



*Administrator*  
Washington, DC 20201

JUL 28 2010

Mr. Ronald Levy  
Director  
Missouri Department of Social Services  
P.O. Box 1527  
Broadway State Office Building  
Jefferson City, MO 65102-1527

Dear Mr. Levy:

We are pleased to inform you that Missouri's request for a section 1115 demonstration, entitled "Gateway to Better Health," has been approved as project number 11-W-00250/7. Under this Demonstration, the State will spend up to \$30 million (total computable) annually to pay for otherwise uncompensated care costs at primary and specialty care clinics in the St. Louis region. Approval of this Demonstration is under the authority of section 1115(a) of the Social Security Act (the Act) and is effective as of the date of this approval letter, through December 31, 2013.

For the first 2 years of the Demonstration, the State will provide financial support to ConnectCare, Grace Hill Neighborhood Health Center, and Myrtle Hilliard Davis Health Center, as these entities work to achieve financial sustainability. Beginning July 1, 2012, the State will implement a pilot program, subject to review and approval by the Centers for Medicare & Medicaid Services (CMS), which will enroll low-income, uninsured individuals who are not currently eligible for Medicaid into a health care coverage model. Finally, for all years of the Demonstration, the State will provide administrative support to the St. Louis Regional Health Commission and Community Referral Coordinator Program as these entities work to achieve financial sustainability.

Our approval of this demonstration project is subject to the limitations specified in the approved waivers, expenditure authorities, and title XIX requirements not applicable. The State may deviate from the Medicaid State plan requirements to the extent those requirements have been specifically waived or listed as granted expenditure authority or title XIX requirements not applicable. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to the Demonstration.

The approval is also conditioned upon compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of Federal involvement in this project. This award letter is subject to our receipt of your written acceptance of the award, including the expenditure authorities and STCs, within 30 days of the date of this letter.

Your contact for this Demonstration is Ms. Julie Sharp, who may be reached at (410) 786-2292 or through e-mail at [Juliana.Sharp@cms.hhs.gov](mailto:Juliana.Sharp@cms.hhs.gov). Ms. Sharp is available to answer any questions concerning the scope and implementation of the project in your application. Communications regarding the program matters and official correspondence concerning the Demonstration should be submitted to her at the following address:

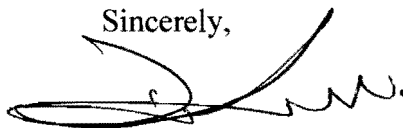
Centers for Medicare & Medicaid Services  
Center for Medicaid, CHIP and Survey & Certification  
7500 Security Boulevard  
Mail Stop: S2-01-16  
Baltimore, MD 21244-1850

Official communications regarding program matters should be sent simultaneously to Ms. Sharp and to Mr. James Scott, Associate Regional Administrator for the Division of Medicaid and Children's Health in our Kansas City Regional Office. Mr. Scott's address is:

Centers for Medicare & Medicaid Services  
Division of Medicaid & Children's Health  
Richard Bolling Federal Building  
Room 235  
601 East 12th Street  
Kansas City, MO 64106

We extend our congratulations to you on this award and look forward to working with you during the course of the Demonstration.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald M. Berwick, M.D.", with a large, sweeping flourish at the end.

Donald M. Berwick, M.D.

Enclosures

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cc:

Mr. James Scott, Associate Regional Administrator, Region VII

Ms. Deborah Read, State Representative

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
EXPENDITURE AUTHORITY**

**NUMBER:** 11-W-00250/7  
**TITLE:** Gateway to Better Health  
**AWARDEE:** Missouri Department of Social Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Missouri for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this Demonstration, be regarded as expenditures under the State's title XIX plan.

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

The 2 expenditure authorities listed below shall apply for the full Demonstration period, the date of the approval letter through December 31, 2013.

1. **Administrative Costs for the St. Louis Regional Health Commission (SLRHC):** Expenditures for administrative expenses incurred by the SLRHC for activities directly related to the Demonstration to support the SLRHC in achieving financial sustainability. For Demonstration Years (DYs) 1 and 5, these expenses must not total more than \$75,000 (total computable) per year. For DYs 2, 3, and 4 these expenses must not total more than \$300,000 (total computable) per year.
2. **Community Referral Coordinator (CRC) Program:** Administrative expenditures for the CRC program to support the CRC program in achieving financial sustainability. For DYs 1 and 5, these expenses must not total more than \$175,000 (total computable) per year. For DYs 2, 3, and 4 these expenses must not total more than \$700,000 (total computable) per year.

The expenditure authorities below shall apply from the date of the approval letter through June 30, 2012:

- State-funded expenditures incurred by the St. Louis Safety Net Funding Pool from the date of the accompanying approval letter, through June 30, 2012, not to exceed \$30 million (total computable) annually that pay 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.

The expenditure authority below shall apply from July 1, 2012, through December 31, 2013, contingent on the State submitting an approvable plan for the pilot program:

- **Demonstration Population 1 (Expansion Population):** Expenditures for services provided to uninsured individuals, ages 19 through 64, 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.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Population 1 beginning July 1, 2012, through December 31, 2013.

**Statewideness**

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

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

**Methods of Administration: Transportation**

**Section 1902(a)(4) insofar as it incorporates 42 CFR 431.50**

To the extent necessary, to enable the State to not assure transportation to and from providers for Demonstration Population 1.

**Amount, Duration, and Scope**

**Section 1902(a)(10)(B)**

To the extent necessary, to permit the State to offer benefits to Demonstration Population 1 that differ from the benefits offered to the categorically needy group.

**Freedom of Choice**

**Section 1902(a)(23)**

To the extent necessary, to enable the State to mandatorily enroll Demonstration Population 1 in a managed care plan that restricts free choice of provider.

**Retroactive Eligibility**

**Section 1902(a)(34)**

To the extent necessary, to enable the State to not provide medical assistance to Demonstration Population 1 for any time prior to when an application for the Demonstration is made.

**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 Special Terms and Conditions (STCs) for Missouri's Gateway to Better Health section 1115(a) Medicaid Demonstration (hereinafter referred to as "Demonstration"). The parties to this agreement are the Missouri Department of Social Services ("State") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective as of the date of the accompanying award letter, unless otherwise specified. This Demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. St. Louis Regional Health Commission (SLRHC) and Community Referral Coordinator (CRC) Program
- V. Support for Safety Net Providers
- VI. Eligibility Determination, Enrollment, and Disenrollment Under the Pilot Program
- VII. Benefits Under the Pilot Program
- VIII. Program Cost Sharing Under the Pilot Program
- IX. Delivery Systems Under the Pilot Program
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. Milestones
- XIV. Evaluation
- XV. Schedule of State Deliverables for the Demonstration

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

Under the Demonstration, the State will spend up to \$30 million (total computable) annually to preserve and improve primary and specialty care in the St. Louis region. To maintain budget neutrality, the State will ensure that these amounts, when added to payments to disproportionate share hospitals (DSHs) will not exceed the DSH allotment calculated in accordance with section 1923 of the Social Security Act (the Act).

For all years of the Demonstration, the State has the authority to fund a portion of the administrative costs incurred by the SLRHC as the SLRHC devises strategies to ensure financial sustainability.

The SLRHC is a non-profit 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 County region; and 3) improve health outcomes among populations in the St. Louis City and County region, especially among those most at risk.

In addition, for all years of the Demonstration, the Demonstration will provide funding to support the administrative costs of the State's existing emergency room diversion efforts through the CRC program.

From the date of the award letter through June 30, 2012, as the State works to devise strategies to ensure the financial sustainability of the area's safety net system, the State will have authority to divert DSH to pay for otherwise uncompensated ambulatory care at specific facilities for the approved Demonstration period. These entities include:

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

By July 1, 2012, the State must implement a pilot program, subject to review and approval by CMS, 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).

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

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

### **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 section III, paragraph 7 below.
7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other

deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the State, consistent with the requirements of section III, paragraph 15, 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.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act are advised to observe the timelines contained in those statutes. 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 section III, paragraph 9.

As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in section III, paragraph 15, 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 suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in section III, paragraph 10, a phase-out plan shall not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. 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. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in section III, paragraph 9, or not

add these individuals to the Medicaid State plan, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate 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.
12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.
13. **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.
14. **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.
15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 (ARRA), when any program changes to the Demonstration, including (but not limited to) those referenced in section III, paragraph 7, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, amendment and/or renewal of this Demonstration.
16. **FFP.** No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

#### IV. SLRHC and CRC PROGRAM

1. **Administrative Support.** For each year of the Demonstration, the State may use 1 percent of the total Demonstration expenses to provide administrative support to the SLRHC. The State must ensure that all administrative costs are recognized and allocated costs according to the requirements in OMB Circular A-87.
2. **CRC Program.** The CRCs work with uninsured individuals who present at emergency rooms to educate patients 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 provider and care site.

For each year of the Demonstration, the State will provide up to \$700,000 (total computable) to support administrative expenses of the CRC Program. 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 State must ensure that all administrative costs are recognized and allocated administrative costs according to the requirements in OMB Circular A-87.

The CRC Program currently operates in the following hospitals:

- Barnes-Jewish Medical Center
- St. Louis University Medical Center
- St. Mary's Medical Center

The CRC Program will expand to the following hospitals:

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

#### V. SUPPORT FOR SAFETY NET PROVIDERS

1. **Affiliation Partners.** From the beginning of the Demonstration through June 30, 2012, the State will provide financial support via the SLRHC Authority to pay for otherwise uncompensated ambulatory care at the facilities or Affiliation Partners listed below to further the goal of transitioning the St. Louis health care delivery system for low-income, uninsured persons to a viable, self-sustaining model.
  - St. Louis ConnectCare
  - Two clinics operated by Myrtle Hilliard Davis Comprehensive Health Centers:

- Homer G. Phillips Clinic
- Florence Hill Health Center
- Two clinics operated by Grace Hill Neighborhood Health Centers:
  - Murphy-O'Fallon Center
  - Soulard-Benton Center

2. **Voucher Program.** From the beginning of the Demonstration through June 30, 2012, if persons seen at the facilities listed above need physician inpatient services or outpatient hospital care, including emergency department physician services, not offered by ConnectCare (such as oncology services), ConnectCare will provide vouchers for such care, as described below.

To qualify for a voucher, the patient must live in St. Louis City or St. Louis County and be uninsured, be seen by a ConnectCare physician, and have a referral from one of the clinics listed above, a Federally Qualified Health Center (FQHC) or St. Louis County Clinic authorizing the service, within the past 12 months from the date of the request. The service request must be deemed medically necessary by ConnectCare's Utilization Management process. ConnectCare will not provide vouchers if Connectcare exceeds its estimated annual funding levels of \$4,850,000 (total computable) in Demonstration Year (DY) 1, \$219,400,000 (total computable) in DY 2, and \$14,550,000 (total computable) in DY3.

The hospitals that participate in the voucher program include Barnes-Jewish Hospital, St. Louis University Hospital, St. Mary's Hospital, St. John's Hospital, and St. Alexius Hospital.

3. **Pilot Program.** By July 1, 2012, the State must implement a pilot program, subject to review and approval by CMS, which would provide health insurance coverage for persons described in section VI. The State must meet the milestones described in section XIII to ensure a successful implementation of the pilot program.

The goal of the pilot program is to bridge to the implementation of health care reform by preparing the safety net providers and uninsured individuals served by the safety net providers in St. Louis City for the coverage options available under health reform by January 1, 2014. The elements of the pilot program with respect to eligibility, benefits, cost-sharing, and delivery systems are addressed in Sections VI-IX of these STCs.

## **VI. ELIGIBILITY DETERMINATION, ENROLLMENT, AND DISENROLLMENT UNDER THE PILOT PROGRAM**

1. **Demonstration Populations.** From July 1, 2012, through December 31, 2013, the population described in the table below will be eligible for the Demonstration. Only persons who do not meet the eligibility requirements of the Medicaid State plan are eligible for the Demonstration.

Population Name	Population Description	FPL or Other Criteria	Expenditure and Eligibility Group Reporting
Expansion Population	Uninsured parents and other adults, ages 19 to 64, who are not otherwise eligible for Medicaid or Medicare who reside in St. Louis City or St. Louis County, subject to an enrollment cap based on available funding	0% FPL to 133% FPL, no resource limit	Expansion Pop.

2. **Enrollment.** The State must ensure that persons are first screened for eligibility under the Medicaid State plan before being enrolled into the Demonstration. The State will follow the same enrollment processes as for Medicaid State plan individuals (subject to an enrollment cap based on available funding as described in section VI, paragraph 4).
3. **Disenrollment.** The State will follow the same disenrollment processes as for individuals eligible under the Medicaid State plan.
4. **Enrollment Cap.** The State may limit enrollment to stay within budget neutrality limits. The State must submit an amendment stipulating the details of any enrollment cap by July 1, 2011, including the minimum number of individuals who will be served under the Demonstration
5. **Wait List Policy.** By July 1, 2011, the State must submit an amendment stipulating the details of the wait list policy for any enrollment cap.

## VII. BENEFITS

1. **Benefits.** From July 1, 2012, through December 31, 2013, the pilot program will offer the benefits listed in the table below. By July 1, 2011, the State must submit an amendment to the Demonstration if there are any changes or limitations to the benefits, including any applicable limits.

Benefit	Notes/ Limitations
Preventative	
Wellcare	
Dental	
Pharmacy	
Durable Medical Equipment	

Oncology	
Rheumatology	
Cardiology	
Endocrinology	
Ear, Nose, and Throat	
Gastroenterology	
Internal Medicine	
Neurology	
Ophthalmology	
Orthopedics	
Pulmonology	
Renal	
Urology	
Outpatient Surgery	

2. **Voucher Program.** From July 1, 2012, through December 31, 2013, the pilot program is expected to provide specialty outpatient services through a voucher program similar to the procedures as described in section V, paragraph 2. By July 1, 2011, the State must submit an amendment to the Demonstration, specifying how the State will operate the voucher program under the pilot program.

If persons seen at the facilities listed above need physician inpatient services or outpatient hospital care, including emergency department physician services, not offered by ConnectCare (such oncology services), the ConnectCare will provide vouchers for such medically necessary care, based on the availability of funding, as described below.

To qualify for a voucher, the patient must live in St. Louis City or St. Louis County and be uninsured, be seen by a ConnectCare physician, and have a referral from an FQHC or St. Louis County Clinic authorizing the service within the past 12 months from the date of the request. The service request must be deemed medically necessary by ConnectCare's Utilization Management process.

The hospitals that participate in the voucher program include Barnes-Jewish Hospital, St. Louis University Hospital, St. Mary's Hospital, St. John's Hospital, and St. Alexius Hospital.

## VIII. COST SHARING UNDER THE PILOT PROGRAM

1. **Co-Payments.** Enrollees will be subject to the same co-payments as required under the Medicaid State plan.
2. **Total Aggregate Out-of-Pocket Expenditures.** The total aggregate amount of Demonstration cost sharing, Medicaid cost sharing, and CHIP premiums and cost sharing 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 section X, paragraph 6.

3. **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 and subject to the expenditure authorities expressly provided for in this Demonstration.

## **IX. DELIVERY SYSTEMS UNDER THE PILOT PROGRAM**

1. **Primary Provider Network.** At a minimum, the provider network includes the following entities:
  - St. Louis ConnectCare
  - Two clinics operated by Myrtle Hilliard Davis Comprehensive Health Centers:
    - Homer G. Phillips Clinic
    - Florence Hill Health Center
  - Two clinics operated by Grace Hill Neighborhood Health Centers:
    - Murphy-O'Fallon Center
    - Soulard-Benton Center
2. **Other Providers.** If the State expects to include additional providers under the pilot program, the State must submit an amendment to the Demonstration by July 1, 2011. The State must provide updates on any plans to add other providers during the monthly calls and in the quarterly and annual reports.

## **X. GENERAL REPORTING REQUIREMENTS**

1. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in these STCs.
2. **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.
3. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR Part 438 *et seq.*, except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.
4. **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 2 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.

5. **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 eligibles, 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 any potential amendment requests such as proposed changes to the benefits, voucher program, or delivery system;
  - i. Updates on the State's success in meeting the milestones outlined in section XIII; and
  - j. Other items as requested.
  
6. **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:

1. 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;

2. Documentation that each of the Affiliation Partners had uncompensated care costs to support all Demonstration funding;
3. Success and challenges of educating and providing outreach to uninsured populations, with an emphasis on young adults aging out of Medicaid;
4. 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 under section XIV, paragraph 1);
5. Data and findings of cost of providing care to persons served under the Demonstration;
6. Total cost of voucher services provided under the Demonstration; and,
7. Updates on the State's success in meeting the milestones listed in section XIII.

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.

7. **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 6 months after the expiration of the Demonstration. The State must submit a final report within 60 days of receipt of CMS comments.

## **XI. GENERAL FINANCIAL REQUIREMENTS**

1. **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 XII (Monitoring Budget Neutrality).
2. **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), Affiliation Partners (first 2 years of the Demonstration), and health care services for Demonstration participants (as defined in section VI above) are subject to the budget neutrality expenditure limit.
3. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality limit:
  - a. **Tracking Expenditures.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid

Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (11-W-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 December 31, 2013.
- c. **DSH Expenditures.** To facilitate monitoring of budget neutrality and compliance with the DSH allotment, the rules below will govern reporting of DSH expenditures for the Demonstration. All DSH expenditures are subject to the DSH allotments defined in section 1923(f) of the Act.
  - i. 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 are 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.
  - iii. 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.
  - iv. Missouri must report DSH expenditures that are subject to FFY 2014 DSH allotment on CMS 64.9 Waiver and CMS-64.9P Waiver 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's DSH allotment.
  - 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.

- i. "ConnectCare" expenditures
- ii. "Grace Hill" expenditures
- iii. "Myrtle Davis" expenditures
- iv. "Residual DSH" expenditures

From July 1, 2012, through December 31, 2013, the following two (2) 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. "Expansion Pop" expenditures
- ii. "Residual DSH" expenditures

g. **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Form CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

h. **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 in section VI, paragraph 1, 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-64.9 Waiver and/or CMS-64.9P Waiver.

- i. **Title XIX Administrative Costs.** The following provisions govern reporting of administrative costs during the Demonstration.
    - i. The administrative costs associated with support of the SLRHC 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.
    - ii. Administrative costs that are directly attributable to the Demonstration that are not described in (i) 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. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
  - j. **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.
4. **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.

5. **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;
  - 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.
6. **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.
7. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.
8. **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.
9. **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.

<b>Deadline</b>	<b>Milestone Reference</b>	<b>Annual Expenditure Authority Cap</b>	<b>Penalty Amount (Total Computable)</b>
10/01/2010	#1 – Submit strategic plan for developing the pilot program	10%	\$3,000,000
01/01/2011	#2 – Submit draft pilot program plan, including business plans	15%	\$4,500,000
07/01/2011	#3 – Submit pilot program plan, including business plans	20%	\$6,000,000
10/01/2011	#5 – Submit draft operational plan for the pilot program	15%	\$4,500,000
01/01/2012	#6 – Submit operational plan for the pilot program	20%	\$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.

10. **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.

## **XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION**

1. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in section XI, paragraph 3.
2. **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 eligibles under this budget neutrality agreement.
3. **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).

<b>DY</b>	<b>Budget Neutrality Limit</b>
DY 1	¼ of the FFY 2010 DSH allotment
DYs 2, 3, 4, 5	Corresponding FFY DSH allotment
DY 5	¼ of the FFY 2014 FFY DSH allotment

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

<b>DY/ FFY</b>	<b>Dates</b>	<b>Annual Expenditure Authority Cap (Total Computable)</b>
DY 1/ FFY 2010 (3 months)	Date of approval letter to 09/30/2010	\$7.5 million
DY 2/ FFY 2011	10/01/2010 to 09/30/2011	\$30 million
DY 3/ FFY 2012	10/01/2011 to 09/30/2012	\$30 million
DY 4/ FFY 2013	10/01/2012 to 09/30/2013	\$30 million
DY 5/ FFY 2014 (3 months)	10/01/2013 to 12/31/2013	\$7.5 million
Cumulative Total		\$105 million

4. **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.
5. **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.

### **XIII. MILESTONES**

The State must meet 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 section XI, paragraph 9.

1. By October 1, 2010, the State must submit its strategic plan for developing the pilot program, including monthly and quarterly goals.
2. By January 1, 2011, the State must submit a draft plan for the pilot program, including eligibility, benefits, cost-sharing, delivery systems, 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.

- i. SLRHC
  - ii. CRC Program
  - iii. ConnectCare
  - iv. Myrtle Davis
  - v. Grace Hill
3. 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 section X, paragraphs 5 and 6.
  4. By July 1, 2011, an independent financial audit of ConnectCare must be conducted and reported to the State and CMS.
  5. By October 1, 2011, the State must submit 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.
  6. 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.
  7. By July 1, 2012, the State must implement the pilot program, contingent on CMS' approval of the plan. 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.
  8. By July 1, 2012, ConnectCare, Grace Hill Health Centers, and Myrtle Davis Health Centers must attain financial sustainability.
  9. 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.

10. By December 31, 2013, the SLRHC and CRC Program must attain financial sustainability.
11. 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.
12. 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.

#### **XIV. EVALUATION**

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

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

1. To what extent, has the State met the milestones listed in section XIII?
  2. 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?
  3. How has access to care improved for low-income individuals?
  4. How successful is the Demonstration in expanding coverage to the region's uninsured by 2 percent each year?
  5. 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.
2. **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.

3. **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.
4. **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.

**XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION**

<b>Date – Specific</b>	<b>Deliverable</b>	<b>STC Reference</b>
~10/01/2010	Submit Draft Evaluation Design	Section XIV, paragraph 1
10/01/2010	Submit strategic plan for developing the pilot plan	Section XIII
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 XIII
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 XIII
07/01/2011	Submit financial audit of ConnectCare	Section XIII
10/01/2011	Submit draft operational plan for the pilot program	Section XIII
01/01/2012	Submit operational plan for the pilot program	Section XIII
07/01/2012	Submit draft Transition Plan	
07/01/2014	Submit Draft Final Report	Section X, paragraph 7

	<b>Deliverable</b>	<b>STC Reference</b>
<b>Annual</b>	By Nov. 1 <sup>st</sup> - Draft Annual Report	Section X, paragraph 6
<b>Quarterly</b>	Quarterly Progress Reports	Section X, paragraph 5