
GREATER NEW ORLEANS COMMUNITY HEALTH CONNECTION

Section 1115 Research and Demonstration Waiver Proposal

DRAFT

Louisiana Department of Health and Hospitals

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INTRODUCTION

The Louisiana Department of Health and Hospitals (DHH) is requesting a Section 1115 demonstration waiver to preserve primary and behavioral health care access to the uninsured that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with the Primary Care Access and Stabilization Grant (PCASG) awarded to the State by the U.S. Department of Health and Human Services' (HHS), to advance and sustain the medical home model begun under PCASG, and to transition the PCASG infrastructure to a financially sustainable model through full participation in an expanded Medicaid program, the Louisiana Children's Health Insurance Program (LaCHIP), and the State Health Benefits Exchange mandated by the Patient Protection and Affordable Care Act of 2010 (ACA) effective January 1, 2014. Such a model will provide a critical primary care and medical home foundation for newly eligible Medicaid populations beginning in 2014.

The demonstration project will make available up to \$30,000,000 per year (total computable) of the state's unspent Medicaid Disproportionate Share Hospital (DSH) allotment to provide primary and behavioral health care services to low-income, uninsured adults in the Greater New Orleans area over the next three and a half federal fiscal years and transition the existing grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, LaCHIP, and other payor sources as the revenue base. The demonstration will provide continued coverage of primary and behavioral health services for uninsured adults currently receiving services through the community-based model of primary care begun under PCASG while DHH works with the community to design and implement enhanced provider network participation requirements, a benefit package available to all demonstration enrollees, payment model(s), and a delivery system to ensure the long-term sustainability of these providers in the Medicaid and Exchange environment that will exist in 2014. To do so, the State will initiate and organize activities in two phases. Phase 1 focuses on service preservation, provider capacity building, and transition planning. Phase 2 focuses on transition plan implementation and assessment, successful transition of demonstration participants into Medicaid and the State Health Exchange and demonstration phase-down.

BACKGROUND

NEED FOR PRIMARY CARE SERVICES IN THE GREATER NEW ORLEANS AREA

Preserving the primary care and mental health safety net health care delivery system in the greater New Orleans area is of great importance to the state of Louisiana. Over the past five years, the region has been impacted by two of the most catastrophic events in our nation's modern history, Hurricane Katrina and the subsequent levee failures and the Deep Water Horizon Oil Spill in the Gulf of Mexico off the Louisiana coast, making the safety net a vital

resource for a vulnerable population. The increased access to a high quality, accessible, neighborhood-based infrastructure has been one of the few bright spots in the recovery from Hurricane Katrina. This safety net has demonstrated value in responding to subsequent hurricanes such as Gustav and to other disasters like the Gulf oil spill. Since Hurricane Katrina, the health care delivery system for this population has shifted from one that was largely hospital-based to a more community-based system of primary care, in part due to the federal Primary Care Access and Stabilization Grant.¹

The Greater New Orleans area, comprised of Orleans, Jefferson, St. Bernard and Plaquemines parishes, is one of the largest population centers in the state. It is home to over 800,000 individuals, and represents roughly 20 percent of the state's population. According to the 2008 American Community Survey, nearly 40 percent of individuals living in the New Orleans area had incomes below 200 percent of the federal poverty level and nearly 20 percent were uninsured, making the area one of the most vulnerable in the nation. The below table highlights the core indicators by parish and for the region as a whole compared to national estimates.

Demographics for Region 1 in Louisiana compared to National Estimates. American Community Survey, 3-year estimates for 2006-2008 (NOTE: population estimates fluctuated in this area and period due to Hurricane Katrina)

	Jefferson	Orleans	Plaquemines	St Bernard	Total Region 1*	National
% of individuals <= 200% FPL	33.4	47.8	29.7	36.7	38.5	30.9
Age Breakdown						
0-19 years of age	26.2	31	30.4	37.2	28.4	27.4
20-64 years of age	60.1	57.4	58	52.1	58.8	60
Racial/Ethnic Composition:						
Caucasian	65	34.4	na	85.3	54.5	74.3
African-American	26.3	60.5	na	10.7	38.3	12.3
Hispanic/Latino	9	4.5	na	na	7.3	15.1
Other	8.7	5.1	na	4	7.2	13.3
Unemployed	3.8	7.2	na	na	5.1	4.1
Not in Labor Force	36.5	40.5	na	na	38	34.8
Less than High School Education	18.8	18.1	21.1	23.5	18.8	15.7
High School Education/GED	51.1	47	53.7	65.7	50.3	45.6

*Region 1 race totals exclude Plaquemines due to small population sample. Hispanic and employment estimates reflect only Jefferson & Orleans parishes.

Consistent with overall Louisiana rankings, the New Orleans population suffers disproportionately from chronic disease and other important public health risks, particularly in comparison to other US cities. Area residents are more likely to have obesity, cardiovascular disease, and sexually transmitted infections. The infant mortality rate is amongst the highest in the nation, as is premature death from cancer, diabetes and cardiovascular disease. According to the 2008 Kaiser Family Foundation Household Survey of New Orleans residents low-income

¹ Government Accountability Office, CMS and HRSA Assistance to Sustain Primary Care Gains in the Greater *New Orleans* Area. GAO-10-773R, June 30, 2010.

adults are more likely than other adult residents to have a health problem². Overall, nearly two-thirds of residents reported a chronic illness, 37 percent reported hypertension or high blood pressure, 17 percent asthma or other breathing problems, 15 percent serious mental illness, and 15 percent diabetes or high blood sugar, and 11 percent heart disease. Thirty-one percent of the residents report general mental health challenges.

Recent events, such as the national economic downturn and the Gulf oil spill coupled with Hurricane Katrina recovery, have compounded the lingering health impact of Hurricane Katrina, particularly mental health needs, and magnified the need for the safety-net. Many regional jobs across a variety of sectors have been negatively impacted by both events³, which can lead to losses in health insurance coverage for the region's residents. Regarding the Deep Water Horizon Oil Spill in particular, a recent report by Louisiana State University (LSU) suggests that for affected communities, the health impact on area residents is substantial, and that negative affective states, physiological symptoms, and disruptions to daily routines are evident, and are generally widespread.⁴

Prior to Hurricane Katrina, much of the health care for the low-income and uninsured population in the Greater New Orleans area was provided in emergency departments and outpatient clinics at Charity and University hospitals, a part of the LSU statewide public hospital system, locally named the Medical Center of Louisiana at New Orleans (MCLNO). Since Hurricane Katrina, the health care delivery system for this population has shifted from one that was largely hospital-based to a more community-based system of primary care, in large part due to the federal Primary Care Access and Stabilization Grant.⁵

CURRENT PRIMARY CARE ACCESS AND STABILIZATION GRANT (PCASG) PROGRAM DESIGN

Since September 2007, 25 not-for-profit or governmental healthcare entities have been participating in the three-year \$100 million PCASG program, set to expire in September 2010. In three short years, this grant program has been cited as a potential national model for

² “New Orleans Three Years After the Storm: The Second Kaiser Post-Katrina Survey, 2008,” Kaiser Family Foundation, August 2008, <http://www.kff.org/kaiserpolls/posr081008pkg.cfm>.

³ “The New Orleans Index AT FIVE: Measuring Greater New Orleans’ Progress Toward Prosperity”, Brooking Institute and GNO Community Data Center, August 2010. <https://gnocdc.s3.amazonaws.com/NOIat5/MeasuringProgress.pdf>

⁴ Louisiana State University Health impacts of Deepwater Horizon disaster on coastal Louisiana residents surveyed. July 2010. http://www.lsu.edu/pa/mediacenter/tipsheets/spill/publichealthreport_2.pdf?id=329

⁵ Government Accountability Office, CMS and HRSA Assistance to Sustain Primary Care Gains in the Greater *New Orleans* Area. GAO-10-773R, June 30, 2010.

healthcare delivery transformation that has improved access to a higher quality, more responsive, and better coordinated health care services for the area's most vulnerable residents.⁶ The 25 participating entities represent a broad spectrum of safety-net provider types, including federally qualified health centers, academic and hospital affiliated outpatient programs, faith-based organizations, state entities, and grassroots medical clinics. Eligible entities were identified in response to a non-competitive request for application process. At the time of grant award, these entities operated 67 service delivery sites across the four parish area. Currently, there are 87 clinics providing outpatient primary and behavioral health services, a 34 percent growth in the number of clinics operating in the region. To date, a total of just over \$92 million has been disbursed to support the operations at these clinics, with organizational awards ranging from \$428,275 to \$7,989,962 for the three-year period. *See Appendix A for a complete list of PCASG organizations and total net award amounts.*

This grant program established a framework for rapidly expanding access for area residents, regardless of ability to pay. Every six months for the first 24 months, the network saw a 13 percent increase in number of patients served from the prior six-month period. The payment methodology encouraged practices to serve the uninsured, Medicaid and Medicare populations, and incentivized practices to offer medication access and/or pharmacy services to patients and to adopt nationally recognized quality standards. The majority of funds disbursed were allocated based on prospective population based awards issued on a semi-annual basis, calculated using the number of patients served for a six-month look back period, and adjusted for type of service, age, and payor type. *See Appendix B for a summary of the PCASG payment methodology.* On a quarterly basis, entities report encounter level data on patients served by organization and clinic. *See Appendix C for information on encounter level data collection and reporting under PCASG.*

Primary care services defined under the grant include:

- primary health care services by licensed primary care practitioners (specialty areas such as internal and family medicine, obstetrics, pediatrics, etc);
- preventative and well care;
- diagnostic laboratory and radiological services;
- dental and optometric services;
- mental health and/or substance abuse screening, assessment, counseling, referral, treatment, and follow-up services;
- urgent medical and mental health care services;
- pharmacy services;
- case management services; and

⁶ MM Doty, MK Abrams, S Mika, SD Rustgi, and G Lawlor, *Coming Out of Crisis: Patient Experiences in Primary Care in New Orleans, Four Years Post-Katrina – Findings from The Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans*, The Commonwealth Fund, January 2010.

- outreach.

In addition, up to 15 percent of an organization's award could be used to support specialty care.

Participating entities were held to allowable expenditures outlined in the federal notice of award or approved by CMS related to the above direct care services. At least 85 percent of the funds awarded supported direct patient care activities with only 15 percent of funds eligible for grant administration, quality improvement and data reporting activities. Expenditures related to health information technology were prohibited.

The federal grant program has been managed by the Louisiana Public Health Institute (LPHI) in close coordination with DHH, the award recipient, and the Centers for Medicare and Medicaid Services, the federal agency administering the grant. As local administrator of the grant, LPHI provides day to day oversight of the program, including but not limited to monitoring financial requirements of the grant and compliance with federal rules and regulations, monitoring and auditing of PCASG related expenditures, collecting and analyzing financial, service utilization, and clinic operational data from participating entities, convening regional planning efforts, and providing technical assistance in the areas of access, quality, sustainability, and coordination across the continuum of care.

PCASG RESULTS TO DATE

In the five years since Hurricane Katrina, this network of 25 organizations has worked collaboratively to build a unique, high quality, efficient, community-based primary care and mental health delivery system for the Greater New Orleans area. This network now serves as the primary source of healthcare for nearly 20 percent of the region's population or 175,000 people each year. Under difficult conditions, the network has developed into a successful new model for rapidly building capacity for quality primary care and community mental health services.

Highlighted accomplishments:

- Rapidly planned and implemented healthcare redesign under challenging conditions by bringing together community healthcare providers and key stakeholders to address the healthcare needs of the region immediately following Hurricane Katrina.
- Reoriented a hospital-based care delivery system to a community-based delivery system, with 87 clinics offering a broad range of primary and behavioral health services throughout the region, a 30 percent increase in the number of clinics since the grant began. *See Appendix D for a complete list of clinic sites by parish and organization. See Appendix E for an overview of the distribution of different types of clinics throughout the region.*

- Expanded hours of operation, increased staffing, and broadened the scope of services available on site and through contractual relationships, in response patient needs.
- Increased access to healthcare for all residents of the Greater New Orleans area. Since the grant began, PCASG clinics served over 292,000 individuals with approximately 1.3 million visits; nearly 20 percent of the region’s population annually. Of those served, 43 percent are uninsured and an estimated 60,000 of those have incomes below 200 percent of poverty. *See Appendix E for an overview of PCASG services by parish of patient residence and clinic location.*
- Improved integration of primary care and mental health services by doubling the number of integrated sites.
- The grant administrator, LPHI, secured over \$1.5 million in additional non-governmental funds and other resources to provide technical assistance and improve the quality and scope of services provided.
- Created an incentive-based payment program that resulted in improved quality of care and grew the numbers of patients served 13 percent every six months for the first two years.
- Provided high quality medical homes to uninsured and insured individuals alike. Forty clinics are recognized as patient-centered medical homes by the National Committee for Quality Assurance; all have established minimum quality standards consistent with high performing health care systems. PCASG patients report better access to high quality healthcare than most U.S. adults, and more confidence in their healthcare providers.⁷
- Continued to strengthen and develop new mechanisms for improved care coordination between the community-based clinics and the Interim LSU Public Hospital and other area hospitals.
- Improved capacity for reimbursement by patients and third party insurers, including Medicaid and LaCHIP, implemented sliding fee scales, and took steps to monitor and improve revenue collection. All participating clinics are now enrolled as Medicaid providers.

In May of 2010, HHS awarded one of 15 Beacon Community Grants, a three-year health information technology grant to develop the health information infrastructure and exchange

⁷ MM Doty, MK Abrams, S Mika, SD Rustgi, and G Lawlor, Coming Out of Crisis: Patient Experiences in Primary Care in New Orleans, Four Years Post-Katrina – Findings from The Commonwealth Fund 2009 Survey of Clinic Patients in New Orleans, The Commonwealth Fund, January 2010.

between a subset of PCASG participating entities and three New Orleans area hospitals, Ochsner Health System, Tulane Medical Center, and the Interim Louisiana State University Public Hospital. Crescent City Beacon Community (CCBC), administered by LPHI, seeks to achieve meaningful and measurable care improvements in health care quality, safety, and efficiency through health information exchange to align the safety net continuum of care. Funding is earmarked for technology development and technical support and not available for support of direct patient care. Currently in the early planning stages, it is anticipated that the CCBC will align with larger health information exchange efforts in the state.

RECENT DEVELOPMENTS AND CRITICAL NEED TO PRESERVE AND TRANSITION PCASG INFRASTRUCTURE TO 2014

The PCASG clinics have become an important source of care for a largely disadvantaged population that has historically relied on the public hospital and emergency rooms for primary care. Without a new funding stream to preserve this model that has improved access to health care, the region will experience a crippling decrease in capacity within the community-based provider network, and likely return to the costly hospital-based care delivery system. Area residents will delay care and seek out emergency department care in crises, when it is often too late to reverse negative health outcomes.

As highlighted most recently by the Government Accountability Office (GAO), the participating entities have worked to enhance sustainability through billing third party payors, increasing revenue streams by charging sliding scale fees, and applying for status as Federally Qualified Health Centers (FQHC). Those involved with PCASG at the state and federal level have indicated that despite these efforts, reimbursement for the insured patients may not sufficiently ensure sustainability of the participating organizations because of the high proportion of uninsured served.⁸ Reliance on PCASG funding is significant for many participating organizations and used to support direct care costs, including personnel and professional service contracts. Ten of the 25 participating organizations reported that PCASG funding accounted for more than 50 percent of their funding for the year, and these same organizations serve a high proportion of uninsured, some more than 70 percent.

The ACA will, in the long run, aid the participating organizations to become more sustainable. However, there is a three year gap between the end of PCASG funding and the expected expansion of health care coverage in 2014. Officials interviewed by GAO are concerned that in the interim, even if all available health insurance revenue is captured by these providers, some will not be sustainable without funding from other sources.

⁸ Government Accountability Office, CMS and HRSA Assistance to Sustain Primary Care Gains in the Greater New Orleans Area. GAO-10-773R, June 30, 2010.

This waiver is as an opportunity to build upon the success of the federal investment that has resulted in a stronger, more coordinated community-based healthcare delivery system and provide valuable information and data to assist in the planning for and the implementation of an expanded Medicaid program and State Health Benefits Exchange in 2014. Maintaining this network is vital to the region's continuing recovery from Hurricane Katrina, is an integral part of the state's long term commitment to the communities impacted by the Gulf oil spill, and is critical to ensure the availability of a robust and prepared network of clinic-based primary care providers in the Greater New Orleans area in 2014.

DEMONSTRATION ELEMENTS

OVERVIEW

This waiver will help preserve primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with the PCASG funds awarded to the State by the U.S. Department of Health and Human Services' (HHS), advance and sustain the medical home model begun under PCASG, and transition the grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, LaCHIP, and other payor sources as the revenue base.

DHH recognizes that the transition will require careful planning and program design with ongoing input from all stakeholders. As such, waiver activities are organized into two broad phases with incremental milestones internal to each:

- Phase 1 spans demonstration months 1-18 (October 2010 – March 2012) and focuses on access preservation and transition planning. In demonstration month 12 (September 2011), the State will submit to CMS for review and approval a waiver amendment detailing plans to be implemented in Phase 2.
- Phase 2 spans demonstration months 19-42 (April 2012 – March 2014) and focuses on plan implementation and assessment, successful transition to Medicaid and the State Health Benefits Exchange, and demonstration phase-down.

The basic waiver design elements are described in the following narrative and summarized in the following table.

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

Waiver Elements	Demonstration Months 1-18 (October 2010-March 2012)	Demonstration Month 19-42 (April 2012-March 2014)
<p>Eligibility and Enrollment</p>	<p>Waiver-eligible individuals will reflect the newly Medicaid eligible population and a subset of the population eligible for enrollment in the State Health Benefit Exchange</p> <ul style="list-style-type: none"> • uninsured for at least 6 months (or have a good cause exception) • 19-64 years old • not eligible for Medicaid, LaCHIP, or Medicare • a resident of one of the participating parishes with income up to 200 percent of the Federal Poverty Level (FPL) • Compliant with DRA citizenship requirements <p>Phase 1 Milestones</p> <p>By demonstration month 3</p> <ul style="list-style-type: none"> • Screen and enroll in Medicaid or LaCHIP eligible but uninsured children under age 19 currently receiving services through the PCASG clinic network <p>By demonstration month 6</p> <ul style="list-style-type: none"> • Develop a web-based system to collect six standard data elements from all patients, including name, DOB, Social Security Number (SSN), physical address, household composition, and self-declared income • Provide training and technical assistance on web-based system • Begin system use • Use data collected by the clinics to verify patients' age, residency, citizenship, and Third Party Liability information through electronic interfaces with available data systems • Use available data to determine eligibility ex-parte (without contacting the individual) • Notify individuals of the eligibility decision. • Enroll eligible individuals in the waiver • Issue an identification card denoting the presenting clinic as the enrollee's assigned medical home. • Eligible individuals will receive 12 months of continuous eligibility • Add to Medicaid Eligibility Data System (MEDS) four new type cases for the waiver, both pairs based on income (<138% FPL and 139-200% of FPL), one for existing clinic patients eligible under the waiver and the other for patients new to the clinics under the demonstration • Use type case data to track waiver expenditures by Medicaid Eligibility Group (MEG), prioritize services for enrollees in the lower income group over those in the higher income group, and prioritize existing clinic patients over new patients in the higher income group 	<p>Phase 2 Milestones</p> <p>By demonstration month 24</p> <ul style="list-style-type: none"> • Plan and begin piloting under the waiver the Modified Adjusted Gross Income (MAGI) eligibility methodology and simplified, streamlined, online application system for enrollment of eligible individuals into Medicaid or the Exchange <p>By demonstration month 36</p> <ul style="list-style-type: none"> • Use system for enrollees pre-apply for Medicaid and Exchange enrollment

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

	<p>By demonstration month 9</p> <ul style="list-style-type: none"> Identify and presumptively enroll in Medicaid or LaCHIP uninsured children under age 19 currently receiving services through the PCASG clinic network <p>By demonstration month 12</p> <ul style="list-style-type: none"> Adapt existing Express Lane Eligibility (ELE) processes to identify and automatically enroll uninsured adults ages 19-64 who live in a Greater New Orleans area household and meet citizenship requirements Begin conducting eligibility redeterminations on the demonstration population enrolled in demonstration month one Submit to CMS a demonstration amendment for Phase 2 <p>By demonstration month 18</p> <ul style="list-style-type: none"> Plan and begin piloting a process of presumptive eligibility by clinics for waiver-eligible individuals 	
<p>Benefits and Cost Sharing</p>	<p>Continue to offer current PCASG benefits, except dental, ophthalmology, and pediatric services</p> <p>Phase 1 Milestones</p> <p>By demonstration month 6</p> <ul style="list-style-type: none"> Assess the service-specific reporting capabilities of each clinic and provide technical assistance to close identified gaps in encounter data reporting Form an Advisory Committee to provide strategic guidance on benefit and delivery model design <p>By demonstration month 12</p> <ul style="list-style-type: none"> Match waiver enrollee data to patient-specific Uncompensated Care Cost (UCC) data Map waiver enrollee traffic patterns between waiver providers and area hospitals and identify the demographics of hospital “frequent flyers” Use maps to improve care coordination and referral relationships with area hospitals Use look-alike data for the frequent flyer demographics to inform Phase 2 benefit and delivery structure design Leverage plans for a State Plan Amendment to help the state’s Community Mental Health Centers (CMHCs) meet the ACA requirement that 40 percent of CMHC services be provided to non-Medicare eligibles Leverage plans for a SPA to modernize behavioral health services for parents with income to 11% of FPL currently eligible for Medicaid Submit to CMS a demonstration amendment detailing the benefit and delivery system model(s) proposed for Phase 2 	<p>Phase 2 Milestones</p> <p>By demonstration month 30</p> <ul style="list-style-type: none"> Use Phase 2 enrollee encounter data to assess whether the Medicaid expansion population behaves more like the Temporary Assistance to Needy Families (TANF) population or the Supplemental Security Income (SSI) disability population Assess whether the expansion population’s behavioral health care needs can be met by the full Medicaid benefit package, minimum essential health benefits, and/or supplemental behavioral health care benefits Use Phase 2 lessons to design benefits for the Medicaid expansion population

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

<p>Providers</p>	<p>Current PCASG providers except for those clinics providing exclusively dental, ophthalmology, and pediatric services</p> <p>Phase 1 Milestones</p> <p>By demonstration month 6</p> <ul style="list-style-type: none"> Perform a needs assessment of existing clinic capacity to bill available payor sources and collect and report detailed data on service utilization <p>By demonstration month 12</p> <ul style="list-style-type: none"> Provide technical assistance to build provider capacity to bill available payor sources and collect and report detailed data on service utilization Use Advisory Committee to develop provider qualification standards for Phase 2 Include in a demonstration amendment to CMS the provider qualifications that will apply in Phase 2 and the state’s plans for securing such provider agreements <p>By demonstration month 15</p> <ul style="list-style-type: none"> Release provider qualification requirements via RFP or other mechanism for provider participation in Phase II and reach agreements with providers for participation in Phase 2 	<p>Phase 2 Milestones</p> <p>By demonstration month 19</p> <ul style="list-style-type: none"> Establish and implement provider participation requirements under the demonstration that all participating providers will be required to agree to in order to participation in Phase 2
<p>Provider Payments</p>	<p>Provider payments will be based on a modification of the PCASG supplemental payment methodology to reflect the population eligible for enrollment under the demonstration</p> <ul style="list-style-type: none"> Eliminate patient type-based payment multipliers for individuals under 19 and over 64 Eliminate payor-type payment multipliers for individuals with Medicaid, Medicare, and private insurance Retain payment multipliers for primary care and behavioral health Make semi-annual payments Cap payments at three-year average of PCASG awards Reserve the difference between aggregate provider payments and available funding for the demonstration year to fund any “woodwork effect” and/or Phase 2 benefits <p>Phase 1 Milestones</p> <p>By demonstration month 6</p> <ul style="list-style-type: none"> Form Advisory Committee to guide Phase 2 payment and delivery system design <p>By demonstration month 12</p> <ul style="list-style-type: none"> Submit as part of the Phase 2 demonstration amendment a proposed payment and delivery system to be implemented beginning in demonstration month 19 Increase clinic capacity to close gaps in service level encounter data collection and reporting to facilitate payment design modeling Design appropriate P4P strategy 	<p>Phase 2 Milestones</p> <p>By demonstration month 19</p> <ul style="list-style-type: none"> Implement payment models designed in Phase 1 <p>By demonstration month 30</p> <ul style="list-style-type: none"> Evaluate the need for changes to this model (or models) Continue collecting and evaluating the quality of the encounter data collection and reporting

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

Budget Neutrality	Unspent DSH allotment and payments under a flexible funding pool tied to milestones.	
State Match/Total Computable		
Evaluation		<ul style="list-style-type: none"> • Which populations are at greatest risk of eligibility loss in the conversion from current income eligibility policy to the MAGI standard and what measures can be taken to protect them? • What eligibility policy, administrative procedure, and information technology system changes will be needed to meet ACA application and enrollment requirements for Medicaid and the Exchange? • How can states prepare primary and behavioral health providers that serve low-income uninsured adults using funding from self-payments, public or private grants, local or State government sources today to bill for services provided to these patients once enrolled in coverage through Medicaid or the Exchange in 2014? • Will the demonstration population behave more like the TANF or SSI-disability eligible individuals? What benefits will be needed to meet the behavioral health care needs of the Medicaid expansion population and low-income adults eligible to enroll in coverage through the Exchange? • What benefit and payment design models best support a medical home model for low-income adults with primary and behavioral health care needs?

ELIGIBILITY AND ENROLLMENT

Individuals eligible for enrollment under the waiver will reflect the demographics of the newly Medicaid eligible population in the Greater New Orleans area and a subset of the population eligible for enrollment in the State Health Benefit Exchange in January 2014. Waiver eligibility will be limited to those who are: uninsured for at least six months (or have a good cause exception); 19-64 years old; not eligible for Medicaid, LaCHIP, or Medicare; and a resident of one of the participating parishes with income up to 200 percent of the Federal Poverty Level (FPL). *See Appendix F for a clinic-specific accounting of total patients served by PCASG compared to uninsured patients ages 19-64 served by PCASG for the most recent grant reporting period.* All waiver enrollees must be in compliance with the citizenship requirements under the Deficit Reduction Act (DRA).

Currently, PCASG clinics accept all patients without regard to a person's ability to pay. Some clinics screen for Medicaid eligibility but procedures vary, and on-site application is not universally available. Some clinics, such as participating Federally Qualified Health Centers, collect more demographic data than others. Data elements collected vary across clinics, and data collected are not uniformly reported or centrally available. In general, the clinics do not have eligibility criteria or enrollment processes.

A first step in the transition to financial sustainability, and the focus of Phase 1, is capacity-building for the collection of clinic patient data for eligibility and enrollment purposes, first in the waiver and ultimately in Medicaid, LaCHIP, the State Health Benefits Exchange, or employer-sponsored insurance.

PHASE 1 MILESTONES

DHH will:

- By demonstration month 3
 - Through an enhanced enrollment effort with providers of pediatric health services, screen and enroll in Medicaid or LaCHIP eligibles among the approximately 10,000 uninsured children under age 19 currently receiving services through the PCASG clinic network, thereby protecting this vulnerable population from losing access to care as adult-only waiver funding replaces PCASG funding unrestricted by age.
- By demonstration month 6

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

- Partner with PCASG clinics to develop a web-based system to collect six standard data elements from all patients, including name, date of birth, Social Security Number, physical address, household composition, and self-declared income.
 - Use data collected by the clinics to verify patients' ages, residency, citizenship, and Third Party Liability information through available electronic interfaces with such data systems as the Louisiana Vital Records Registry (VRR), Social Security Citizenship Match, Louisiana Automated Management Information (L'AMI), Coordination of Benefits (COB) Match.
 - Use available data to determine eligibility ex-parte (without contacting the individual) and notify individuals of the eligibility decision.
 - Enroll eligible individuals in the waiver, and issue an identification card denoting the presenting clinic as the enrollee's assigned medical home. Eligible individuals will receive 12 months of continuous eligibility regardless of changes in circumstance during that period with the exception of the enrollee moving out of the region or gaining third party coverage, particularly through Medicaid.
 - Add to its Medicaid Eligibility Data System (MEDS) two pairs of new type cases for the waiver. Both pairs will be based on income: 1) under 138% of FPL (in anticipation of a modified adjusted gross income standard) and 2) between 139 and 200% of FPL. One pair will be for eligible individuals currently receiving services in the clinic network, and the other pair for eligible individuals who begin receiving services in the clinic network on or after October 1, 2010.
 - The type case data will be used to track waiver expenditures by Medicaid Eligibility Groups and inform program management decisions that ensure that enrollment of individuals in the lower income eligibility group is prioritized over individuals in the higher income eligibility group. Individuals below 200% of FPL currently receiving services in the clinic network will receive priority for funding and enrollment. Beyond the existing population served, DHH will prioritize new enrollment of individuals with income below 138% over enrollment of individuals with higher income and may utilize enrollment caps and wait lists to assist in this prioritization.
- By demonstration month 9
 - Identify and presumptively enroll in Medicaid uninsured children under age 19 currently receiving services through the PCASG clinic network
 - By demonstration month 12

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

- Adapt existing Express Lane Eligibility (ELE) processes to identify and automatically enroll uninsured adults ages 19-64 who live in a Greater New Orleans area household and meet DRA citizenship requirements. Through automated electronic interface with Supplemental Nutrition Assistance Program (SNAP) data systems, existing ELE processes, Medicaid identifies and automatically enrolls children who live in a household with an active SNAP (“Food Stamps”) case. Under the waiver, the SNAP decision will be used to verify age and residency and serve as a proxy for income; and, automated electronic interfaces with Coordination of Benefits (COB) Match and Social Security Citizenship Match will verify insurance status and citizenship.
- Adapt for waiver use existing Express Lane Eligibility processes that, through electronic interface with SNAP data systems, identify and automatically enroll children who live in a household with an active SNAP (“Food Stamps”) case in Medicaid or LaCHIP, effectively using the SNAP decision as a proxy for income and residency. Under the waiver, the SNAP decision will be used as proxy for income and residency.
- Begin conducting eligibility redeterminations on the demonstration population enrolled in demonstration month one. DHH will apply the same renewal strategies to waiver enrollees as it does to Medicaid and LaCHIP enrollees. It will seek to establish continued eligibility through a spectrum of administrative procedures designed to maximize the (re)use of available data and automation and minimize action required by eligibility workers and enrollees.
- Apply the same retention strategies to waiver enrollees as applied to Medicaid and LaCHIP enrollees. In addition to issuing advance notice of closure giving the enrollee 10 days to respond prior to closing the case as required by federal regulations, to comply with State administrative policy eligibility workers must attempt enrollee phone contact on three different days and times and document the call attempts in the agency’s Electronic Case Record all call attempts. Workers cannot close a case without supervisory approval, which comes only after the supervisor has further attempted and failed to make enrollee contact. The effectiveness of the State’s retention strategies are evidenced by its statewide procedural closure rates of less than one percent. These strategies will be important in retaining these former uninsured as waiver enrollees and bridging them into either Medicaid or the Exchange in 2014.
- Submit to CMS a demonstration amendment detailing any changes to the eligibility and enrollment process proposed for Phase 2 based lessons learned in

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

Phase 1. The amendment will reflect DHH's plans to pilot the modified adjusted gross income test approach and pre-apply individuals for Medicaid, CHIP or Exchange eligibility shortly prior to January 1, 2014.

- By demonstration month 18
 - Plan and begin piloting a process of presumptive eligibility by clinics for individuals eligible to enroll in the waiver. This demonstration of a presumptive eligibility process by clinics will serve to inform the development and implementation of a presumptive eligibility process by hospitals for the Medicaid expansion population in 2014.

Having first in Phase 1 built capacity for and established use of Medicaid-like eligibility and enrollment processes based on current income eligibility methodologies and stand-alone and systems, Phase 2 will focus on the transition to the income eligibility methodologies and integrated systems for Medicaid and the State Health Benefit Exchange mandated by the ACA.

PHASE 2 MILESTONES

DHH will

- By demonstration month 24
 - Plan and begin piloting under the waiver the Modified Adjusted Gross Income (MAGI) eligibility methodology and simplified, streamlined, online application system for seamless enrollment of eligible individuals into Medicaid or the Exchange effective January 2014. Income eligibility methods to be piloted in Phase 2 will be developed in Phase 1, in tandem with federal guidance and State policy making in preparation for the mandatory Medicaid expansion.

Development will include comprehensive review of current State income eligibility policy, administrative procedures work processes, and information technology systems, including but not limited to the Medicaid Eligibility Data System (MEDS); inventory and analysis of ACA mandates related to eligibility and enrollment for Medicaid and the Exchange; and, identification of changes to State law or rule and agency policy, procedure, work processes or information technology systems required to comply with federal law.

The online application system will utilize the MAGI method and build on the web-based system developed in Phase 1. Its design will model plans for the eligibility and enrollment functions of the Exchange currently under development

by DHH and the Louisiana Department of Insurance under the auspices of an Interagency Task Force on federal health care reform appointed by the Governor.

- By demonstration month 36
 - The system will enable enrollees to pre-apply for Medicaid and Exchange enrollment and minimize loss of access to essential health care services in the transition to comprehensive coverage.

The demonstration will “road test” planned changes and help prepare the State to demonstrate Exchange readiness in January 2013. It will provide valuable rubber-meets-the-road lessons for broader implementation and pave the way for smoother operations into 2014. Lessons learned will inform health care reform implementation efforts not only in Louisiana but in other states across the nation. Louisiana’s experience will be particularly influential given the State’s demonstrated leadership in the sort of simplification and streamlining of Medicaid enrollment and retention processes envisioned by the ACA.

BENEFITS AND COST SHARING

Phase 1 of the demonstration focuses on preserving access to the benefits available to individuals currently being served by the PCASG clinics while providing time to evaluate the needs of the demonstration population and craft the benefits and delivery system model(s) that will be implemented in Phase 2.

PRESERVING ACCESS

Through Phase 1, the demonstration will continue to offer most of the benefits currently offered through PCASG. It will focus on primary and behavioral health care with limited access to pharmacy and specialty care. Three noteworthy differences between PCASG and waiver benefits are dental, ophthalmology, and pediatric services. Dental and ophthalmology services will not be offered under the waiver because the benefits are not available to adults under the Medicaid program. Pediatric services will not be offered because the population eligible to enroll in the demonstration is limited to adults ages 19-64.

Phase 1 benefits will include:

- primary health care services by licensed primary care practitioners (specialty areas such as internal and family medicine, obstetrics, pediatrics, etc);
- preventative and well care;
- diagnostic laboratory and radiological services;
- mental health and/or substance abuse screening, assessment, counseling, referral, treatment, and follow-up services;

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

- urgent medical and mental health care;
- limited pharmacy;
- case management
- other specialty or non-hospital services to the extent described in Section 1905(a) of the Social Security Act as necessary to meet the unique needs of an individual clinic's population and stay within budgetary limits.

EVALUATING NEEDS

A prerequisite for the design of Phase 2 benefits and delivery system model(s) is a thorough understanding of the primary and behavioral health care needs of the demonstration population. Such understanding typically comes from analysis of administrative (health care claims and enrollment) data. Diagnoses codes, service utilization, and resource use (costs) help to describe the patient population. These data can indicate complexity and serve as proxies for overall care coordination needs, which are key considerations in crafting a benefit and delivery system model(s) that supports a health home model to improve the health and quality of life for individuals, especially those with chronic and complex physical and/or mental health conditions.

The PCASG clinics have worked hard to realize a medical (health) home model, and a primary goal of this demonstration is to sustain and advance that work. To achieve this goal, more data will be needed than what is currently collected by the PCASG provider network as a whole. Data now collected varies by PCASG clinics and only limited encounter level data is reported to a central source. Some clinics, such as participating Federally Qualified Health Centers, collect more encounter data than others. Encounter data reported to the PCASG grant administration is limited to the date, provider type, aggregate patient visit type (primary care or behavioral health, and only two diagnoses codes. *See Appendix C for information on encounter level data collection and reporting under PCASG.* The additional data required for Phase 2 will be obtained through Phase 1 milestones.

CRAFTING BENEFITS AND DELIVERY SYSTEM MODEL(S)

Phase 2 benefits and delivery system model(s) will be crafted to improve the health and quality of life of waiver enrollees, especially those with chronic and complex physical and/or mental health conditions, and more seamlessly transition waiver enrollees into the benefits available under Medicaid or the Exchange in 2014.

PHASE 1 MILESTONES

DHH will:

- By demonstration month 6

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

- Assess the service-specific reporting capabilities of each clinic and provide technical assistance to close identified gaps in encounter data reporting.
- Form an Advisory Committee to provide strategic guidance on benefit and delivery model design. The committee will be comprised of stakeholders from provider, payor, consumer, and quality organizations.
- By demonstration month 12
 - Match data collected for waiver eligibility and enrollment purposes to patient-specific Uncompensated Care Cost (UCC) data (supplied to DHH as a condition of eligibility for Disproportionate Share Hospital (DSH) payments).
 - Map waiver enrollee traffic patterns between waiver providers and area hospitals (emergency departments and inpatient units) and identify the demographics of hospital “frequent flyers.”
 - Use traffic pattern maps to improve care coordination and referral relationships with area hospitals.
 - Use look-alike data for the frequent flyer demographics, such as available from national sources of Federally Qualified Health Center data, to inform Phase 2 benefit and delivery structure design.
 - Leverage concurrent plans for a State Plan Amendment to help the state’s Community Mental Health Centers meet the ACA requirement that 40 percent of CMHC services be provided to non-Medicare eligible individuals and to more seamlessly transition waiver enrollees into the benefits available under Medicaid in 2014.
 - Leverage concurrent plans for a State Plan Amendment to modernize behavioral health services for adults (parents with income to 11% of FPL) currently eligible for Medicaid to more seamlessly transition waiver enrollees into the benefits available under Medicaid in 2014.
 - Consider leveraging opportunities presented by the ACA, such as the optional State Plan Amendment for health homes for chronic conditions, including Serious Mental Illness, and grants for co-location of primary care services in community-based behavioral care settings.
 - Submit to CMS a demonstration amendment detailing the benefit and delivery system model(s) proposed for Phase 2. It will reflect Phase 1 data collection and analysis and Advisory Committee recommendations, and be designed to

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improve the health and quality of life of waiver enrollees, especially those with chronic and complex physical and/or mental health conditions, more seamlessly transition waiver enrollees into the benefits available under Medicaid or the Exchange in 2014, and stay within the cost constraints of the demonstration.

PHASE 2 MILESTONES

DHH will:

- By demonstration month 30
 - Use Phase 2 enrollee encounter data to assess whether the Medicaid expansion population is more likely to exhibit diagnostic and utilization patterns more like the TANF population (parents with incomes up to 11% of poverty currently eligible for Medicaid in Louisiana) or the SSI-disability population (parents and childless adults with incomes up to 74% of poverty) which has significantly more severely and persistently mentally ill adults. It is anticipated that the expansion population will have significantly higher behavioral health care needs than the current TANF population. The demonstration will help determine whether the expansion population's behavioral health care needs can be met by the full Medicaid benefit package, minimum essential health benefits (even with mental health services parity, benchmark or benchmark-equivalent benefit plans may not be adequate for this population), and/or supplemental behavioral health care benefits. Lessons learned from the demonstration will inform State decision making on benefit design for the Medicaid expansion and low-income adults eligible for coverage through the Exchange.
 - Use Phase 2 lessons in the design of the benefits that will be available to all newly eligible Medicaid enrollees beginning January 1, 2014.

Throughout the demonstration cost sharing will not exceed the amount allowable under Medicaid rules and no cost-sharing will be applied to preventive health services.

PROVIDERS

In order to ensure the long-term sustainability of the primary and behavioral health care infrastructure begun under the PCASG model, DHH recognizes the need to continue building capacity within the existing clinics to collect patient-specific eligibility information, to increase their ability to bill all available payor sources, and to collect and report encounter data, as is expected to be required of Medicaid and the Exchange. For example, even though all clinics participating under PSCAG have now become Medicaid-participating providers, not all providers have the ability to bill Medicaid for the services they are providing. These clinics need

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

time to develop this capacity and agree to be held to provider participation standards that will in developed for Phase 2 of the demonstration.

In Phase 1, waiver providers will include current PCASG grantees except for those clinics providing exclusively dental, ophthalmology and pediatric services. Dental and ophthalmology service providers are excluded under the waiver because the benefit is not available to adults under the Medicaid program. Pediatric service providers are excluded because the population eligible to enroll in the demonstration is limited to adults ages 19-64. *See Appendix F for list of PCASG clinics not eligible to participate in the waiver.*

However, as part of an enhanced enrollment feature of the demonstration, DHH will identify all uninsured children that have been receiving services through PCASG clinics, including pediatric providers, and presumptively enroll children in Medicaid or LaCHIP to the extent possible. In addition, short-term plans for a State Plan Amendment to modernize behavioral health services for children currently eligible for Medicaid will help transition pediatric behavioral health services offered through PCASG to financial sustainability and preserve access to behavioral health services for PCASG patients under age 19 as adult-only waiver funding replaces PCASG funding unrestricted by age.

Phase 1 will provide DHH with time to provide intensive technical assistance to clinics, establish provider participation standards for Phase 2, and enter into agreements with providers under the delivery system model to be designed for Phase 2.

PHASE 1 MILESTONES

DHH will:

- By demonstration month 6
 - Perform a needs assessment of existing clinic capacity to bill available payor sources and collect and report detailed data on service utilization.
- By demonstration month 12
 - Provide technical assistance to providers to build clinic capacity to bill available payor sources and collect and report detailed data on service utilization
 - Utilize the Advisory Committee to develop provider qualification standards for Phase 2.
 - Include in a demonstration amendment to CMS the provider qualifications that will apply in Phase 2 and the state's plans for securing such provider agreements.
- By demonstration month 15

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- Release provider qualification requirements via RFP or other mechanism for provider participation in Phase II and reach agreements with providers for participation in Phase 2.

PHASE 2 MILESTONES

DHH will:

- By demonstration month 19
- Establish and implement provider participation requirements under the demonstration that all participating providers will be required to agree to in order to continue participation beyond Phase 1. While DHH develops these requirements and implements a process to selectively contract with only those providers who agree to meet these requirements to participate in Phase 2, at a minimum, all providers will be required to actively participate in Medicaid and utilize available third party payment sources during Phase 1.

PROVIDER PAYMENTS AND DELIVERY SYSTEM

DHH recognizes the need to transition payments to the clinics away from the population-based payment allocation that originated with the grant funding to a payment and delivery system design consistent with Medicaid payment design as envisioned in 2014 (e.g., non-risk payment methodology, prepaid rates, enhanced primary care case management), including consideration of Medicaid payment reform and payment that ensures the continued success of the medical home model implemented under the PCASG funding. Providing for payment consistent with the direction of Medicaid payment will be critical to the successful transition of the participation providers and populations to the Medicaid expansion in 2014.

In Phase 1, provider payments will be based on a modification of the PCASG supplemental payment methodology to reflect the population eligible for enrollment under the demonstration. Specifically, patient type-based payment multipliers for individuals under 19 and over 64 will be eliminated, as well as payor-type payment multipliers for individuals with Medicaid, Medicare, and private insurance. Only the payment multipliers for primary care and behavioral health will remain. DHH will impose a ceiling on the amount of funding a provider can receive through this allocation methodology based on a three-year average of the funding received under the PCASG funding. *See Appendix B for details on the PCASG payment methodology.* The tables below detail the modifications to be made to the PCASG payment methodology for Phase 1.

UNDUPLICATED PATIENT TYPES AND PAYMENT MULTIPLIERS

Unduplicated Patient Type	Payment Multiplier
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Primary care 19 to 64 years	2x
Behavioral Health (19-64 years)	2x

PAYOR TYPE AND PAYMENT MULTIPLIER

Payor Type	Payment relative to Private Insurance	Payment Multiplier (1 – Payment relative to Private Insurance)
Uninsured	0%	1.00x

The difference between the aggregate amount available to pay providers and the available funding for the Demonstration year will be reserved in order to have adequate funding to enroll additional populations (i.e., the “woodwork effect”) as needed, with new populations with incomes up to 138% FPL receiving priority enrollment. If additional funding still remains, this funding will be considered in the amounts available for the benefit package design for Phase 2.

During the initial phase of the demonstration, participating clinics will receive semi-annual payments based upon this formula. Such payments will provide the clinics with stability during their transition from a grant funded model to a service-based reimbursement and care management model to be planned for Phase 2.

See Appendix J for sample comparison of PCASG grant awards and demonstration Phase 1 provider payments.

Under the PCASG grants, provider payments were made by LPHI. DHH proposes to assume this payment function in Phase 1 with technical assistance from LPHI to ensure a continuity of payments from the grants to payments under the demonstration.

Clinics will be accountable for documenting all expenditures under the demonstration.

PHASE 1 MILESTONES

DHH will:

- By demonstration month 6
 - Form an Advisory Committee to provide strategic guidance on payment and delivery system design for Phase 2. The committee will be comprised of stakeholders from provider, payor, consumer, and quality organizations.
 - Consider leveraging concurrent Medicaid and LaCHIP plans for implementation of Coordinated Care Networks (enhanced primary care case management and prepaid models) to also serve demonstration enrollees.

SUMMARY OF WAIVER DESIGN ELEMENTS AND MILESTONES BY PHASE

- By demonstration month 12
 - Submit as part of the Phase 2 demonstration amendment a proposed payment and delivery system to be implemented beginning in demonstration month 19.
 - Increase clinic capacity to close gaps in service level encounter data collection and reporting to facilitate payment design modeling.
 - Design appropriate P4P strategy.

PHASE 2 MILESTONES

DHH will:

- By demonstration month 19:
 - Implement the payment models designed in Phase 1
- By demonstration month 30:
 - Evaluate the need for changes to this model (or models)
 - Continue collecting and evaluating the quality of the encounter data collection and reporting

ADMINISTRATION AND PROGRAM OVERSIGHT

DHH estimates a total of \$1.5 million in administrative costs attributable to the waiver. These costs include eligibility systems development contracts, frontline eligibility staff and related expenses. This amount also includes outreach, MMIS changes, technical assistance to providers, and oversight and evaluation of the demonstration. DHH will submit a detailed description of expenditures necessary to administer the demonstration to CMS within 90 days of the demonstration approval.

BUDGET NEUTRALITY

Currently, more than \$1 billion of Medicaid and uninsured care funding in Louisiana is tied to hospital care. Under Medicaid Disproportionate Share Hospital (DSH) rules, funding is only available for hospital care and is not available for outpatient primary, preventive, and behavioral health care provided outside of a hospital setting.

The State intends to fund the cost of the demonstration by redirecting a portion of this available DSH funding to provide primary, preventive and behavioral health care to uninsured residents of the Greater New Orleans area through the clinic model begun under the PCASG grants. The State anticipates that approximately three percent of total available DSH funding per year will be

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redirected for the purpose of funding the coverage model for primary care and behavioral health. As such, the State requests that the budget neutrality agreement be measured based on an aggregate budget neutrality cap for DSH redirection.

The State anticipates that, in the absence of an approved demonstration, the Greater New Orleans area will experience a loss of the primary and preventive care infrastructure begun under the PCASG model and the area will experience an increase in hospital uncompensated care costs as uninsured individuals seek more costly care in DSH hospitals. Louisiana proposes to direct no more than three percent of its annual statutory DSH allotment for the CNOM expenditures dedicated to primary care and preventive care. This would provide the State with the flexibility to use up to \$30 million dollars (total computable) annually in total funding for the coverage of services to the demonstration population.

DHH requests that the \$30 million share (total computable) of the DSH allotment available for demonstration services be considered annual allotments and any unspent dollars are allowed to roll over for use in subsequent demonstration years. The evolution of the benefit and payment methodology over the demonstration as well as the unknown “woodwork” effect on enrollment necessitates flexibility in the annual amounts of funding. Though capped at the total for the entire demonstration period, the ability to carry forward unspent amounts will maximize the ability of DHH to transition this program to 2014 and beyond.

Any funds not expended for the redirection of DSH will continue to be available for uncompensated hospital care consistent with the DSH funding methodology. The State believes that the ability to preserve DSH funding for uncompensated care is critical in preserving safety net providers. The full DSH allotment will continue to be available to the State for qualified DSH expenditures, with up to \$30 million (total computable) authorized for redirection for waiver expenditures.

CALCULATION OF WITHOUT WAIVER EXPENDITURES

Without Waiver Expenditures have been projected based upon historical DSH allotments and projected CPIU growth for Louisiana. As Louisiana evolves its hospital program and available State funds, it is important to consider the entire DSH allotment available, especially given the uncertainty of how that allotment balance may change in FFY 2014 and beyond. Due to the growing number of uninsured and limitations of Medicaid reimbursement, the full need for these funds is expected throughout the demonstration period.

Although the entire DSH allotment is being included within the waiver request, the request for the DSH allotment limitation is consistent with CMS’ approach for other waivers requesting DSH redirection, i.e. Maine and Wisconsin 1115 requests. CMS terms and conditions for Maine Care for Childless Adults required that “demonstration costs that may be recognized as

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expenditures under the plan are limited to an amount that, when added to total DSH payments under the plan, does not exceed the allowable aggregate DSH allotment.”

CALCULATION OF WITH WAIVER EXPENDITURES

It is expected that \$30 million annually (approximately 3%), total computable, of the DSH allotment per year will be available for redirection during the first three years of the waiver; then \$15 million (total computable) in the final year of the waiver, with the subsequent percentage of total funding in the final year dependent upon the total allotment available as determined by CMS due to the implementation of health care reform. These costs are projected at \$19 million of federal funds during each of the first three years of the waiver, and then phased down due to the expansion of Medicaid eligibility in 2014 for individuals up to 133% FPL and the implementation of health care exchanges for those above Medicaid eligibility standards. Expenditures in DY4 will be limited to amounts necessary to continue the demonstration through December 31, 2013, transition enrollees under 138% FPL into Medicaid beginning January 1, 2014, and transition waiver enrollees up to 200% FPL into the State Health Benefit Exchanges. Any portion of this pool that is not used for redirection will continue to be available for distribution through the regular DHS program.

The State will manage the With Waiver budget neutrality based on the aggregate portion of DSH identified for redirection. While it is unknown how much the final primary care benefit design will cost as planned for Phase 2 implementation, Louisiana has committed to limiting total payments to those approved under the waiver, and will plan to implement enrollment and benefit limitations as necessary to meet this objective. Such limitations will prioritize enrollment and coverage for uninsured individuals up to 138% FPL over enrollment and coverage for those individuals with incomes up to 200% FPL.

The proposed benefits will not be entitlements, and the State intends to monitor the expenditures and enrollment of the program and implement limitations as necessary to ensure that total expenditures will not exceed the State’s total DSH allocation in any year of the demonstration.

DSH expenditures for FFY 2011 and beyond are projected as the difference between the allotment and waiver expenditures, as the State requests recognition of the entire allotment, including any amounts identified for waiver expenditures but not expended, for allowable DSH expenditures consistent with ongoing DSH authority.

See Appendix I for budget neutrality worksheets.

STATE MATCH AND TOTAL COMPUTABLE

The State estimates that approximately \$10,000,000 million in state share will be available annually to fund services under the demonstration. This amount will be provided via allowable intergovernmental transfers (IGTs), certified public expenditures (CPEs), or a combination of

both from Orleans, Jefferson, Plaquemines, and St. Bernard Parishes. Each Parish has identified amounts available through federal Disaster Community Development Block Grant (CDBG) funding that may be used to fund community health services. DHH seeks any authority necessary from CMS to use this funding as the state share of the demonstration expenditures.

The use of US Department of Housing and Urban Development (HUD) Community CDBG funding to support the Waiver is consistent with the intent of CDBG funding to assist communities in addressing local needs. As illustrated, the Waiver is intended to primarily benefit low and/or moderate income people residing the New Orleans area by preserving and expanding access to primary and behavioral health care services for adult residents living below 200 percent of the federal poverty level. With the national economic downturn and the Gulf Oil Spill, additional job losses and/or reductions in health insurance benefits has the potential to further increase the numbers of uninsured individuals who may benefit from the Waiver program in the region.

Additionally, the Waiver will sustain the economic growth that was created as the result of the \$92 million PCASG federal investment, in terms of the retention and expansion of health sector jobs. Personnel costs and professional services contracts make up nearly 70 percent of the 25 PCASG organizations' operating expenses, and approximately 800 health care professionals are involved in direct patient care. In addition, other personnel in the areas of administration and facilities maintenance are critical to the operations and maintenance of these 87 neighborhood-based health care clinics. PCASG organizations report that without additional funding, there would be significant reductions in staff, clinic closures, and/or reductions in the hours of operations, estimated at 30% to 40% for many organizations. Health care is an important employment sector that lost a tremendous amount of jobs as a result of Hurricane Katrina. PCASG and other federal funding targeted for healthcare workforce recruitment and retention were important to this region's economic recovery. The ability to use CDBG funding to support these organizations, their neighborhood clinics, providers, and administrative and support staff is essential to continue to serve low income individuals in the region.

Examples of CDBG funding used for primary care services in other cities include:

City of Davis – Use of CDBG funding for primary care services

<http://cityofdavis.org/cs/cdbg/0910pdf/0910-communicare.pdf>

City of Canton – CDBG funding into health care for low income community

http://www.usmayors.org/bestpractices/usmayor00/canton_article.htm

City of Tallahassee – Use of CDBG funding for primary care.

<http://www.talgov.com/e cd/community/humansvcs.cfm>

As certain clinics may qualify to certify public expenditures, the State would like to include this option for qualifying clinics based upon the circumstances of the clinics and the parishes throughout the demonstration period. This option may be attractive for providers from the onset,

or may become a reasonable alternative as the reimbursement methodology evolves and clinics approach the end of the demonstration.

If any Parish decides to contribute amounts less than anticipated or not at all, or cannot afford CPE at projected levels, DHH reserves the right to modify the demonstration-eligible population to a more restrictive geographical area with income limits and/or benefit modifications as necessary to live within the available level of funding.

See Appendix J for a copy of DHH's responses to the CMS Standard Funding Questions.

EVALUATION

The demonstration will provide valuable information to help answer national health care reform implementation questions on eligibility and enrollment, information technology, and benefit and payment design. These questions include:

- 1) Which populations are at greatest risk of eligibility loss in the conversion from current State income eligibility policy to the Modified Adjusted Gross Income standard? What measures can be targeted to at-risk populations to ensure the conversion does not result in the loss of eligibility as mandated by the ACA?
- 2) What are the major eligibility policy, administrative procedure, and information technology system changes that will be needed to satisfy ACA requirements on application for and enrollment into Medicaid and the State Health Benefits Exchange, most notably: the development of a single, streamlined form for all applicable State health subsidy programs that can be completed in-person, online, by telephone or mail; and, the development of a secure electronic interface allowing an exchange of data that allows a determination of eligibility for all programs based on a single application, and if an individual applying to the Exchange is found through screening to be eligible for Medicaid or CHIP, the individual is enrolled in that program?
- 3) How can lessons learned regarding capacity building for the transition to financial sustainability through full participation in the Medicaid eligibility expansion to 138% of poverty and the State Health Benefits Exchange mandated by the Affordable Care Act of 2010 effective January 2014 best be spread among providers similarly situated to current PCASG grantees? How can providers of primary and behavioral health services to low-income uninsured adults with self-payments, public or private grants, local or State government funding sources today prepare to serve the same patients once enrolled in Medicaid or coverage through the Exchange in 2014?

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- 4) With regard to mental health and substance abuse service utilization, will the expansion population behave more like the TANF population (parents with incomes up to 11% of poverty currently eligible for Medicaid in Louisiana) or the SSI-disability eligible individuals (parents and childless adults with incomes up to 74% of poverty)? To what extent will the expansion population's behavioral health care needs be met by minimum essential benefits? What, if any, supplemental behavioral health care benefits may be needed? How will the application of mental health parity and the ACA requirement that Community Mental Health Centers provide at least 40 percent of their services to non-Medicare eligible individuals affect the benefit design for the State's Medicaid expansion population?
- 5) What benefit and payment design models best support a community-based medical home for low-income adults with primary and behavioral health care needs?

PUBLIC NOTICE AND STAKEHOLDER INVOLVEMENT

The following outlines public notice and stakeholder involvement efforts undertaken to engage the Greater New Orleans community in this Section 1115 waiver proposal development process.

PRESS RELEASES

- LA Department of Health and Hospitals Press Release announcing the State/City Concept Paper for the 1115 Waiver, "DHH secretary, New Orleans mayor stress importance of federal funding for primary care clinics," June 1, 2010.
- City of New Orleans Press Release announcing the State/City Concept Paper for the 1115 Waiver, "Mayor Landrieu & Secretary Levine Offer Funding Solutions To Keep Primary Care Clinics Open," June 1, 2010.

WEBSITE POSTINGS

- Waiver Concept Paper posted on the DHH website, June 1, 2010
- Waiver Concept Paper posted on the City of New Orleans website, June 1, 2010
- Waiver Concept Paper posted on the PCASG.org website, July 6, 2010
- GAO Report posted on DHH website, July 10, 2010

PUBLIC/STAKEHOLDER FORUMS

- Primary Care Access and Stabilization Grantees Meeting, June 17, 2010
- Public Meeting, New Orleans City Council, Health Care and Social Services Committee, June 24, 2010

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- Mayor Elect of New Orleans Healthcare Transition Task Force Meetings
- Testimony to the US House Committee for Oversight and Government Reform, December 3, 2009, “Post-Katrina Recovery: restoring Health Care in the New Orleans Area. Speakers included: Alan Levine (DHH), Roxane Townsend (LSUHCSD), Clayton Williams (formerly of LPHI), Marcia Brand (HRSA), Diane Rowland (HJ Kaiser Foundation), Cynthia Bascetta (US GAO), Don Erwin (St Thomas CHC), Joia Crear-Perry (CNOHD), Alice Craft-Kerney (Lower 9th Ward Clinic), Michael Griffin (Daughters of Charity Services of NO), Karen DeSalvo (Tulane Medical School and Covenant House Clinic)

DISSEMINATION TO KEY STAKEHOLDERS

- Louisiana Primary Care Association
- Louisiana Health Care Quality Forum
- Primary Care Access and Stabilization Grant Participating Organizations

CURRENT RESOLUTIONS IN SUPPORT OF CONTINUING HEALTHCARE IN GREATER NEW ORLEANS REGION

- Louisiana Legislature, House Concurrent Resolution No. 238, 2009
- New Orleans City Council, Resolution R-09-432, 2009

These Resolutions express support for continuing efforts at the local, state, and federal level to create a sustainable financing model, which will support high-quality, community-based health care in the Greater New Orleans region once the PCASG expires in Sept. 2010.

LETTERS OF SUPPORT

- Obtained letters of support for the concept paper from the following:
 - Louisiana Primary Care Association
 - City of New Orleans Mayor Mitch Landrieu
 - 504 HealthNet
 - Catholic Charities Archdiocese of New Orleans
 - Louisiana Congressional Delegation
 - Louisiana Health Care Quality Forum
 - Louisiana Legislative Black Caucus
 - New Orleans Business Council
 - New Orleans City Council

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- N.O. Aids Task Force
- Performing Arts Medicine Association
- Urban League
- Women of the Storm
- Former DHH Secretary Alan Levine
- Bonnie Raitt
- Dr. John

PUBLIC/STAKEHOLDER FORUMS

- DHH Medical Care Advisory Committee, July 27, 2010
- Public meeting, Ashe Cultural Arts Center, August 3, 2010
- PCASG grantee meeting, August 5, 2010

NOTIFICATION OF FEDERALLY RECOGNIZED INDIAN TRIBES

- In compliance with provisions of the Americans Recovery and Reinvestment Acts of 2009 (ARRA), DHH notified all of Louisiana's federally recognized tribes of the State's plans for the proposed waiver. On July 14, 2010 cover letters and copies of the white paper detailing waiver plans were mailed to the leaders of each of the Chitimacha, Coushatta, Jenna, Tunica Biloxi tribes. *See Appendix K for a copy of the letter.*

APPENDICES

- A) PCASG Organizations and Total Net Award by Parish of Organization
- B) Summary of the PCASG Payment Model
- C) PCASG Encounter-Level Data Collection and Reporting
- D) PCASG Organizations and Clinic Locations
- E) Overview of PCASG Clinics by Type and Patients Served by Parish of Residence and Clinic Location
- F) PCASG Clinics by Type and Parish, Total Patients Served Compared to Uninsured Patients Ages 19-64 Served for the Period September 2009 – March 2010
- G) PCASG Clinics Not Eligible to Participate in the Demonstration
- H) Sample Comparison of PCASG Grant Awards and Demonstration Phase 1 Provider Payments
- I) Budget Neutrality Worksheets
- J) DHH Responses to CMS Standard Funding Questions
- K) Notification to Louisiana's Federally Recognized Indian Tribes

APPENDIX A: PCASG ORGANIZATIONS AND TOTAL NET AWARD BY PARISH OF ORGANIZATION

Organization	Parish of Organization			
	Jefferson	Orleans	Plaquemines	St Bernard
	Total Net Award	Total Net Award	Total Net Award	Total Net Award
Administrators of Tulane Educational Fund		\$ 7,678,297		
Catholic Charities Archdiocese of New Orleans		\$ 578,459		
Children's Hospital Medical Practice Corp.		\$ 5,831,036		
City of New Orleans Health Department		\$ 4,988,705		
Common Ground Health Clinic		\$ 2,719,983		
Covenant House New Orleans		\$ 881,549		
Daughters of Charity Services of New Orleans		\$ 7,989,962		
EXCELth, Inc.		\$ 3,219,327		
Jefferson Community Health Care Centers, Inc.	\$ 7,656,773			
Jefferson Parish Human Services Authority	\$ 5,906,509			
Leading Edge Services Intl. DBA Family Health Center		\$ 1,064,420		
Lower 9th Ward Health Clinic (closed 5/2010)		\$ 967,002		
LSU Health Sciences Center New Orleans (School Based Health Centers)		\$ 1,260,536		
LSU Healthcare Network Behavioral Science Center		\$ 2,252,811		
Medical Center of Louisiana at New Orleans (MCLNO)		\$ 7,805,514		
Metropolitan Human Services District		\$ 3,703,479		
New Orleans Musicians' Assistance Foundation		\$ 1,853,541		
NO/AIDS Task Force		\$ 1,992,592		
Odyssey House Louisiana, Inc.		\$ 2,187,709		
Plaquemines Medical Center			\$ 1,839,563	
Sisters of Mercy Ministries d/b/a Mercy Family Ctr	\$ 1,794,840			
Southeast LA Hospital (was NOAH Outpatient)		\$ 428,275		
St. Bernard Health Center, Inc.				\$ 6,511,531
St. Charles Community Health Center - Kenner	\$ 3,353,028			
St. Thomas Community Health Center		\$ 7,819,832		
TOTAL	\$18,711,150	\$65,223,029	\$ 1,839,563	\$ 6,511,531

APPENDIX B: SUMMARY OF THE PCASG PAYMENT MODEL

BACKGROUND

As a part of the federal response to Hurricane Katrina, on May 23, 2007, the Department of Health and Human Services (HHS) awarded a three-year \$100 million grant fund, entitled the Primary Care Access and Stabilization Grant (PCASG) to restore and expand outpatient primary care services including medical, mental health, and other supportive services in the affected communities in the Greater New Orleans area. These grant funds, administered by the federal Centers for Medicare and Medicaid (CMS), were awarded to the Louisiana Department of Health and Hospitals (DHH) with the requirement that a local partner be selected to administer the grant on behalf of the state. The Louisiana Public Health Institute (LPHI) was selected to provide day-to-day fiscal and programmatic oversight and technical assistance.

In August 2007, 25 entities were deemed eligible to participate in the three-year grant program in response to a non-competitive request for applications released by LPHI. In order to be eligible to participate in the grant program, organizations had to be not-for-profit healthcare providers operating and providing outpatient primary care and/or behavioral health services within the four-parish region as of June 18, 2007; demonstrate their enacted policies to serve all, regardless of ability to pay; and agree to additional terms and conditions established in the NOA and/or approved by CMS.

The federal timeline outlined in the PCASG notice of award (NOA) dated July 23, 2007 stipulated the release of two grant payments to eligible entities, one within 60 days from the NOA date, and the second within 90 days of the first payment.

The design principles for the distribution of grant funds were determined through discussions with HHS, LDHH, and national experts, and were as follows:

- Base funding based on capacity at the time of application (Base Payments);
- Future payments tied to actual services that served as incentives for growth (Supplemental Payments); and
- Incentives to encourage quality improvement (Quality Incentives).

BASE PAYMENTS

The purpose of the base payment was to provide a means for the eligible entities to stabilize current service levels and begin to expand capacity to meet community needs for primary care and related services. The first grant awards (base funding) were made to eligible organizations based on the number of eligible health care provider level of effort or full-time equivalents (FTE) reported and verified during the request for application process. Providers were weighted based on provider type e.g. primary care physicians (weighted as 1.0), physician extenders (0.5), resident physician (0.5), and psychologist and licensed clinical social worker (0.25). Prior to calculating the overall FTE for the organization, audits of personnel records were conducted to verify provider employment and level of efforts. The formula amount used in the calculation was based on Medical Group Management Association cost standards for primary care practices. A

APPENDIX B: SUMMARY OF THE PCASG PAYMENT MODEL

\$4 million base payment was set aside for the City of New Orleans as per the NOA, and they were not eligible to receive an additional base payment. All base awards were disbursed on September 21, 2007, and totaled \$16,721,920.

SUPPLEMENTAL PAYMENTS

The supplemental payments were designed to encourage the expansion of primary care and mental health services to as many uninsured as possible, and to provide incentives to care for the un- and under-insured, including Medicaid and Medicare beneficiaries.

- 1) Grant funds were front-loaded over the life of the three-year grant in order to expedite stabilization and expansion.
- 2) Awards were made at 6 month intervals between December 2007 and December 2009, which totaled \$75,770,922.
- 3) The population allocation was based on the number of unduplicated patients served by an organization weighted using a formula that takes into account: age, payor type, and service type for a prior 6 month period. Incentives were built into the weights to care for the underinsured, including Medicaid and Medicare beneficiaries. (See below.)

UNDUPLICATED PATIENT TYPES AND PAYMENT MULTIPLIERS

Unduplicated Patient Type	Payment Multiplier
Primary care 0 to <19 years	1x
Primary care 19 to 64 years	2x
Primary care 65+	4x
Behavioral Health (any age)	2x

PAYOR TYPE AND PAYMENT MULTIPLIER

Payor Type	Payment relative to Private Insurance	Payment Multiplier (1 – Payment relative to Private Insurance)
Private Insurance	100%	0.00x
Medicare	83%	0.17x
Medicaid	74%	0.26x
Uninsured	0%	1.00x
Unknown	NA	0.00x

- 4) Encounter-level patient data used to calculate the payments were submitted by organizations using an organization-specific unique identifier, core demographics (date of birth, gender, payor type, race, ethnicity, zip code), and encounter information (date of encounter, provider type, encounter type (face to face, telephone), and patient type (behavioral health or primary care)).

APPENDIX B: SUMMARY OF THE PCASG PAYMENT MODEL

- 5) Prior to each payment, a team of LPHI/DHH staff conducted medical record reviews of a randomly drawn sample of the unduplicated patients reported by an organization for the period. Medical records were tested on critical elements outlined in the payment schema e.g. encounter date, date of birth, payor type, provider type, type of visit, and patient type. Errors were recorded, and then applied to entire patient population used to calculate the population award for that period. It is important to note that error rates diminished over time and represented roughly 3% by the final payment.
- 6) Ten percent of total supplemental funds available to clinic sub-awardees in each round were allocated to clinic sub-awardees offering pharmacy services.
- 7) To level the playing field and to ensure that both the smaller clinic sub-awardees had an opportunity to expand services and manage patient population under this grant and that the lion's share of the funds did go to the largest clinics, a minimum (floor) and maximum (cap) distribution per organization was determined for each payment distribution round. The top three organizations were adjusted downward to the four highest level of award; the bottom three were adjusted upwards similarly, which was followed by an overall adjustment to those in the middle.
- 8) Organizations had to spend all grant funds within a given budget period, a minimum of 12 months. Funds not spent at the end of the given period would be returned to the pool for disbursement in the next round.
- 9) Important notes on the behavioral health multiplier. Practices were incentivized to offer both primary and behavioral health care services to patients. If a patient was seen for both primary care and behavioral health care services and categorized as such by patient type, the patient would be counted twice in the payment schema. This is the only instance where two allocations could be made for an individual patient. Early in the grant, it was noted that the multiplying factor for behavioral health was low, relative to the number of visits an individual patient would have for behavioral health vs. primary care in the six month period.

As outlined in the federal NOA, the definition of primary care encompassed the following services: comprehensive primary and preventive care, including diagnostic and radiological services, dental, optometric, behavioral health (mental and substance abuse), emergency medical or mental health (urgent care), pharmacy, case management and enabling services. At the request of the participating entities, DHH/LPHI petitioned for and obtained CMS approval for funding to support a limited level specialty services (15% cap per grantee).

QUALITY INCENTIVES

Five percent of the total supplemental awards was reserved for quality incentives intended to encourage the adoption of national quality standards. Interested grantees voluntarily underwent the National Committee for Quality Assurance (NCQA) Physician Practice Connections®-

APPENDIX B: SUMMARY OF THE PCASG PAYMENT MODEL

Patient Centered Medical Home[™] (PPC-PCMH) recognition scoring process in order to be eligible for a payment. Incentives were calculated according to a relative scale based on each organization's level of NCQA achievement. These payments were released in March 2009, June 2009, and December 2009, which totaled \$3,850,000.

APPENDIX C: PCASG ENCOUNTER LEVEL DATA COLLECTION

Area	Category	Current collected under PCASG	Not Collected under PCASG; Needed for Waiver
Patient Eligibility and Enrollment	Unique Identifiers	Organization Specific Patient Medical Record Number Patient Date of Birth	Social Security # Patient Fname, Lname
	Demographics	Patient Sex Patient Zip Code Patient Race Patient Ethnicity	Physical Address Citizenship
	Income		Household Income Number of Persons in Household MAGI
	Insurance Information	Patient Primary Insurance Type Patient Secondary Insurance Type	Insurance ID Number Insurance Carrier's Name
Benefits / Services	Encounter Information	Type of Encounter Patient Type Encounter Date	
		Principal Diagnosis Code Secondary Diagnosis Code	ICD-9 Diagnosis Codes ICD-9 Procedure Code (CPT Code)
	Provider Detail Organization/Service Delivery Site (Clinic) Information	Provider Type Organization Name Organization Service Delivery Site / Encounter Location	Billing Provider Name Billing Provider NPI
Organization Detail	Organization Detail	Organization Name, Primary/Secondary Signatory, Physical Address, Contact Information, Website	
		Organization's Outpatient Service Revenue and Expenditures	Clinic Level Revenue and Expenditures

APPENDIX C: PCASG ENCOUNTER LEVEL DATA COLLECTION

Evaluation	Clinic Detail	<p>Clinic Physical Address, Phone Number, Parish Date Open/Date Closed, Fixed & Mobile Special Populations Served Days of Week, Hours of Operation Language services offered Type of Insurances accepted Medicaid Enrollment On-Site Scope of Services By Category (On-site, by Contract, by Referral) Provider Name, License, Level of Effort, Specialty, Hire Date, End Date, LA License #, LA Medicaid, NPI Clinic Appointment Availability</p>	
	Hospital / ER Data		Cost and Overlap - Access to UCC Data, Hospital/ED Data
	Health Outcomes		<p>See above E-Codes, CPT Codes Diabetes Control: Type 1/2 Diabetes with HbA1c <7% (ICD-9, Date, Age, HbA1c Lab Value) Hypertension: BP <140/90 (Date, BP Value) Cervical Cancer Screening: (Procedure Code) Depression (see below)</p>
	Meaningful Use / HIT / HIE	HIT Survey	Survey participating in programs (REC/Medicaid)
	Quality Process Performance Metrics	UCSF Quality Survey	
	BH / PC Integration		Depression Screening (PHQ-9), Frequency, Score; Medications

APPENDIX D: PCASG ORGANIZATIONS AND CLINIC LOCATIONS

Organization/Clinic	Parish								Total	
	Jefferson		Orleans		Plaquemines		St Bernard			
	Organization	Sites	Organization	Sites	Organization	Sites	Organization	Sites	Organization	Sites
Administrators of Tulane Educational Fund			1	6					1	6
Catholic Charities Archdiocese of New Orleans		1	1	1					1	2
Children's Hospital Medical Practice Corp.		7	1	7					1	14
City of New Orleans Health Department			1	7					1	7
Common Ground Health Clinic			1	2					1	2
Covenant House New Orleans			1	1					1	1
Daughters of Charity Services of New Orleans		1	1	5					1	6
EXCELth, Inc.			1	3					1	3
Jefferson Community Health Care Centers, Inc.	1	4							1	4
Jefferson Parish Human Services Authority	1	5							1	5
Leading Edge Services International, Inc.d/b/a Family Health Center			1	1					1	1
Lower 9th Ward Health Clinic*			1						1	0
LSU Health Sciences Center New Orleans (School Based Health Centers)			1	2					1	2
LSU Healthcare Network Behavioral Science Center			1	1					1	1
Medical Center of Louisiana at New Orleans (MCLNO)			1	9					1	9
Metropolitan Human Services District			1	6		1		1	1	8
New Orleans Musicians' Assistance Foundation			1	2					1	2
NO/AIDS Task Force			1	1					1	1
Odyssey House Louisiana, Inc.			1	1					1	1
Plaquemines Medical Center				0	1	1			1	1
Sisters of Mercy Ministries d/b/a Mercy Family Center	1	1		1					1	2
Southeast LA Hospital (formerly NOAH - Outpatient)			1	5		1			1	6
St. Bernard Health Center, Inc.							1	1	1	1
St. Charles Community Health Center - Kenner	1	1							1	1
St. Thomas Community Health Center			1	1					1	1
TOTAL	4	20	19	62	1	3	1	2	25	87

APPENDIX E: OVERVIEW OF PCASG CLINICS BY TYPE AND PATIENTS SERVED BY PARISH OF RESIDENCE AND CLINIC LOCATION

Table 1. Clinic Type by Parish

Clinic Type	Fixed Mobile or	Parish				Total # of Clinics
		Jefferson	Orleans	Plaquemines	St. Bernard	
Primary Care	Fixed	12	26	1	1	40
	Mobile		9			9
Behavioral Health	Fixed	7	17	1	1	26
	Mobile		1	1		2
School Based Health Center	Fixed		3			3
Dental	Fixed		3			3
	Mobile	1	2			3
Ophthalmology	Fixed		1			1
TOTAL		20	62	3	2	87

Table 2. Parish of Residence for Patients Served by PCASG Clinics (Sept 2007 to March 2010)

	Jefferson	Orleans	Plaquemines	St. Bernard	Total Area	GNO	Outside GNO	Missing Zip code	Total
Number of patients	99,179	127,586	8,602	25,944	261,311		25,659	5,724	292,694
Percent of patients seen	34%	44%	3%	9%	89%		9%	2%	100%
Number of Uninsured	47,033	63,219	2,559	7,309	120,120		10,310	4,272	134,702
Percent of Uninsured	35%	47%	2%	5%	89%		8%	3%	100%
Population as of 7/2009**	443,342	354,850	20,942	40,655	859,789				
Patients as percent of population	22%	36%	41%	64%	30%				

*Less than closed clinic numbers
<http://www.gnocdc.org>

**Source: GNO Community Data Center

Table 3. # of Patients Served By Location of PCASG Clinics (Sept 2007 to March 2010)

	Jefferson	Orleans	Plaquemines	St. Bernard	Total Area	GNO	Outside GNO	Missing Zip code	Total
Current Total Patients By Clinic Location	93,838	149,295	9,211	26,430	278,774				
Uninsured 19-64 Yrs By Clinic Location*	25,835	75,610	1,806	6,037	109,288				

APPENDIX F: PCASG CLINICS BY TYPE AND PARISH, TOTAL PATIENTS SERVED COMPARED TO UNINSURED PATIENTS AGES 19-64 SERVED FOR THE PERIOD SEPTEMBER 2009 – MARCH 2010

ORLEANS PARISH

Organization Name	Clinic Name	Clinic Type	Total # of Patients	# Patients 19-64 Uninsured
Administrators of Tulane Educational Fund	New Orleans Children's Health Project (NOCHP)	Primary Care	1,691	94
Administrators of Tulane Educational Fund	Drop In Center	Behavioral Health	504	274
Administrators of Tulane Educational Fund	Drop-In Clinic at Covenant House	Primary Care	4,296	1,362
Administrators of Tulane Educational Fund	Tulane Community Health Center New Orleans East	Primary Care	1,595	1,194
Administrators of Tulane Educational Fund	Tulane Community Health Center at Covenant House	Primary Care	7,362	5,642
Administrators of Tulane Educational Fund	Tulane Community Health Mobile Medical Unit	Primary Care	931	546
Catholic Charities Archdiocese of New Orleans	Howard Ave.	Behavioral Health	507	141
Children's Hospital Medical Practice Corporation	Kids First MidCity	Primary Care	1,886	2
Children's Hospital Medical Practice Corporation	Kids First New Orleans East	Primary Care	1,262	1
Children's Hospital Medical Practice Corporation	Kids First TigerCARE Canal	Primary Care	4,248	5
Children's Hospital Medical Practice Corporation	Kids First Prytania	Primary Care	4,098	-
Children's Hospital Medical Practice Corporation	Rapid Treatment Program	Behavioral Health	855	-
Children's Hospital Medical Practice Corporation	Napoleon Pediatrics (Uptown)	Primary Care	6,871	21
Children's Hospital Medical Practice Corporation	Kids First Louisa	Primary Care	253	1
City of New Orleans Health Department	Algiers/Fisher Dental	Dental	777	524
City of New Orleans Health Department	Dental Program for Senior Citizens	Dental	443	112
City of New Orleans Health Department	Edna Pilsbury Health Clinic	Primary Care	2,453	160
City of New Orleans Health Department	Health Care for The Homeless	Primary Care	2,289	1,692
City of New Orleans Health Department	Ida Hymel/Algiers Fisher Health	Primary Care	2,044	53
City of New Orleans Health Department	New Orleans East	Primary Care	1,100	556
City of New Orleans Health Department	School Based Dental Van	Dental	233	8
Common Ground Health Clinic	Algiers Clinic	Primary Care	6,051	4,827
Common Ground Health Clinic	Latino Health Outreach Project	Primary Care	414	400

APPENDIX F: PCASG CLINICS BY TYPE AND PARISH, TOTAL PATIENTS SERVED COMPARED TO UNINSURED PATIENTS AGES 19-64 SERVED FOR THE PERIOD SEPTEMBER 2009 – MARCH 2010

Covenant House New Orleans	Covenant House	Behavioral Health	937	295
Daughters of Charity Services of New Orleans	Daughters of Charity - Carrollton	Primary Care	6,325	4,553
Daughters of Charity Services of New Orleans	Daughters of Charity - St. Cecilia	Primary Care	4,866	3,412
Daughters of Charity Services of New Orleans	Daughters of Charity - March of Dimes Mobile #2	Primary Care	512	4
Daughters of Charity Services of New Orleans	Daughters of Charity - March of Dimes Mobile #1	Primary Care	70	148
Daughters of Charity Services of New Orleans	Neighborhood Health Partnership	Primary Care	2,091	1,785
EXCELth, Inc.	Ida Hymel/Algiers Community Health Clinic	Primary Care	4,966	2,817
EXCELth, Inc.	Mobile Medical Unit - Children's Defense Fund	Primary Care	250	43
EXCELth, Inc.	Mobile Medical Unit - New Orleans	Primary Care	260	96
Leading Edge Services International, Inc d/b/a Family Health Center	Family Health Center - Algiers	Primary Care	874	381
LSU Health Sciences Center New Orleans (School Based Health Centers)	Eleanor McMain Secondary School	School Based Health Center	1,133	6
LSU Health Sciences Center New Orleans (SBHC)	NOC-Science & Math	School Based Health Center	1,095	9
LSU Healthcare Network Behavioral Science Center	Behavioral Sciences Center	Behavioral Health	4,237	986
Medical Center of Louisiana at New Orleans (MCLNO)	HIV Outpatient Program/HOP	Primary Care	2,451	931
Medical Center of Louisiana at New Orleans (MCLNO)	Martin Behrman Community Clinic	Primary Care	2,425	1,848
Medical Center of Louisiana at New Orleans (MCLNO)	Murray Henderson Community Clinic	Primary Care	1,229	535
Medical Center of Louisiana at New Orleans (MCLNO)	HOP Dental Clinic	Dental	458	265
Medical Center of Louisiana at New Orleans (MCLNO)	MCL Dental Clinic	Dental	8,437	6,919
Medical Center of Louisiana at New Orleans (MCLNO)	Medicine Clinic (Lord & Taylor)	Primary Care	10,465	6,761
Medical Center of Louisiana at New Orleans (MCLNO)	MHERE	Behavioral Health	2,681	1,590
Medical Center of Louisiana at New Orleans (MCLNO)	O. Perry Walker Clinic	School Based Health Center	955	42
Medical Center of Louisiana at New Orleans (MCLNO)	Ophthalmology Clinic	Ophthalmology	920	727
Metropolitan Human Services District (MHSD)	Algiers-Fischer Behavioral Health Center	Behavioral Health	1,526	583
Metropolitan Human Services District (MHSD)	Criminal Court Behavioral Health Center	Behavioral Health	1,703	1,577

APPENDIX F: PCASG CLINICS BY TYPE AND PARISH, TOTAL PATIENTS SERVED COMPARED TO UNINSURED PATIENTS AGES 19-64 SERVED FOR THE PERIOD SEPTEMBER 2009 – MARCH 2010

Metropolitan Human Services District (MHSD)	Central City Behavioral Health Center	Behavioral Health	3,564	1,624
Metropolitan Human Services District (MHSD)	New Orleans East Behavioral Health Center	Behavioral Health	1,266	670
Metropolitan Human Services District (MHSD)	Chartres-Pontchartrain Behavioral Health Center	Behavioral Health	5,559	2,862
Metropolitan Human Services District (MHSD)	NHS ICM	Behavioral Health	76	19
New Orleans Musicians' Assistance Foundation	NOMC-Napoleon	Primary Care	2,327	1,961
New Orleans Musicians' Assistance Foundation	SAMM/Mobile Van	Primary Care	2,186	1,364
NO/AIDS Task Force	NO/AIDS Task Force	Primary Care	1,247	700
Odyssey House Louisiana, Inc.	Odyssey House Medical Clinic	Primary Care	2,597	1,926
Sisters of Mercy Ministries d/b/a Mercy Family Center	Mercy Family Center - Westbank	Behavioral Health	396	2
Southeast Louisiana Hospital (SLH) formerly New Orleans Adolescent Hospital Outpatient	Westbank Clinic	Behavioral Health	537	-
Southeast Louisiana Hospital (SLH) formerly New Orleans Adolescent Hospital Outpatient	Access Unit	Behavioral Health	600	-
Southeast Louisiana Hospital (SLH) formerly New Orleans Adolescent Hospital Outpatient	Multisystemic Therapy	Behavioral Health	69	-
Southeast Louisiana Hospital (SLH) formerly New Orleans Adolescent Hospital Outpatient	Midtown Clinic	Behavioral Health	326	-
Southeast Louisiana Hospital (SLH) formerly New Orleans Adolescent Hospital Outpatient	Dialectical Behavioral Therapy	Behavioral Health	5	-
St. Thomas Community Health Center	St. Thomas Community Health Center	Primary Care	15,511	10,554
TOTAL			149,295	75,610

APPENDIX F: PCASG CLINICS BY TYPE AND PARISH, TOTAL PATIENTS SERVED COMPARED TO UNINSURED PATIENTS AGES 19-64 SERVED FOR THE PERIOD SEPTEMBER 2009 – MARCH 2010

JEFFERSON PARISH

Organization Name	Clinic Name	Clinic Type	Total # of Patients	# Patients 19-64 Uninsured
Catholic Charities Archdiocese of New Orleans	Aris Avenue	Behavioral Health	534	278
Children's Hospital Medical Practice Corporation	Kids First TigerCARE Kenner	Primary Care	925	-
Children's Hospital Medical Practice Corporation	Klein Lawrence Pediatric Group	Primary Care	2,746	5
Children's Hospital Medical Practice Corporation	Lakeside Children's Clinic	Primary Care	8,910	16
Children's Hospital Medical Practice Corporation	Metairie Pediatrics	Primary Care	8,146	8
Children's Hospital Medical Practice Corporation	Napoleon Pediatrics (Metairie)	Primary Care	9,406	42
Children's Hospital Medical Practice Corporation	Physicians of River Ridge	Primary Care	4,459	23
Children's Hospital Medical Practice Corporation	Tooth Bus	Dental	8,199	222
Daughters of Charity Services of New Orleans	Daughters of Charity - Metairie	Primary Care	6,285	4,796
Jefferson Community Health Care Centers, Inc.	Avondale Clinic	Primary Care	4,578	2,342
Jefferson Community Health Care Centers, Inc.	Grand Isle Clinic	Primary Care	312	108
Jefferson Community Health Care Centers, Inc.	Marrero Clinic	Primary Care	7,116	4,774
Jefferson Community Health Care Centers, Inc.	River Ridge Clinic	Primary Care	4,701	3,288
Jefferson Parish Human Services Authority	Access Service Center	Behavioral Health	6,548	3,129
Jefferson Parish Human Services Authority	East Jefferson Service Center	Behavioral Health	4,270	1,363
Jefferson Parish Human Services Authority	Kenner Service Center	Behavioral Health	18	14
Jefferson Parish Human Services Authority	Problem Gambling	Behavioral Health	121	45
Jefferson Parish Human Services Authority	West Jefferson Service Center	Behavioral Health	6,447	1,548
Sisters of Mercy Ministries d/b/a Mercy Family Center	Mercy Family Center - Metairie	Behavioral Health	2,187	119
St. Charles Community Health Center - Kenner	St. Charles Community Health Center Kenner	Primary Care	7,930	3,715
TOTAL			93,838	25,835

APPENDIX F: PCASG CLINICS BY TYPE AND PARISH, TOTAL PATIENTS SERVED COMPARED TO UNINSURED PATIENTS AGES 19-64 SERVED FOR THE PERIOD SEPTEMBER 2009 – MARCH 2010

PLAQUEMINES PARISH

Organization Name	Clinic Name	Clinic Type	Total # of Patients	# Patients 19-64 Uninsured
Plaquemines Medical Center	Plaquemines Medical Center	Primary Care	7,748	1,343
Metropolitan Human Services District	Plaquemines Behavioral Health Center	Behavioral Health	1,221	463
Southeast Louisiana Hospital formerly New Orleans Adolescent Hospital Outpatient	Noah's Arc	Behavioral Health	242	-
TOTAL			9,211	1,806

ST. BERNARD PARISH

Organization Name	Clinic Name	Clinic Type	Total # of Patients	# Patients 19-64 Uninsured
Metropolitan Human Services District	St. Bernard Behavioral Health	Behavioral Health	1,221	540
St. Bernard Health Center, Inc.	St. Bernard Health Center	Primary Care	25,209	5,497
TOTAL			26,430	6,037

APPENDIX G: PCASG CLINICS NOT ELIGIBLE TO PARTICIPATE IN THE DEMONSTRATION

Administrators of Tulane Educations Fund

New Orleans Children's Health Project (NOCHP)

Children's Hospital Medical Practice Corp.

Kids First MidCity

Kids First New Orleans East

Kids First TigerCARE Canal

Kids First Prytania

Rapid Treatment Program

Napoleon Pediatrics (Uptown)

Kids First Louisa

Kids First TigerCARE Kenner

Klein Lawrence Pediatric Group

Lakeside Children's Clinic

Metairie Pediatrics

Napoleon Pediatrics (Metairie)

Physicians of River Ridge

Tooth Bus

Daughter's of Charity Services of New Orleans

Daughters of Charity - March of Dimes Mobile #2

EXCELth, Inc.

Mobile Medical Unit - Children's Defense Fund

LSU HSC (School Based Health Centers)

Eleanor McMain Secondary School

NOC-Science & Math

Medical Center of Louisiana

HOP Dental Clinic

MCL Dental Clinic

O. Perry Walker Clinic

Ophthalmology Clinic

New Orleans Adolescent Hospital and Community Services

Westbank Clinic

Access Unit

Multisystemic Therapy

Midtown Clinic

Dialectical Behavioral Therapy

Noah's Arc

APPENDIX G: PCASG CLINICS NOT ELIGIBLE TO PARTICIPATE IN THE DEMONSTRATION

New Orleans Health Department

Algiers/Fisher Dental

Dental Program for Senior Citizens

School Based Dental Van

Sisters of Mercy Ministries DBA Mercy Family

Mercy Family Center - Westbank

APPENDIX H: SAMPLE COMPARISON OF PCASG GRANT AWARDS AND DEMONSTRATION PHASE 1 PROVIDER PAYMENTS

Waiver-Eligible PCASG Providers (no shading) / Waiver-Ineligible PCASG Providers (shaded)	Year 3 PCASG - Actual			Phase 1 Waiver - Estimate			Reserve -3 Yr Avg PCASG
	Unduplicated Patient Nos (Unadjusted)	Award		Unduplicated Patient Nos (Unadjusted)	Award		
		Site Totals	Org. Totals		Site Totals	Org. Totals	
Administrators of Tulane Educations Fund	9,112		2,757,742	9,018		2,839,659	56,280
<i>New Orleans Children's Health Project (NOCHP)</i>	94			-			
<i>Drop In Center</i>	274			274	86,279		
<i>Drop-In Clinic at Covenant House</i>	1,362			1,362	428,877		
<i>Tulane Community Health Center New Orleans East</i>	1,194			1,194	375,976		
<i>Tulane Community Health Center at Covenant House</i>	5,642			5,642	1,776,598		
<i>Tulane Community Health Mobile Medical Unit</i>	546			546	171,929		
Catholic Charities Archdiocese of New Orleans	419		123,240	419		131,938	16,860
<i>Howard Ave.</i>	141			141	44,399		
<i>Aris Avenue</i>	278			278	87,539		
Children's Hospital Medical Practice Corp.	346		2,210,716	-		-	
<i>Kids First MidCity</i>	2			-			
<i>Kids First New Orleans East</i>	1			-			
<i>Kids First TigerCARE Canal</i>	5			-			
<i>Kids First Prytania</i>	-			-			
<i>Rapid Treatment Program</i>	-			-			
<i>Napoleon Pediatrics (Uptown)</i>	21			-			
<i>Kids First Louisa</i>	1			-			
<i>Kids First TigerCARE Kenner</i>	-			-			
<i>Klein Lawrence Pediatric Group</i>	5			-			

APPENDIX H: SAMPLE COMPARISON OF PCASG GRANT AWARDS AND DEMONSTRATION PHASE 1 PROVIDER PAYMENTS

<i>Lakeside Children's Clinic</i>	16			-	-		
<i>Metairie Pediatrics</i>	8			-	-		
<i>Napoleon Pediatrics (Metairie)</i>	42			-	-		
<i>Physicians of River Ridge</i>	23			-	-		
<i>Tooth Bus</i>	222			-	-		
Common Ground Health Clinic	5,227		519,310	5,227		1,645,919	670,843
<i>Algiers Clinic</i>	4,827			4,827	1,519,964		
<i>Latino Health Outreach Project</i>	400			400	125,955		
Covenant House	295		245,015	419		131,938	
<i>Floor Adjustment</i>				124	39,046		
<i>Covenant House</i>	295			295	92,892		
Daughter's of Charity Services of New Orleans	14,620		2,836,873	10,512		3,310,102	402,056
<i>Cap Adjustment</i>				(4,104)	(1,292,300)		
<i>Daughters of Charity - Carrollton</i>	4,553			4,553	1,433,685		
<i>Daughters of Charity - St. Cecilia</i>	3,412			3,412	1,074,398		
<i>Daughters of Charity - March of Dimes Mobile #2</i>	4			-	-		
<i>Daughters of Charity - March of Dimes Mobile #1</i>	70			70	22,042		
<i>Neighborhood Health Partnership</i>	1,785			1,785	562,075		
<i>Daughters of Charity - Metairie</i>	4,796			4,796	1,510,202		
EXCELth, Inc.	2,956		959,057	2,913		917,268	
<i>Ida Hymel/Algiers Community Health Clinic</i>	2,817			2,817	887,039		
<i>Mobile Medical Unit - Children's Defense Fund</i>	43			-	-		
<i>Mobile Medical Unit - New Orleans</i>	96			96	30,229		

APPENDIX H: SAMPLE COMPARISON OF PCASG GRANT AWARDS AND DEMONSTRATION PHASE 1 PROVIDER PAYMENTS

Jefferson Community Health Care Centers, Inc.	10,512		1,474,758	10,512		3,310,102	1,008,876
<i>Avondale Clinic</i>	2,342			2,342	737,467		
<i>Grand Isle Clinic</i>	108			108	34,008		
<i>Marrero Clinic</i>	4,774			4,774	1,503,275		
<i>River Ridge Clinic</i>	3,288			3,288	1,035,351		
Jefferson Parish Human Services Authority	6,099		2,122,437	6,099		1,920,501	
<i>Access Service Center</i>	3,129			3,129	985,284		
<i>East Jefferson Service Center</i>	1,363			1,363	429,192		
<i>Kenner Service Center</i>	14			14	4,408		
<i>Problem Gambling</i>	45			45	14,170		
<i>West Jefferson Service Center</i>	1,548			1,548	487,446		
Leading Edge Services International, Inc.	381		332,002	419		131,938	
<i>Floor Adjustment</i>				38	11,966		
<i>Family Health Center - Algiers</i>	381			381	119,972		
Lower 9th Ward Health Clinic	-		444,989	-		-	
<i>Lower 9th Ward Health Clinic</i>	-			-	-		
LSU HSC (School Based Health Centers)	15		479,183	-		-	
<i>Eleanor McMain Secondary School</i>	6			-	-		
<i>NOC-Science & Math</i>	9			-	-		
LSU Healthcare Network	986		677,043	986		310,479	
<i>Behavioral Sciences Center</i>	986			986	310,479		
Medical Center of Louisiana	19,618		2,719,952	10,512		3,310,102	475,836
<i>Cap Adjustment</i>				(1,153)	(363,066)		
<i>HIV Outpatient Program/HOP</i>	931			931	293,161		

APPENDIX H: SAMPLE COMPARISON OF PCASG GRANT AWARDS AND DEMONSTRATION PHASE 1 PROVIDER PAYMENTS

<i>Martin Behrman Community Clinic</i>	1,848			1,848	581,913		
<i>Murray Henderson Community Clinic</i>	535			535	168,465		
<i>HOP Dental Clinic</i>	265			-	-		
<i>MCL Dental Clinic</i>	6,919			-	-		
<i>Medicine Clinic (Lord & Taylor)</i>	6,761			6,761	2,128,957		
<i>MHERE</i>	1,590			1,590	500,672		
<i>O. Perry Walker Clinic</i>	42			-	-		
<i>Ophthalmology Clinic</i>	727			-	-		
Metropolitan Human Services District	8,338		2,460,811	8,338		2,625,535	805,502
<i>Algiers-Fischer Behavioral Health Center</i>	583			583	183,580		
<i>Criminal Court Behavioral Health Center</i>	1,577			1,577	496,578		
<i>Central City Behavioral Health Center</i>	1,624			1,624	511,378		
<i>New Orleans East Behavioral Health Center</i>	670			670	210,975		
<i>Chartres-Pontchartrain Behavioral Health Center</i>	2,862			2,862	901,209		
<i>NHS ICM</i>	19			19	5,983		
<i>Plaquemines Behavioral Health Center</i>	463			463	145,793		
<i>St. Bernard Behavioral Health</i>	540			540	170,039		
New Orleans Adolescent Hospital and Community Services	-		123,522	-		-	
<i>Westbank Clinic</i>	-			-	-		
<i>Access Unit</i>	-			-	-		
<i>Multisystemic Therapy</i>	-			-	-		
<i>Midtown Clinic</i>	-			-	-		

APPENDIX H: SAMPLE COMPARISON OF PCASG GRANT AWARDS AND DEMONSTRATION PHASE 1 PROVIDER PAYMENTS

<i>Dialectical Behavioral Therapy</i>	-			-	-		
<i>Noah's Arc</i>	-			-	-		
New Orleans Health Department	3,105		936,738	2,461		774,939	309,900
<i>Algiers/Fisher Dental</i>	524			-	-		
<i>Dental Program for Senior Citizens</i>	112			-	-		
<i>Edna Pilsbury Health Clinic</i>	160			160	50,382		
<i>Health Care for The Homeless</i>	1,692			1,692	532,790		
<i>Ida Hymel/Algiers Fisher Health</i>	53			53	16,689		
<i>New Orleans East</i>	556			556	175,078		
<i>School Based Dental Van</i>	8			-	-		
New Orleans Musicians' Assistance Foundation	3,325		629,839	3,325		1,047,002	421,326
<i>NOMC-Napoleon</i>	1,961			1,961	617,495		
<i>SAMM/Mobile Van</i>	1,364			1,364	429,507		
NO/AIDS Task Force	700		789,113	700		220,422	
<i>NO/AIDS Task Force</i>	700			700	220,422		
Odyssey House Louisiana, Inc.	1,926		687,604	1,926		606,474	
<i>Odyssey House Medical Clinic</i>	1,926			1,926	606,474		
Plaquemines Medical	1,343		517,986	1,343		422,894	
<i>Plaquemines Medical Center</i>	1,343			1,343	422,894		
Sisters of Mercy Ministries DBA Mercy Family	121		190,924	419		131,938	
<i>Floor Adjustment</i>				300	94,466		
<i>Mercy Family Center - Westbank</i>	2			-	-		
<i>Mercy Family Center - Metairie</i>	119			119	37,472		

APPENDIX H: SAMPLE COMPARISON OF PCASG GRANT AWARDS AND DEMONSTRATION PHASE 1 PROVIDER PAYMENTS

St. Bernard Health Center, Inc.	5,497		2,240,185	5,497		1,730,939	
<i>St. Bernard Health Center</i>	<i>5,497</i>			<i>5,497</i>	<i>1,730,939</i>		
St. Charles Community Health Center	3,715		1,242,810	3,715		1,169,809	71,370
<i>St. Charles Community Health Center Kenner</i>	<i>3,715</i>			<i>3,715</i>	<i>1,169,809</i>		
St. Thomas Community Health Center	10,554		2,821,094	10,512		3,310,102	470,108
<i>Cap Adjustment</i>				<i>(42)</i>	<i>(13,225)</i>		
<i>St. Thomas Community Health Center</i>	<i>10,554</i>			<i>10,554</i>	<i>3,323,327</i>		
TOTAL	109,210		29,974,432	95,272		30,000,000	4,708,957

APPENDIX H: SAMPLE COMPARISON OF PCASG GRANT AWARDS AND DEMONSTRATION PHASE 1 PROVIDER PAYMENTS

BUDGET NEUTRALITY												
Federal Funds With and Without Waiver												
WITHOUT WAIVER	Historical Data					Base Year	Demonstration Period					
	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY2008	FFY 2011	FFY 2012	FFY 2013	FFY 2014	Total Demo.	
DSH Allotment	\$ 731,960,000	\$ 731,960,000	\$ 731,960,000	\$ 731,960,000	\$ 750,259,000	\$ 731,960,000	\$ 731,960,000	\$ 761,238,400	\$ 791,687,936	\$ 823,355,453	\$ 3,108,241,789	
Total	\$ 731,960,000	\$ 731,960,000	\$ 731,960,000	\$ 731,960,000	\$ 750,259,000	\$ 731,960,000	\$ 731,960,000	\$ 761,238,400	\$ 791,687,936	\$ 823,355,453	\$ 3,108,241,789	
WITH WAIVER	Historical Data					Base Year	Demonstration Period					
	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY2008	FFY 2011	FFY 2012	FFY 2013	FFY 2014	Total Demo.	
MEG 1 Payments (0-133% FPL)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 19,083,000	\$ 19,083,000	\$ 19,083,000	\$ 9,541,500	\$ 66,790,500	
MEG 2 Payments (134% - 200% FPL)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DSH Expenditures	\$ 731,960,000	\$ 512,342,425	\$ 638,412,159	\$ 701,980,533	\$ 702,220,070	\$ 701,980,533	\$ 712,877,000	\$ 742,155,400	\$ 772,604,936	\$ 813,813,953	\$ 3,041,451,289	
Total	\$ 731,960,000	\$ 512,342,425	\$ 638,412,159	\$ 701,980,533	\$ 702,220,070	\$ 701,980,533	\$ 731,960,000	\$ 761,238,400	\$ 791,687,936	\$ 823,355,453	\$ 3,108,241,789	
Savings Under Waiver							\$0	\$0	\$0	\$0	\$0	

APPENDIX I: BUDGET NEUTRALITY WORKSHEETS

BUDGET NEUTRALITY												
Total Computable Funds With and Without Waiver												
WITHOUT WAIVER	Historical Data					Base Year	Demonstration Period					
	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2008	FFY 2011	FFY 2012	FFY 2013	FFY 2014	Total Demo.	
DSH Allotment	\$ 1,030,349,099	\$ 1,048,803,554	\$ 1,050,308,509	\$ 1,010,017,938	\$ 1,052,109,101	\$ 1,010,017,938	\$ 1,150,699,576	\$ 1,196,727,559	\$ 1,244,596,661	\$ 1,294,380,527	\$ 4,886,404,322	
Subtotal	\$ 1,030,349,099	\$ 1,048,803,554	\$ 1,050,308,509	\$ 1,010,017,938	\$ 1,052,109,101	\$ 1,010,017,938	\$ 1,150,699,576	\$ 1,196,727,559	\$ 1,244,596,661	\$ 1,294,380,527	\$ 4,886,404,322	
WITH WAIVER	Historical Data						Demonstration Period					
	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2008	FFY 2011	FFY 2012	FFY 2013	FFY 2014	Total Demo.	
MEG 1 Payments (0-133% FPL)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 30,000,000	\$ 30,000,000	\$ 30,000,000	\$ 15,000,000	\$ 105,000,000	
MEG 2 Payments (134% - 200% FPL)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DSH Expenditures	\$ 1,030,349,099	\$ 734,120,110	\$ 916,074,269	\$ 968,649,831	\$ 984,742,772	\$ 968,649,831	\$ 1,120,699,576	\$ 1,166,727,559	\$ 1,214,596,661	\$ 1,279,380,527	\$ 4,781,404,322	
Subtotal	\$ 1,030,349,099	\$ 734,120,110	\$ 916,074,269	\$ 968,649,831	\$ 984,742,772	\$ 968,649,831	\$ 1,150,699,576	\$ 1,196,727,559	\$ 1,244,596,661	\$ 1,294,380,527	\$ 4,886,404,322	
Savings Under the Waiver							\$0	\$0	\$0	\$0	\$0	

APPENDIX J: DHH REPOSSES TO CMS STANDARD FUNDING QUESTIONS

DHH proposes to fund the non-Federal share (NFS) of demonstration expenditures, in whole or part, with U.S. Department of Housing and Urban Development (HUD) Community Development Block Grant (CDBG) funds allocated to the parishes participating in the waiver.

Previously, the use of CDBG funds as a matching requirement, share, or contribution for any other Federal program has been prohibited.⁹ However, the Department of Housing and Urban Development Appropriations Act of 2010 (Public Law 111-117) removed the restrictions on use of disaster recovery CDBG funds under Gustav and Ike as a matching requirement, share, or contribution of funds for Federal Emergency Management Agency (FEMA) Public Assistance (PA) or any other federal funding.¹⁰

⁹ The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (Pub. Law 110-329), enacted on September 30, 2008, appropriated \$6.5 billion through the Community Development Block Grant (CDBG) program for “necessary expenses related to disaster relief, long-term recovery, and restoration of infrastructure, housing, and economic revitalization in areas affected by hurricanes, floods, and other natural disasters occurring during 2008 for which the President declared a major disaster...”. It specifically prohibited the use of funds for activities reimbursable by, or for which funds are made available by, the Federal Emergency Management Agency or the Army Corps of Engineers” and that “none of the funds...may be used...as a matching requirement, share, or contribution for any other Federal program.

¹⁰ Department of Housing and Urban Development Appropriations Act, 2010 (Public Law 111-117), enacted on December 16, 2009, states in Section 236: “The matter under the heading “Community Development Fund”, under the heading “Community Planning and Development”, under the heading “Department of Housing and Urban Development” in chapter 10 of title I of division B of the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (Public Law 110–329; 122 Stat. 3601) is amended by striking “: *Provided further*, That none of the funds provided under this heading may be used by a State or locality as a matching requirement, share, or contribution for any other Federal program” http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ117.111.pdf Page 74 of 376

APPENDIX J: DHH REPOSSES TO CMS STANDARD FUNDING QUESTIONS

Please answer these questions in terms of how the proposed section 1115 demonstration would be funded.

1. Section 1903(a) (1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan.

a. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

Response:

b. Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?

Response:

c. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Response:

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

Response:

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Response:

c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

Response:

APPENDIX J: DHH REPOSES TO CMS STANDARD FUNDING QUESTIONS

d. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Response:

e. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Response:

f. For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response:

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response:

4. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Response:

5. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

Response:

a. In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms

APPENDIX J: DHH REPOSSES TO CMS STANDARD FUNDING QUESTIONS

such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Response:

b. If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

Response:

c. If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response:

APPENDIX K: NOTIFICATION TO LOUISIANA'S FEDERALLY RECOGNIZED INDIAN TRIBES

Bobby Jindal
GOVERNOR



Alan Levine
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

July 14, 2010

Madeline Phelps
Chitimacha Tribe of Louisiana
Health Director
3231 Chitimacha Trail
Clarenton, LA 70523

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Irene Gonzales
Tunica Biloxi Tribe
Health Director
PO Box 331
Marksville, LA 71351

APPENDIX K: NOTIFICATION TO LOUISIANA'S FEDERALLY RECOGNIZED INDIAN TRIBES

July 14, 2010
Page 2

Earl J. Barbry, Sr
Tunica-Biloxi Tribe of Louisiana
Chairman
P.O. Box 1589
Marksville, LA 71351-1589

Dear Louisiana Tribal Contacts:

RE: Tribal Notification of Louisiana Medicaid Changes

In compliance with the provisions of the Americans Recovery and Reinvestment Act of 2009 (ARRA), the Louisiana Medicaid program is taking this opportunity to notify all of the federally recognized tribes in Louisiana of proposed Medicaid changes that may affect them, and to give them time to comment on the proposed changes.

In order to sustain the primary care work done through the Primary Care and Access Stabilization Grant (PCASG)-funded clinics in New Orleans, the Department plans to submit a Section 1115 Demonstration Waiver to CMS for approval. In order to protect the effective dates of the waiver and continue the work of the clinics, the Department must submit the waiver application by August 16, 2010.

Enclosed, please find a copy of the white paper detailing the plans for the waiver. Additional materials can be found on the Louisiana Medicaid Web site at this link: <http://www.dhh.louisiana.gov/offices/page.asp?id=92&detail=9515>. All online materials may also be provided via mail by contacting Dawn Love with Louisiana Medicaid at (225) 342.6375 or by using the contact information listed below.

Please provide any written comments you may have by August 4, 2010 to Dawn Love via e-mail: dawn.love@la.gov or via postal mail: Louisiana Medicaid, 628 North 4th St, 6th Floor, Baton Rouge, LA, 70802.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Don Gregory', with a stylized flourish at the end.

Don Gregory,
Medicaid Director

Attachments

APPENDIX