the purposes of this demonstration, the St. Louis providers eligible for reimbursement under these terms and conditions consist of Legacy FQHCs, non-Legacy community health centers, and St. Louis ConnectCare as described below:

a. **Legacy FQHCs:** Legacy FQHCs are four primary care clinics affiliated with the former St. Louis Regional Hospital and a part of the St. Louis Safety Net Provider Network. Primary care providers at these sites will provide Tier 1 primary care services, as described in STC 30. These clinics include: two clinics operated by Myrtle Hilliard Davis Comprehensive Health Centers (Homer G. Phillips Clinic and Florence Hill Health Center) and two clinics operated by the Grace Hill Neighborhood Health Centers (Murphy-O'Fallon Center and Soulard-Benton Center).

    i. From the beginning of the demonstration to June 30, 2012, the state will provide financial support for the four clinics via SLRHC authority to pay for otherwise uncompensated ambulatory care.

    ii. Beginning July 1, 2012, through the expiration of the demonstration on December 31, 2014, clinics will be 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.

b. **Non–Legacy Community Health Centers:** Non-legacy community health centers are eleven clinics connected with the St. Louis Safety Net provider network. These non-legacy community health centers may provide Tier 1 primary care services for demonstration population 1 beneficiaries, if the Legacy FQHCs cannot provide the Tier 1 primary care services on-site (i.e. operations of the Legacy FQHC is affected and/or different primary care services are available at different sites); qualified individuals in population 2 whose medical home is a non-Legacy community health centers may receive specialty services, upon referral, as described below.

    i. Beginning July 1, 2012, non-legacy community health centers that are a part of the St. Louis provider network will serve as the eligibility sites for determining referrals for specialty services.

    ii. Beginning July 1, 2012, non-Legacy community health centers may be reimbursed for the provision of primary care services to Population 1 if capacity is reached at the Legacy sites. If these payments are made, the services shall appear on any financial reporting as contingency network providers. These payments shall be subject to the same incentive and reimbursement criteria as the Legacy FQHCs.

    iii. Beginning January 1, 2014, non-Legacy community health centers shall become designated primary care providers that may provide primary care services as well as refer population 1 for specialty care services.

    iv. Non-Legacy Community Health Centers include:

        1. Grace Hill Health Centers (non-legacy clinics);
        2. Myrtle Hilliard Davis Comprehensive Health Centers (non-legacy clinics);

3. Betty Jean Kerr People's Health Centers;
4. Family Care Health Centers; and
5. St. Louis County Health Centers.

c. **St. Louis ConnectCare:** ConnectCare is a specialty provider network formerly associated with the St. Louis Regional Hospital. Specialists within the network shall provide Tier 2 specialty care services, as described in STC 30. Eligible individuals in need of specialty care services will receive care at ConnectCare upon referral from a participating Legacy FQHCs or Non-Legacy community health center. This authority expires as of December 31, 2013,

i. From the date of the initial award until June 30, 2012, the state will fund operations and the provision of care via the SLRHC.

ii. Beginning July 1, 2012, care provided to population 1, as defined in STC 23, will be reimbursed on an alternative payment rate at 120 percent of Medicare. Care provided for populations 2 and 3 shall be reimbursed fee-for-service at 120 percent of Medicare. Pharmacy provided for populations 2 and 3 shall be reimbursed on an alternative payment rate.

iii. Additionally, ConnectCare will be eligible to draw payments for infrastructure payments as defined in STC 22.

20. **Specialty Voucher Program Parameters.** From the beginning of the demonstration through December 31, 2014, if persons seen at the facilities listed above need physician inpatient services or outpatient hospital care not offered or available either through ConnectCare, vouchers for such care, as described below and as funding allows, will be available to demonstration enrollees. The provision of voucher services shall assist the state in meeting access to care requirements consistent with section 1902(a)(30)(A) of the Act. 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 of $4,850,000 (total computable) in demonstration year (DY) 1, $19,400,000 (total computable) in DY 2, and $14,550,000 (total computable) in DY3.

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% of the Medicare rate for each service.

21. **Incentive Payments.** Effective through December 2014, as a 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 will be provided in Attachment D.

a. The protocol will outline performance metrics that the providers must meet, schedule on which the providers must submit data, and the date that the SLRHC must make the payment, and the reconciliation process for any overpayments which cannot be converted into coverage.

b. The state will submit the incentive protocol as a part of Attachment D to CMS for review and approval by September 1, 2012. The one percent administrative portion will be withheld until the state is able to provide the protocol.

c. Any incentive payment that is unclaimed by providers, must be rolled into coverage. In the event that an increase in enrollment is not possible, the SLRHC will reconcile any overpayment with the state at the end of the demonstration period. CMS will defer the last quarter of payment until the reconciliation is made.

22. **Infrastructure Payments**. Effective through December 31, 2013, a portion of the $30 million total computable demonstration funds may be allocated to support health care delivery system infrastructure costs for ConnectCare only. The infrastructure payments are to support activities/initiatives that will be used to improve access, improve provider operations, and increase business efficiencies. These payments shall not be duplicative of other cost considerations in the service payment rates to ConnectCare providers or any other payment provided under the demonstration. Activities may include, but are not limited to, costs associated with purchasing billing software, hardware for systems, and/or costs associated with extended hours of operations.

a. The costs shall not exceed $2.9 million total computable from July 1, 2012 through December 31, 2013.

b. In the event that the state is at risk for exceeding the $30 million total computable, the state must prioritize reimbursing services and benefits for enrollees before disbursing the infrastructure funds related to this STC. All such expenditures must be consistent with applicable cost principles under the Office of Management and Budget guidance documents. Any unspent dollars from the infrastructure pool cannot carry over into the next demonstration year.

c. Allowable infrastructure costs may include, but are not limited to, costs associated with purchasing billing software, hardware for systems, costs associated with extended hours of operation, salaries, benefits and payroll taxes, professional and contractual services, supplies, insurance, occupancy costs, depreciation, and other miscellaneous costs associated with provider operations.

d. The state must meet the enrollment limits outlined in STC 27 in order to claim infrastructure payments in DY 5.

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

23. **Eligibility.**
    a. From July 1, 2012 through December 31, 2014, individuals eligible for the demonstration under one of the following populations are as follows:

Populations eligible for the Demonstration	
Population 1: Uninsured Individuals receiving both Primary and Specialty Care through the demonstration	Effective through 12/31/13, uninsured individuals, ages 19-64 years, residing in St. Louis City or St. Louis County, with family incomes between 0 and 133 percent of the federal poverty level (FPL) who do not meet eligibility requirements of the Medicaid state plan and receive care through a designated primary care provider under the demonstration and/or are referred to ConnectCare for specialty care. Effective 1/1/14, this population will be limited to those with incomes at or 100 percent of the FPL. Specialty care services will be provided solely through the specialty voucher program
Population 2: Uninsured Individuals receiving only Specialty Care through the demonstration	Effective through 12/31/13, uninsured individuals, ages 19-64 years, residing in St. Louis or St. Louis County with family incomes between 0 and 133 percent of the FPL who do not meet eligibility requirements of the Medicaid state plan who have been referred to ConnectCare for specialty care, and are not enrolled for primary care benefits by a primary care provider under the demonstration.
Population 3: Uninsured Individuals receiving only Specialty Care through this demonstration	Effective through 12/31/13, uninsured individuals, ages 19-64 years, residing in St. Louis or St. Louis County, with family income between 134 and 200 percent of the FPL who do not meet eligibility requirements of the Medicaid state plan who have been referred to ConnectCare for specialty care and are not enrolled for primary care benefits from a designated primary care provider under the demonstration.

24. **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.

25. **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.

26. **Eligibility Period.** An individual who meets program eligibility criterion who is determined eligible prior to December 31, 2013, will remain eligible for an 18-month period or until the end of the demonstration, whichever is first. Beginning January 1, 2014, anyone determined eligible will be determined for a 12-month period or until the end of the demonstration, whichever is first. Beginning October 1, 2013, individuals with income above 100 percent of the FPL will be referred to appropriate health coverage options beginning January 1, 2014.

27. **Enrollment Target.** The state generally may cap enrollment to stay within budget neutrality. The state will maintain enrollment caps for primary care services provided at the Legacy FQHCs. The state shall set an enrollment target for participants enrolled in a Gateway to Better Health primary care clinic at 16,894 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 16,844.

28. **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.

d. In the event that the enrollment target is not met by July 1, 2013, the state must provide CMS with an enrollment plan outlining barriers to reaching the enrollment targets and details to increase enrollment. If enrollment does not increase by September 30, 2013, CMS shall withhold the 1 percent annual administrative expenditure in first quarter of DY 5. Additionally, CMS will defer the infrastructure payment in the first quarter of DY5 until the state is able to increase enrollment.

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29. **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 28.

VII. SAFETY NET PILOT PROGRAM BENEFITS

30. **Benefits.** Beginning July 1, 2012, through December 31, 2014, all enrollees shall receive Tier 1 and/or Tier 2 services dependent on one's income:

a. Enrollees in population 1, as defined in STC 23, are eligible for Tier 1, primary care services (listed below), through the Legacy FQHCs and non-Legacy Community Health Centers, if applicable under STC 19.b, with limitations noted in Table 2 below.

Table 2	
Tier 1 Benefit	**Notes/ Limitations**
Preventive	Internal, family practice, gynecology
Well care	
Dental	diagnostic, periodontal, preventive
Pharmacy	Generics at Legacy FQHCs and non-Legacy community health centers, if applicable; if brand names are required, individuals may apply for coverage under the pharmaceutical manufacturers' Prescription Assistance Programs.

b. Effective through December 31, 2013, populations 1, 2, and 3 listed in STC 23 are eligible specialty care services, with the limitations noted in Table 3 below. Effective January 1, 2014, population 1 will receive specialty care benefits.

Table 3	
Tier 2 Benefits	**Notes/Limitations**
Urgent Care	Up to 5 urgent care visits
Durable Medical	Crutches, walkers, Wound Vac, and supplies for

Equipment	the Wound Vac
Oncology	
Rheumatology	
Cardiology	
Endocrinology	
Ear, Nose, and Throat	
Gastroenterology	
Internal Medicine	
Neurology	
Ophthalmology	
Orthopedics	
Pulmonology	
Pharmacy	Generics at the Specialty Site; if brand names are needed, individuals may apply for coverage under the pharmaceutical manufacturers' Prescription Assistance Program.
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)	

c. All enrollees are eligible for services through the specialty care voucher program. From the beginning of the demonstration through December 31, 2014, if persons seen at the facilities listed above need physician inpatient services or outpatient hospital care not offered by or available through ConnectCare, 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 20, within the past 12 months from the date of the request. The service request must be deemed medically necessary by SLHRC Utilization Management process.

VIII. COST SHARING UNDER THE SAFETY NET PILOT PROGRAM

31. **Co-Payments.** Enrollees will be subject to the same co-payments as required under the Medicaid state plan.

32. **Total Aggregate Out-of-Pocket Expenditures.** The total aggregate amount of demonstration cost sharing, Medicaid cost sharing, and CHIP premiums and cost sh**a**ring must not exceed 5 percent of family income. Family income will be determined under the methodology applicable to the group under the state Medicaid

plan. The state must develop a process for ensuring that families do not exceed the 5 percent cost sharing limit, and must include a description of this process in the first annual report required in STC 38.

33. **Cost Sharing for Certain American Indian/Alaskan Native Eligibles.** American Indian/Alaskan Native individuals enrolled in the demonstration are subject to cost sharing exemptions of section 5006 of ARRA.

IX. GENERAL REPORTING REQUIREMENTS

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

35. **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.

36. **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. For the first two years of the demonstration, areas to be addressed include financial sustainability of safety net providers, SLRHC, and CRC program, overview of and/or update on business plans for these entities, success and challenges of the CRC Program, success and challenges of SLRHC, and progress on pilot program implementation plan.

Beginning July 1, 2012, 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.

37. **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. Plans to secure the financial sustainability of the Affiliation Partners, SLRHC, and CRC Program;

g. Updates on the pilot program and implementation plan;

h. Updates on enrollment, disenrollment, and the waiting list for Tier 1 and Tier 2 services;

i. Updates on provider incentive payments;

j. Updates on the infrastructure payments;

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

l. Provide updates on financial sustainability of the ConnectCare specialty care network;

m. Updates on the state's success in meeting the milestones outlined in section XII; and

n. Other items as requested.

38. **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. Updates on the financial sustainability of the SLRHC, CRC program, and the Affiliation Partners, including an assessment as to whether the entities have met the benchmarks established in the business plans;

b. Documentation that each of the Affiliation Partners had uncompensated care costs to support all demonstration funding;

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

d. 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 57);

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

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

g. Analysis on utilization and performance/outcome trends;

h. Analysis on program implementation and operations barriers and action plans to resolve concerns related to eligibility/enrollment, outreach, provider enrollment, provider reimbursement, and administration of the pilot plan;

i. Progress report on the sustainability of ConnectCare heading into 2014 coverage;

j. Total cost of voucher services provided under the demonstration;

k. Include payments for infrastructure and incentive payments; and

l. Updates on the state's success in meeting the milestones listed in section XII.

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.

39. **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

40. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section 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 waiver. The documentation in support of the summary report will be the individual claims paid by the state to ConnectCare 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 to ConnectCare.

d. 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 and the City of St. Louis.

e. 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.

f. The Certification of Expenditures by the city of St. Louis meets the Missouri Partnership Plan (MPP) requirement on Attachment C of the MPP since the city of St. Louis is 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	$6,250,000 (supported by MMIS reports)
Total paid by the City of St. Louis	$1,250,000 (supported by MMIS reports)
Total	$7,500,000

41. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure limit.** All expenditures to support the administrative costs of the SLRHC and CRC programs (all years of the demonstration), Safety Net Provider Network (beginning July 1 through December 31, 2014) for primary care and specialty care for demonstration participants, provider incentive and ConnectCare infrastructure payments are subject to the budget neutrality expenditure limit.

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

a. 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 the date of the approval letter through September 30, 2010. DYs 2 through 4 will coincide with FFYs 2011, 2012, and 2013, respectively. DY 5 will begin October 1, 2013, and will end September 30, 2014. DY 6 will begin October 1, 2014 and will end on December 31, 2014.

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

    i. Missouri must report DSH expenditures that are subject to the FFY 2010 DSH allotment on Forms CMS-64.9 Base (or CMS-64.9 Base for Line 8 adjustments), until such expenditures equal three quarters of the DSH allotment for that year. These initial DSH expenditures for FFY 2010 are not demonstration expenditures and not subject to the budget neutrality limit.

    ii. FFY 2010 DSH expenditures in excess of the amount reported under subparagraph (i) are considered demonstration expenditures, and must be reported on Forms CMS-64.9 Waiver (or CMS-64.9P Waiver for line 8 adjustments for DY 1. All DSH expenditures for FFYs 2011 through 2013 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.

    iii. Missouri must report DSH expenditures that are subject to FFY 2014 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 2014, demonstration expenses and actual DSH expenditures must not exceed the state DSH allotment.

    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 reported on Forms CMS-64.9 Waiver or CMS-64.9P Waiver must be reported using the waiver name “Residual DSH.”

vi. 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.** From the beginning of the demonstration through June 30, 2012, the following four (4) waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report Title XIX expenditures associated with the demonstrations. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

vii. "Connect Care" expenditures
viii. "Grace Hill" expenditures
ix. "Myrtle Davis" expenditures
x. "Residual DSH" expenditures

From July 1, 2012, through December 31, 2014, the following seven (7) 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. "ConnectCare" expenditure
ii. "Grace Hill" expenditures
iii. "Myrtle Davis" expenditures
iv. "Contingency Provider Network" expenditures
v. "Voucher" expenditures
vi. "Infrastructure" expenditures
vii. "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 Affiliation Partners or on behalf of individuals who are enrolled in this demonstration, as defined STC23, 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.

xi. The administrative costs associated with support of the SLRHC and CRC 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. A separate form must also be submitted, using the waiver name **"CRC Adm"** to report expenses related to the administrative support of the CRC Program.

xii. 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.

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

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

quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

44. **Extent of 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.

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

    a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the 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 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 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. As defined in the Quarterly Expenditure Reconciliation, the quarterly calculation of documented waiver claims is derived from MMIS paid claims reports within the quarter.

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

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

48. **Penalty For Failing to Achieve Pilot Plan Milestones Listed in Section XIII.** Failure to implement or operationalize the pilot plan milestones listed in section XIII will result in the loss of a percentage of the $30 million (total computable) allowable under the expenditure authorities. If the state fails to meet a pilot plan milestone, the annual expenditure authority cap shall be reduced by the amount(s) listed in the table below.

Deadline	Milestone Reference	Annual Expenditure Authority Cap	Status	Penalty Amount (Total Computable)
10/01/2010	#1 – Submit strategic plan for developing the pilot program	10%	Completed	$3,000,000
01/01/2011	#2 – Submit draft pilot program plan, including business plans	15%	Completed	$4,500,000
07/01/2011	#3 – Submit pilot program plan, including	20%	Completed	$6,000,000

	business plans			
10/01/2011	#5 – Submit draft operational plan for the pilot program	15%	Completed	$4,500,000
01/01/2012	#6 – Submit operational plan for the pilot program	20%	Completed	$6,000,000

If the state does not implement the pilot program by July 1, 2012, the only funding available under the demonstration will be to support the administrative expenses of the SLRHC and the CRC Program.

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

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

50. **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 42.

51. **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.

52. **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, 3, 4, 5	Corresponding FFY DSH allotment
DY 6	¼ of the FFY 2015 FFY 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	Date of approval letter	$7.5 million

(3 months)	to 09/30/2010	
DY 2/ FFY 2011	0/01/2010 to 09/30/2011	$30 million
DY 3/ FFY 2012	0/01/2011 to 09/30/2012	$30 million
DY 4/ FFY 2013	0/01/2012 to 09/30/2013	$30 million
DY 5/ FFY 2014	10/01/2013 to 9/30/201	$30 million
DY 6/FFY 2015 (3 months	10/1/2013/ to 12/31/2014	$7.5 million
Cumulative Total		$135 million

53. **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.

54. **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. MILESTONES

55. **Milestones:** The state has completed the following milestones. All plans regarding the pilot program are contingent on review and approval by CMS. Failure to meet any of the pilot plan milestones listed below will result in the loss of a percentage of the $30 million (total computable) annual expenditure authority cap as described in STC 48.

    a. By October 1, 2010, the state must submit its strategic plan for developing the pilot program, including monthly and quarterly goals.

    b. By January 1, 2011, the state must submit a draft plan for the pilot program, including eligibility, benefits, cost-sharing, delivery systems, and enrollment, disenrollment, and outreach strategies. The draft pilot plan must include a draft business plan for each entity/program listed below showing how each entity/ program will achieve financial sustainability. The draft pilot plan must contain quantifiable benchmarks for how the state will assess whether the entity or program is making progress towards achieving financial sustainability. The business plans must include a detailed description of current and future funding sources and expenses.

xiii. SLRHC
xiv. CRC Program
xv. ConnectCare

xvi. Myrtle Davis
xvii. Grace Hill

c. By July 1, 2011, the state must submit its plan for the pilot program including eligibility, benefits, cost-sharing, delivery systems, enrollment, disenrollment, and outreach strategies. The final plan for the pilot program must include final business plans for each entity/program listed in Milestone #2, showing how each entity/ program will achieve financial sustainability, and the business plans must include a detailed description of current and future funding sources and expenses. The state must provide updates as to the progress of each entity/program meeting the benchmarks stipulated in the business plan in each demonstration quarterly and annual report as required in STCs 37 and 38.

d. By July 1, 2011, an independent financial audit of ConnectCare must be conducted and reported to the state and CMS.

e. By October 1, 2011, the state must submits a draft operational plan for the pilot program, including a description of any needed system changes and dates by which the system changes will be made.

f. By January 1, 2012, the state must submit its operational plan for the pilot program, including any needed system changes and dates by which the system changes will be made.

56. **Additional Milestones:** The state must submit the following deliverables for CMS review and approval. These milestones support the objectives of the demonstration.

a. By July 1, 2012, the state must implement the pilot program. No FFP will be available for the pilot program if the state does not submit and receive approval of its plan for the pilot program. The state must adhere to the deadlines specified above regarding its plans for the pilot program.

b. By December 31, 2014, ConnectCare, Grace Hill Health Centers, and Myrtle Davis Health Centers must attain financial sustainability. Financial sustainability is defined as the provider continuing operations and providing quality services to the safety-net community absent funding from an 1115 demonstration.

c. As specified in STC 16, the state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the ACA for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the ACA. The state must submit a

draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The state will revise the Transition Plan as needed.

d. By December 31, 2013, the SLRHC and CRC Program must attain financial sustainability.

e. For the first 2 years of the demonstration, the state must ensure that there is a 2 percent increase in the number of uninsured persons receiving services at ConnectCare, Grace Hill, and Myrtle Davis.

f. All individuals who present themselves for care at ConnectCare, Grace Hill, and Myrtle Davis must be screened for eligibility under Medicaid and the Children's Health Insurance Program and assisted in enrolling, if eligible.

XIII. EVALUATION

57. **Submission of Draft Evaluation Design.** The state shall submit to CMS for approval, within 120 days from the amended 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 amended 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 amended 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 amended 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. To what extent, has the state met the milestones listed in section XII?

b. How successful have the FQHCs and ConnectCare been at developing a business model that is based on receiving reimbursement through a claims-based system rather than receiving direct payments to the facilities?

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

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

e. 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.

f. Describe provider incentives and activities.

g. Determine if performance incentives have impact of population metrics with a comparison of Gateway providers to other community health centers in the state.

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

i. Provide financial analysis of the Legacy and ConnectCare providers for the pre- and post-coverage phase of the demonstration.

j. The state must provide an updated draft of the evaluation design sixty days after the approval of amendments.

k. Analyze the cost of care and access to services at the Legacy FQHC providers, comparing the first 18-months of the demonstration when the providers received direct payments to the last 18-months of the demonstration when the providers were paid on a capitated basis with incentive payments.

58. **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.

59. **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.

60. **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.

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date – Specific	Deliverable	STC Reference
10/01/2010	Submit Draft Evaluation Design	Section XII, STC 57
10/01/2010	Submit strategic plan for developing the pilot plan	Section XII
01/01/2011	Submit draft plan for the pilot program including business plans for the SLRHC, CRC Program, and each of the Affiliation Partners	Section XII
07/01/2011	Submit plan for the pilot program, including any needed amendments to the demonstration and final business plans for the SLRHC, CRC Program, and each of the Affiliation Partners	Section XII
07/01/2011	Submit financial audit of ConnectCare	Section XII
10/01/2011	Submit draft operational plan for the pilot program	Section XII
01/01/2012	Submit operational plan for the pilot program	Section XII
8/1/2012	Submit MOU between the State and SLRHC for CMS review	
9/1/2012	Incentive Protocol	Section V
1/29/2014	Submit revised Evaluation Design	Section XIII, STC 57
6/30/2014	Submit Transition Plan	Section III
07/01/2015	Submit Draft Final Report	Section XII, STC 59

	Deliverable	STC Reference
Annual	By February 1st, 2013 - Draft Annual Report	STC 38
Annual	Within 30 days of receipt of CMS comments – Final Annual Report	STC 38
Quarterly	Quarterly Progress Reports	STC 37

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: 1 (October 1, 2011 – September 31. 2012)

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.

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

Demonstration Programs	**Current Enrollees** (to date)
Tier 1 and Tier 2 Primary and Specialty Care for Population 1	
Tier 2 –Specialty Care for Population 2	
Tier 2 –Specialty Care for Population 3	

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

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

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

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

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

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

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

The state may also add additional program headings as applicable.

Date Submitted to CMS:

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.

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

I certify that:

1. I am the executive officer of the city of St. Louis 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 to ConnectCare 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

Incentive Payments

The state will withhold 7% from payments made to the primary care health centers (PCHC) and St. Louis ConnectCare (SLCC). The amount withheld will be tracked on a monthly basis as two separate incentive pools - one for primary care health centers and one for specialty care. The SLRHC will be responsible for monitoring the PCHC and SLCC 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.

Reporting Periods:

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

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 and SLCC 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 Patients Enrolled As of 7/1/2012 - Minimum of at least 1 office visit (including a health risk assessment and health and wellness counseling) within the first 6 months following enrollment	80%	20%	Claims Data
Patients with Diabetes, Hypertension, CHF or COPD – 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	80%	20%	Claims Data
Patients with Diabetes - HgbA1c testing performed within the first 4 months following the latter of either: a) initial enrollment, or b) initial diagnosis	85%	20%	Claims Data
Patients with Diabetes – percentage of diabetics who have a HgbA1c <8% within six months following the latter of either: a) initial enrollment, or b) initial diagnosis	60%	20%	Self-Reported by Health Centers

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
Emergency Department Utilization among Tier 1/Tier 2 Enrollees	TBD pending final actuarial analysis	30%	Claims data
Rate of Referral to Specialist among Tier 1/Tier 2 Enrollees	TBD pending final actuarial analysis	70%	Claims data

The primary care providers will be eligible for the remaining funds based on the percentage of Tier 1 and Tier 2 patients (Blue Plan) 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. Funds not distributed will be used to create additional enrollment slots where demand and capacity exist. 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%

- 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.

St. Louis ConnectCare Pay-for-Performance Eligibility

For those patients with Tier 1 and Tier 2 benefits (Blue Plan), St. Louis ConnectCare will receive an alternative payment for medical and pharmaceutical expenses. The payment to St. Louis ConnectCare will be subject to a 7% withhold, which will be paid out in whole or part within the first quarter following the attainment of certain quality measures.

For those patients with Tier 2 only benefits (Silver Plan), reimbursement to St. Louis ConnectCare will be based on a fee-for-service methodology at 120% of Medicare with a withhold of 7%, which will be paid out in whole or part within the first quarter following the

attainment of certain quality measures.

The pay-for-performance incentive payment will be based on achieving specified goals for the following:

TABLE 3

St. Louis ConnectCare Pay-for-Performance Metrics

<table>
<tr><th>Pay-for-Performance Incentive Criteria</th><th>Threshold</th><th>Weighting</th><th>Source</th></tr>
<tr><td><u>Timely Patient Access as Measured by Appointment Wait Times</u> -
<table>
<tr><th>Specialty</th><th>Benchmark (weeks)</th><th></th><th>Specialty</th><th>Benchmark (weeks)</th></tr>
<tr><td>Cardiology</td><td>5</td><td></td><td>Neurology</td><td>9</td></tr>
<tr><td>Dermatology</td><td>4</td><td></td><td>Orthopedics</td><td>6</td></tr>
<tr><td>Endocrinology</td><td>7</td><td></td><td>Pulmonology</td><td>8</td></tr>
<tr><td>ENT</td><td>4</td><td></td><td>General Surgery</td><td>3</td></tr>
<tr><td>GI</td><td>6</td><td></td><td>Urology</td><td>8</td></tr>
<tr><td>Nephrology</td><td>5</td><td></td><td></td><td></td></tr>
</table></td><td>80%</td><td>50%</td><td>Semi-Annual Self Reporting/AHS</td></tr>
<tr><td><u>Coordination of Care</u> – (a) Receipt of consultation documentation within 10 business days; (b) Completion of a primary care – specialist physician compact of collaborative guidelines *</td><td>(a) 80%
(b) 100%</td><td>(a) 15%
(b) 10%</td><td>AHS/RHC</td></tr>
<tr><td><u>Timely, Accurate Filing of Patient Encounters and Claims Data</u>– Utilization data for patients covered by cap payments and claims data all submitted within 60 days of date of service</td><td>90%</td><td>25%</td><td>Claims Processing Vendor</td></tr>
<tr><td>TOTAL POSSIBLE SCORE</td><td></td><td>100%</td><td></td></tr>
</table>

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: SLCC and state are represented on the Pilot Program Planning Team.)

Remaining funding in the specialty care incentive pool will be used to create additional enrollment slots where demand and capacity exist. Payments will not be redirected for administrative or infrastructure payments. Incentive payments will be calculated based on the data received and the methodology described below.

St. Louis ConnectCare (SLCC) Calculations

Step 1: Calculate the SLCC Incentive Pool (SIP).

- SIP = SLCC Payments Received x 7%

Step 2: Calculate the SLCC Incentive Pool Earned Payment (SIPEP) to be paid to SLCC.

- Identify which performance metrics were achieved
- Determine the SLCC Incentive Pool Weight (SIPW) by adding the weights of each performance metric achieved

Example: If SLCC achieves 2 of the 3 performance metrics - timely patient access and coordination of care, then:

SIPW = 50% + 25% = 75%

- SIPEP = SIP x SIPW

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 any remaining funds. Payments will not be redirected for administrative or infrastructure payments.