Missouri Gateway to Better Health Demonstration
Number 11-W-00250/7
Section 1115 Draft Annual Report

Demonstration Year: 9 (10/01/2017- 09/30/2018)

Table of Contents

I. Introduction

On July 28, 2010, CMS approved the State of Missouri's "Gateway to Better Health" Demonstration, which preserved access to ambulatory care for low-income, uninsured individuals in St. Louis City and County. The Demonstration was amended in June 2012, to enable the Safety Net Pilot Program to be implemented by July 1, 2012. The July 1, 2012, implementation of the Pilot Program ensured patients of the St. Louis safety net maintained access to primary and specialty care. CMS approved a one-year extension of the Demonstration on September 27, 2013, July 16, 2014, December 11, 2015, June 16, 2016, and again on September 1, 2017 for a five-year extension. The State has been authorized to spend up to $30 million (total computable) annually to preserve and improve primary and specialty care in St. Louis in lieu of spending that amount of statutorily authorized funding on payments to disproportionate share hospitals (DSHs). The Demonstration includes the following main objectives:

I. Preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured;
II. Connect the uninsured to a primary care home, which will enhance coordination, quality, and efficiency of health care through patient and provider involvement; and
III. Maintain and enhance quality service delivery strategies to reduce health disparities.

For the first two years of the Demonstration, through June 30, 2012, certain providers, referred to as Affiliation Partners, were paid directly for uncompensated care. These providers included St. Louis ConnectCare, Affinia Healthcare (formerly known as Grace Hill Health Centers), and CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers).

The program transitioned to a coverage model pilot on July 1, 2012. From July 1, 2012, to December 31, 2013, the Pilot Program provided primary, urgent, and specialty care coverage to uninsured[1] adults in St. Louis City and St. Louis County, aged 19-64, who were below 133% of the Federal Poverty Level (FPL). The Demonstration was scheduled to expire on December 31, 2013.

The State also had authority through December 31, 2013, to claim as administrative costs limited amounts incurred by the Saint Louis Regional Health Commission (SLRHC) pursuant to an MOU for functions related to emergency room diversion efforts through the Community Referral Coordinator program.

The Missouri legislature did not expand Medicaid eligibility during its 2013-2017 legislative sessions. Therefore, on September 27, 2013, July 16, 2014, December 11, 2015, and again on June 16, 2016, CMS approved one-year extensions of the Gateway Demonstration program for patients up to 100% FPL. On September 1, 2017, CMS approved a five-year extension of the demonstration program for patients up to 100% FPL.

In August 2018, the State of Missouri, Department of Social Services, requested authority to further amend the Gateway program to include a substance use treatment benefit with an implementation date of January 1, 2019. The proposed benefit covers outpatient substance use services, including pharmacotherapy, for Substance Use Disorder (SUD) treatment of Gateway enrollees with a primary or secondary diagnosis of ICD-10 Codes F10-F18. All office visits and generic pharmaceuticals are to be

[1] To be considered "uninsured," applicants must not be eligible for coverage through the Medicaid State Plan. Screening for Medicaid eligibility is the first step of the Gateway to Better Health eligibility determination.

provided by the primary care home and are considered a core primary care service. This request is still under consideration by CMS.

In order to meet the requirements for the Demonstration project, the State of Missouri Department of Social Services asked the SLRHC to lead planning efforts to determine the Pilot Program design – subject to the review and approval of the Centers for Medicare and Medicaid Services (CMS) – and to incorporate community input into the planning process. Accordingly, on July 21, 2010, the SLRHC approved the creation of a "Pilot Program Planning Team." The MO HealthNet Division of the Missouri Department of Social Services is represented on the Planning Team to ensure the SLRHC and MO HealthNet are working closely to develop the deliverables and to fulfill the milestones of the Demonstration project.

The information provided in this annual report updates Demonstration process outcomes and key developments for Demonstration Year 9 (October 1, 2017 – September 30, 2018).

Extension of the Gateway Demonstration

The demonstration project has been approved for five years, from January 1, 2018 to December 31, 2022. This five-year extension enables the uninsured population to continue to access preventative and other ambulatory health care services. During Demonstration Year 9, Gateway covered nearly 22,200 unique members, which is approximately 62 percent of those uninsured, 19 – 64 years old, and living below the federal poverty level in St. Louis City and County.

II. Operational Updates

Engagement of SLRHC Advisory Boards and Teams

Each month the SLRHC shares information and gathers input about the Demonstration from its 17-member board and its advisory boards. Full rosters of the advisory boards may be found at www.stlrhc.org. The SLRHC shares monthly financial, enrollment, and customer service reports about the Pilot Program with its advisory boards in addition to the Pilot Program Planning Team and the committees that report to this team. These committees include the Operations and Finance workgroups. Members of the community, health center leadership, health center medical staff, and representatives from other medical providers in the St. Louis region are represented on these committees. Full rosters of the Pilot Program Planning Team and the committees that report to this team can be found in Appendix II of this report.

With continual input from diverse stakeholders, the SLRHC is able to foster inter-agency cooperation and communication. Furthermore, the structure allows for the prevention of operational challenges. All key decisions goes through multiple advising committees before any changes are implemented in the Gateway to Better Health Demonstration. For example, the decision to submit an amendment request for a new substance use treatment benefit passed through all advisory teams at multiple stages of the decision-making and planning process. Therefore, if the benefit were to be approved, all stakeholders, including leadership from the health centers and community, already fully understand what the benefit entails, preventing potential barriers. For this potential benefit, additional training for the health centers is being provided, but the advisory board structure allows for open communication that could prevent unforeseen challenges.

Community Meetings and Patient/Provider Communications

The RHC hosted public community meetings to inform stakeholders about the Gateway program throughout the Demonstration Year. These meetings provided information on Gateway enrollment, trends in accessing safety net services, and any changes to the Gateway network.

On June 19, 2018, a Post Award Public Notice Input session was held to inform the public on the progress of the Gateway demonstration and to receive feedback about the program thus far. The notice for this meeting was posted on the MO HealthNet web site 30 days in advance. The meeting was held as part of the regularly scheduled Community Advisory Board meeting of the St. Louis Regional Health Commission. Thirty-three individuals attended the hearing.

Attendees received information on the number of people served and the number of services and visits provided by Gateway each year. The current membership of the program, including the distribution of chronic conditions and a demographic profile of Gateway members was also presented. An overview of patient and provider satisfaction feedback, as well as results from quality metrics, were reviewed. The audience was given an opportunity to provide feedback on the program's progress to date. Attendees expressed their satisfaction with the progress of the Demonstration and their support for the continued work of the Demonstration. A full list of comments from the post award public notice session are included below:

- *"Great program!"*
- *"Thank God for Gateway to Better Health!"*

- *"Students are very dependent on Gateway. A student almost had to lose his thumb from an illness, but because of Gateway coverage, his thumb was saved. He will now get better quality medical care."*
- *"Gateway to Better Health is an excellent program. It doesn't solve everything, but it helps a lot of people and expands access."*
- *"Gateway has been essential in managing chronic diseases for many, sick uninsured patients. Without it, there would be an increase in readmission."*

III. Performance Metrics

Coverage for Beneficiaries and the Uninsured Population: Enrollment

During Demonstration Year 9, Gateway served 21,169 unique individuals. The RHC provided training to community health centers and other community organizations to assist patients with the Gateway enrollment application process. Gateway primary care providers work with all of their uninsured patients, including young adult patients aging out of Medicaid, to assess their eligibility for Gateway and other programs, and enroll them in the Pilot Program, as applicable. In Demonstration Year 9, more than 5,800 new patients were enrolled in the Gateway program. As of October 1, 2018, 18.1% of Gateway enrollees were between the ages of 19 and 29; 21.4% between the ages of 30 and 39; 23.4% between the ages of 40 and 49; 28.1% between the ages of 50 and 59; and 9.0% between the ages of 60 and 64.

During Demonstration Year 9, SLRHC launched a Gateway Enrollment Enhancement Implementation Plan to maintain a stable level of enrollment. The plan included strategies around outreach and awareness, application completion, member engagement, and annual review and retention. Progress includes drafting new infographics and outreach materials for prospective enrollees, as well as beginning the process of creating new orientation materials for community health center and hospital staff. Other deliverables are in progress.

In addition, screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more than 34,680 individuals in MO HealthNet programs, including but not limited to:

- 4,300 adults approved for MO HealthNet for the Aged, Blind, or Disabled
- 4,887 adults approved for MO HealthNet for Families

The coverage model provides primary, urgent and specialty care coverage to uninsured adults in St. Louis City and St. Louis County with incomes up to 100% FPL. As of October 1, 2018, 13,507 unique individuals were enrolled in the Gateway to Better Health. Pilot Program enrollment by health center in Demonstration Year 9 is provided below:

Pilot Program Enrollment by Population*

Demonstration Populations	**Unique Individuals Enrolled as of October 1, 2018**	**Member Months October 2017 – September 2018**
Population 1: Uninsured individuals receiving both Primary and Specialty Care through the Demonstration	13,507	182,181
Population 2. Uninsured individuals receiving only Specialty Care through the Demonstration (<133% of FPL)	N/A	N/A
Population 3. Uninsured individuals receiving only Specialty Care through the Demonstration (134-200% of FPL)	N/A	N/A
Total for All Populations	**13,507**	**182,181**

*Enrollment numbers are based on MO HealthNet enrollment data as of October 1, 2018.

Gateway to Better Health Enrollment by Health Center*

Health Center	Unique Individuals Enrolled as of October 1, 2018	Member Months October 2017 - September 2018
BJK People's Health Centers	2,268	30,724
Family Care Health Centers	1,265	16,205
Affinia Healthcare	5,491	76,552
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)	2,620	34,977
St. Louis County Dept. of Health	1,863	23,723
Total	13,507	182,181

*Enrollment numbers are based on MO HealthNet enrollment data as of October 1, 2018.

Wait Lists

There were no waiting lists during Demonstration Year 9, as enrollment did not reach the enrollment cap of 21,423.

Disenrollment

During Demonstration Year 9, a total of 10,094 members were disenrolled from Gateway, averaging 841 members each month. The table below provides Gateway disenrollment by month in Demonstration Year 9:

Gateway Member Disenrollment by Month, October 2017 – September 2018*

Month	Beginning Enrollment	New Enrollment	Disenrollment	Net Change	End of Month Enrollment
Oct '17	14,975	696	791	-95	14,880
Nov '17	14,880	738	853	-115	14,765
Dec '17	14,765	615	811	-196	14,569
Jan '18	14,569	809	883	-74	14,495
Feb '18	14,495	566	851	-285	14,210
March '18	14,210	812	658	154	14,364
April '18	14,364	822	770	52	14,416
May '18	14,416	694	814	-120	14,296
June '18	14,296	835	844	-9	14,287
July '18	14,287	718	884	-166	14,121
Aug '18	14,121	712	884	-172	13,949
Sept '18	13,949	609	1,051	-442	13,507
Total	N/A	8,626	10,094	-1,468	N/A

*Data based on MO HealthNet enrollment data as of September 30, 2018.

Based on preliminary analysis in October 2017, redeterminations (specifically, failure to return the annual review form and to request verification) and income limitations played a critical role during Demonstration Year 9 in reducing membership for Gateway. Additionally, many of the Gateway members became eligible for Medicaid. These factors contributed to the decline in membership during the Demonstration Year. While approximately 10,094 total patients disenrolled from Gateway in Demonstration Year 9, more than 5,800 new patients joined the program during this time.

Coverage for Beneficiaries and the Uninsured Population: Utilization

Outlined below are key findings regarding the Gateway program service utilization for Demonstration Year 9 (October 1, 2017 – September 30, 2018). Information presented is based primarily on an initial review of Gateway claims and service referral data.

Primary and Dental Care

Gateway provided more than 28,000 total primary care and dental visits during Demonstration Year 9. Gateway primary care physicians saw over 1,800 patients in their offices each month. Gateway dentists at community health centers saw approximately 500 patients in their offices each month. The table below reviews the annual distribution of primary and dental care office visits by provider:

*Primary Care and Dental Office Visits by Rendering Provider, October 1, 2017 – September 30, 2018**

Provider	Primary Care Office Visits	Dental Office Visits	Total Visits
BJK People's Health Centers	3,989	1082	5,071
Family Care Health Centers	2613	567	3180
Affinia Healthcare (formerly known as Grace Hill)	7,648	2571	10,219
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)	3532	984	4516
St. Louis County Dept. of Health	4,260	789	5,049
All Providers	**22,042**	**5,993**	**28,035**

**Reported utilization based on Gateway claims data as of October 29, 2018.*

Chronic Conditions

Approximately 39% of all Gateway patients live with at least one chronic condition[2].

*Percentage of Patients with Chronic Conditions**

Medical Condition	Percentage of Patients
Hypertension	31.8%
Diabetes (Type 1 & 2)	11.2%
Asthma/COPD	9.7%
CVD, CHF, Heart Disease	4.8%
Total Unduplicated	39.3%

[2] Chronic conditions include hypertension, diabetes type I and type II, asthma/chronic obstructive pulmonary disease, cardiovascular disease, congestive heart failure, and heart disease.

Medications

Gateway provided more than 176,700 medications to manage chronic conditions and other diseases in Demonstration Year 9, including more than 13,000 prescriptions for brand name insulin and inhalers.

Specialty Care

Providers made more than 1,700 referrals for specialty care services each month. Of the more than 20,500 referrals made in Demonstration Year 9, more than 9,100 were for diagnostic services and more than 2,200 were for surgical procedures. Gateway provided more than 5,800 specialty office visits in Demonstration Year 9. The table below reviews the annual distribution of specialty care office visits by provider.

*Specialty Care Office Visits by Rendering Provider, October 1, 2017 – September 30, 2018**

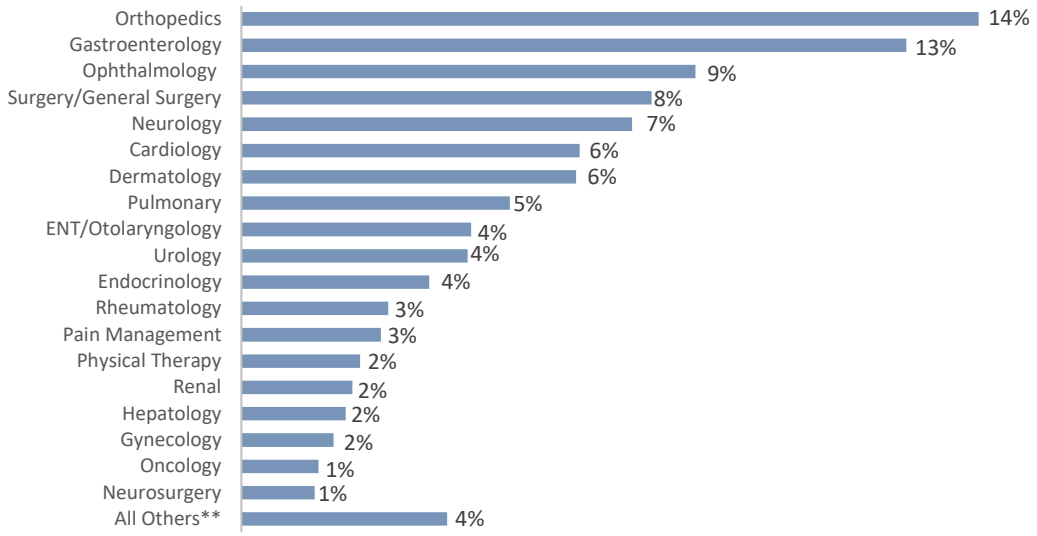
Provider	Specialty Care Visits
SLUCare	2942
Washington University School of Medicine	2487
All Other Providers**	432
Total	**5,861**

**Reported utilization based on Gateway claims data as of October 29, 2018.*
*** Other providers include the following: Eye Associates Limited; Nephrology and Hypertension Specialists, LLC; St. Alexius Hospital; Mercy; BJC Medical Group; SSM Medical Group; and Dr. Theodore Otti.*

In Demonstration Year 9, orthopedics, gastroenterology and ophthalmology were the leading specialty care services to which Gateway patients were referred. The percent of specialty care referrals by service for Demonstration Year 9 is further detailed below:

Specialty Care Referrals by Service, October 1, 2017 – September 30, 2018

Figure 1. Specialty Care Referrals by Service, October 1, 2017 - September 30, 2018*



**Reported specialty care referrals are based on Automated Health Systems data as of October 22, 2018.*
***Other services include: allergy, endoscopy, infectious disease, hematology, wound management and pathology.*

Urgent Care

Gateway provided more than 3,600 urgent care visits in Demonstration Year 9. Between October 1, 2017 and September 30, 2018, there were approximately 300 urgent care visits each month.

Table 5. Urgent Care Office Visits by Rendering Provider, October 1, 2017 – September 30, 2018*

Provider	Urgent Care Visits
Affinia Healthcare**	2858
SSM Urgent Care***	795
All Providers	**3,653**

**Reported utilization based on Gateway claims data as of October 29, 2018.*

*** As of January 1, 2017, CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers) began contracting with Affinia Healthcare to provide urgent care services to their patients at Affinia's urgent care location.*

****SSM Urgent Care provides urgent care services for BJK People's Health Centers, Family Care Health Centers and St. Louis County Department of Health Gateway members.*

Outcomes of Care

A series of health indicators have been selected to evaluate the system of care outcomes. The following table provides results for each of the selected health indicators for the first six months of 2018.

Health Indicator	Percent of Gateway Enrollees that Met Indicator
Tobacco Use Assessment & Cessation Intervention Percentage of patients age 18 and older assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy	89%
Cervical Cancer Screening Percentage of women 24 to 64 years of age who received one or more Pap tests to screen for cervical cancer	57%
Hypertension: Controlling High Blood Pressure Proportion of patients aged 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading	50%
Diabetes: HbA1c Control Proportion of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading in the measurement year.	71%
Adult Weight Screening and Follow-Up Percentage of patients aged 18 and over who had documentation of a calculated BMI during the most recent visit or within the 6 months prior to that visit	70%
Flu Shot for Patients 6 Months of Age and Older[3] Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	32%
Use of Appropriate Medications for Asthma Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period	90%

Data included in this chart is sourced from Missouri Primary Care Association, as of June 30, 2018.

[3] Flu shot data from 2017.

Quality and Cost of Care

The Gateway program has operationalized its commitment to quality with a provider incentive program. The State withholds 7% from payments made to the primary care health centers. These funds are used to pay provider incentives based upon provider performance on two sets of quality measures, tier 1 and tier 2. Tier 1 measures are:

- All Newly Enrolled Patients- Minimum of at least 1 office visit within 1 year (6 months before/after enrollment date)
- Patients with Diabetes, Hypertension, CHF or COPD – Minimum of at least 2 office visits within 1 year (6 months before/after reporting period start date)
- Patients with Diabetes - Have one HbA1c test within 6 months of reporting period start date
- Patients with Diabetes – Have a HbA1c less than or equal to 9% on most recent HbA1c test within the reporting period
- Hospitalized Patients - Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days after hospital discharge.

The following table outlines the results of each quality measure for reporting period January – June 2018 and is compared with the threshold for provider incentive payment.

		Actual Outcomes Achieved					
Pay-for-Performance Criteria for Tier 1	**Threshold**	**AH**	**MHD**	**FC**	**BJKP**	**County**	**Total**
1 - All Patients (1 visit)	80%	74%	58%	84%	81%	82%	73%
2 - Patients with Chronic Disease (2 visits)	80%	90%	93%	96%	99%	92%	92%
3 - Patients with Diabetes HgbA1c Tested	85%	97%	94%	94%	100%	86%	94%
4 - Patients with Diabetes HgbA1c < 9%	60%	55%	61%	76%	77%	61%	63%
5 - Hospitalized Patients	50%	88%	54%	88%	52%	65%	68%

According to the Payment Protocol, each health center is eligible for the remaining funds based on their percentage of patients enrolled provided that the specialist referral rate criteria is met. This measure is the tier 2 metric. The outcome for referral rates to specialty care was compared to the thresholds and the results are summarized as follows:

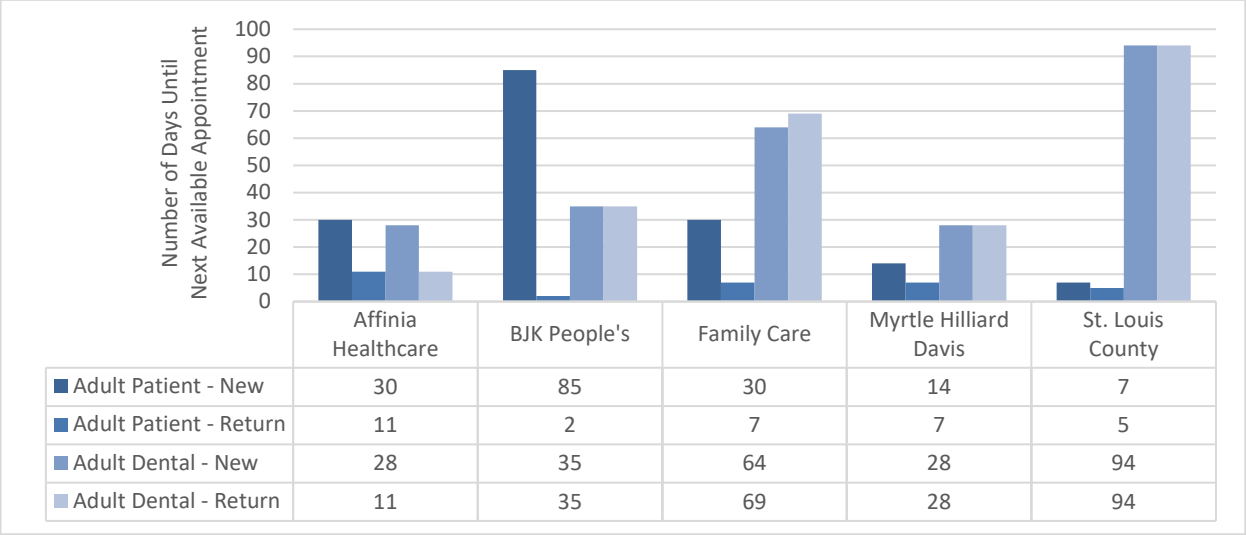
Table 2 Pay-for-Performance Criteria for Tier 2	Threshold	*Actual Outcomes Achieved*					
		AH	MHD	FC	BJKP	County	Total
Referral Rate to Specialists	680/1000	333	289	595	365	621	391

Access to Care Outcomes

During Demonstration Year 9, the call center answered 13,965 calls, averaging approximately 56 calls per day. Of calls answered during this time, 50 (less than one percent) resulted in a consumer complaint. All consumer issues were resolved directly with the patient and associated provider(s). The most common source of complaint for this Demonstration Year was related to "Access to Care," which includes a range of issues including the patients' ability to get a timely appointment, get a prescription filled, get a referral to see a specialist, as well as coordinating specialty care with primary care homes.

Primary and specialty care wait times are monitored to measure access to care. In DY 9, on average, new patients were able to access primary care services within five weeks, and returning patients, within one week. To access dental services, both new and returning patients had to wait approximately seven weeks. The following table displays the primary care wait times as of the end of DY9 (September 30, 2018).

Primary Care Wait Times (Non-Urgent Appointments in Days), as of September 30, 2018*



	Affinia Healthcare	BJK People's	Family Care	Myrtle Hilliard Davis	St. Louis County
Adult Patient - New	30	85	30	14	7
Adult Patient - Return	11	2	7	7	5
Adult Dental - New	28	35	64	28	94
Adult Dental - Return	11	35	69	28	94

**Wait times self-reported by individual health center as of September 30, 2018, and are calculated for Gateway patients only.*

Specialty care appointment wait times at specialty care providers as of June 2018 are provided below. Wait times varied greatly by specialty, but on average, new patients were able to schedule an appointment within five weeks and returning patients within four weeks.

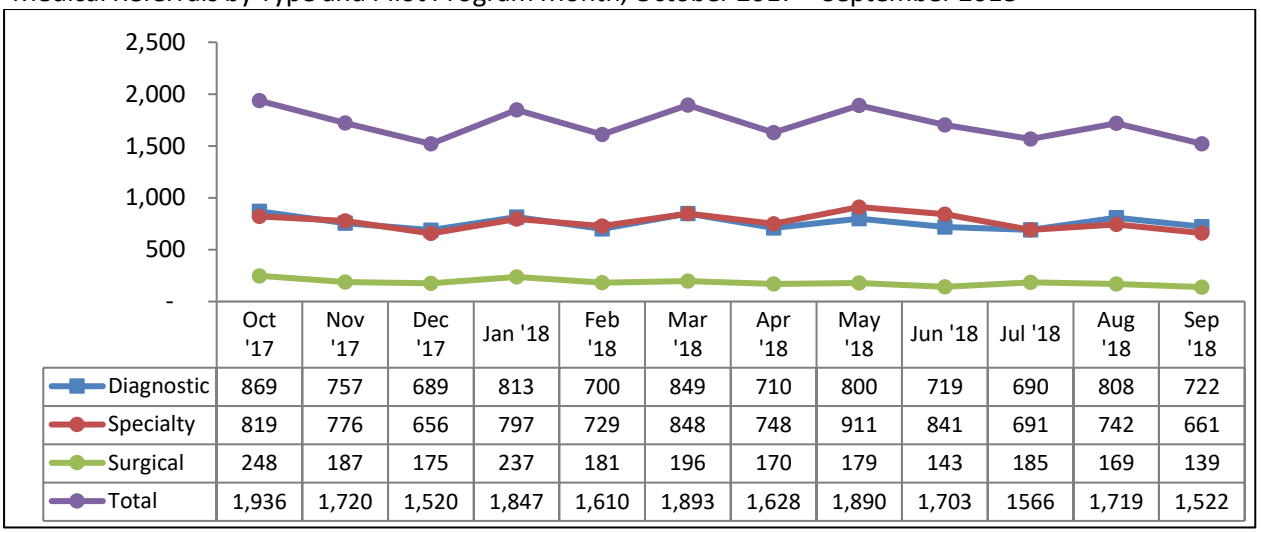
*Adult Wait Times by Specialty**

	# of Days Until the Next Available Appointment	
Appointment Type	**New Patient**	**Return Patient**
Cardiology	28	26
Dermatology	42	19
Endocrinology	60	69
ENT/Otolaryngology	10	12
Gastroenterology (GI)	65	57
Gynecology	18	17
Hematology	16	21
Hepatology	62	30
Infectious Disease	39	29
Mental/Behavioral Health	29	21
Nephrology	30	33
Neurology	48	40
Neurosurgery	51	23
Obstetrics/Prenatal Care	16	14
Oncology	19	17
Ophthalmology/Eye Care	31	31
Orthopedics	18	18
Pain Management	18	19
Physical Therapy	21	11
Podiatry	-	-
Pulmonology	49	48
Rheumatology	71	55
Surgery -- General	19	12
Urology	28	28
Average	**34**	**28**

* Wait times listed are the averages for self-reporting organizations (Barnes-Jewish Hospital, SLUCare, Mercy JFK Clinic, and Washington University in St. Louis School of Medicine – Adult).

In order to monitor access to specialty care, referrals to these services are tracked and trended. DY 9 results are presented in the table below.

Medical Referrals by Type and Pilot Program Month, October 2017 – September 2018*



	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18
Diagnostic	869	757	689	813	700	849	710	800	719	690	808	722
Specialty	819	776	656	797	729	848	748	911	841	691	742	661
Surgical	248	187	175	237	181	196	170	179	143	185	169	139
Total	1,936	1,720	1,520	1,847	1,610	1,893	1,628	1,890	1,703	1566	1,719	1,522

**Reported medical referrals are based on Automated Health Systems data as of October 22, 2018.*

Results of Beneficiary Satisfaction Survey

The State and SLRHC are continually monitoring the performance of the Pilot Program to ensure it is providing access to quality health care for the populations it serves.

The SLRHC conducts satisfaction surveys with Gateway to Better Health enrollees on a regular basis.

Patient Satisfaction Survey

Patient satisfaction has been assessed ten times from 2012 – 2018 with Gateway to Better Health patients. The most recent evaluation of patient satisfaction utilized surveys completed by patients at the end of their appointments. This assessment was conducted between May and August 2018, where a total of 343 patients participated. Results from this most recent evaluation found that Gateway patients are highly satisfied with their providers and the quality of the primary care services they received. One-hundred percent of respondents indicated that they would recommend their health center to others.

Patient Satisfaction Survey Results for Primary Care Services, May - August 2018

Survey Item	Average Ratings*
Doctor and staff listened and explained things well	4.53
Overall quality of service	4.52

**5-point rating scale (poor = 1, fair = 2, okay = 3, good = 4, very good = 5).*

IV. Budget Neutrality and Financial Reporting

Budget Neutrality

The State continues to monitor budget neutrality for this quarter as claims are processed. The program remained budget neutral for DY9 as well as for the fourth quarter of the federal fiscal year. See Appendix III for the updated budget neutrality workbook.

Annual Gateway Program Expenses

The table below documents Gateway Pilot Program expenses in Demonstration Year 9 as compared to the operating budget. An explanation of key variances by provider type is also provided.

Gateway Actual to Operating Budget, October 1, 2017 - September 30, 2018*

Provider Type	Actual	Operating Budget	Percent Variance
Primary Care Providers	$ 11,588,752	13,173,989	88%
Specialty Care Providers	$7,197,315	8,005,012	90%
Transportation	$236,833	265,778	89%
Gateway Administration	$3,452,862	3,784,373	91%
Total Allowable Gateway Program Expenses	**$22,475,762**	**$25,229,152**	**89%**

*Reported information based on data as of September 30, 2018. Additional allowable expenses may be incurred for the federal fiscal year.

Gateway primary care providers were paid $11.6 million from October 1, 2017 to September 30, 2018 (FFY18), or 12% less than the operating budget for the fiscal year. As referenced on page 8 of this report, redeterminations, income limitations, and new eligibility for Medicaid contributed to the decline in Gateway membership with a concomitant decline in revenue for the primary care providers, which are paid on a per-member-per-month basis.

Specialty Care:

Specialty care providers were paid $7.2 million, or 10% less than the operating budget for the fiscal year as of September 30, 2018. This variance is primarily due to claims lag and members qualifying for Medicaid or no longer qualifying for the program due to income limitations or redeterminations.

Other Program Expenses:

Gateway transportation and administrative expenses to date have been 11% and 9%, respectfully, less than the operating budget for FFY1. This variance is attributed to the decline in membership.

Cost of Specialty Care Services

The table below reviews specialty care costs in Demonstration Year 9 for Gateway providers based on claims data. Claims are still being submitted for the fourth quarter of Demonstration Year 9. It is anticipated that claims amount for the period may increase as additional claims are filed.

Cost of Specialty Care Services, October 1, 2017 – September 30, 2018*

Provider Name	Provider Payments
BJC Healthcare	1,917,240
Mercy & Affiliates	17,265
SLUCare	1,207,076
SSM Managed Care	1,682,586
Washington University School of Medicine	2,254,422
All Other	118,726
Total	**7,197,315**

*Reported information based on data as of September 30, 2018. Additional allowable expenses may be incurred for the federal fiscal year.

Provider Incentive Payments

The Incentive Payment Protocol (provided in Appendix IV) requires seven percent of provider funding to be withheld from Gateway primary care providers. The seven percent withhold is tracked and managed on a monthly basis. The SLRHC is responsible for monitoring the health centers' performance against the pay-for-performance metrics in the Incentive Payment Protocol. Withholds for Gateway providers during Demonstration Year 9 are outlined below:

Summary of Provider Payments and Withholds, October 1, 2017 - September 30, 2018*

Providers	Provider Payments**	Provider Payments Withheld
Affinia Healthcare (formerly known as Grace Hill)	4,836,548	337,462
BJK People's Health Centers	1,919,481	135,441
Family Care Health Centers	1,015,956	71,474
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)	2,161,166	154,212
St. Louis County Department of Public Health	1,480,855	104,592
Total	**11,414,006**	**803,182**

Payments in the table above are subject to change as patient enrollment/eligibility changes.
*Reported provider payments and withholds are based on data as of September 30, 2018.
**Amount represents actual payments including incentive payments.

Annual pay-for-performance incentive payments are paid out at six-month intervals of the Pilot Program based on performance during the following reporting periods:

1) January 1, 2018 – June 30, 2018
2) July 1, 2018 – December 31, 2018

The first pay-for-performance reporting period ended on June 30, 2018. The complete results are provided in Appendix V. In general, the providers continued to build off gains from previous reporting periods and have improved in attaining the clinical quality measures.

All primary care providers achieved at least three of the six clinical quality measures. Family Care Health Centers, Betty Jean Kerr People's Health Center, and St. Louis County Department of Public health achieved

all quality metrics. Across all primary care providers, 73% of patients enrolled for six months had a primary care visit during that time, with a threshold of 80%. Ninety-two percent of patients with chronic conditions enrolled six months had two primary care visits during that time, with a threshold of 80%. In addition, 63% of the patients with diabetes had HbA1c measures <9%, with a threshold of 60%. Of all diabetic patients, 94% had their HbA1c drawn within six months. Also, 68% of hospitalized patients received follow-up within 7 days of discharge, with a threshold of 50%.

All primary care providers successfully attained the measure related to rate of referrals to specialists (threshold of 680/1000).

Pay-for-performance incentive outcomes for the time period of July 1, 2018 – December 31, 2018, are not yet available but will be shared in future reports.

V. Evaluation Activities and Interim Findings

The Gateway to Better Health Demonstration accomplished several important milestones in DY 9. November 2017, Mercer Government Human Services was selected to serve as an independent evaluator. Mercer's task is to develop a program evaluation in accordance with the guidelines of the CMS Standard Terms and Conditions (STC). Collaborating with the Gateway program and their providers, Mercer developed a program evaluation that included a driver diagram, three hypotheses and associated research questions, and measures and analytic approaches that address the specific research questions.

One challenge in developing the program evaluation is the absence of a comparison group of uninsured individuals with health care data. This limitation was mitigated by using enrollee and provider reports of decreased barriers to healthcare and improved health through specific questions from the beneficiary and provider surveys.

Another milestone was the revision of surveys to align self-report data with research questions. Additional metrics were devised that required a revision of the Gateway provider data collection tool. Each of these revisions have been implemented. When SUD services were proposed to be added to the Gateway program in August, 2018, the program evaluation was updated and additional measures were developed to assess this potential component of the program.

In order to evaluate the program hypotheses, the proposed data analytic approach requires multiple data points. Developing interim findings is not yet possible given the abbreviated study period.

APPENDIX I: Quarter IV Results

State of Missouri
Gateway to Better Health Demonstration 11-W-00250/7
Section 1115 Quarterly Report

Demonstration Year: 9 (October 1, 2017 – September 30, 2018)
Federal Fiscal Quarter: 4/2018 (July 1, 2018 – September 30, 2018)

The information provided below details Pilot Program process outcomes and key developments for the fourth quarter of Demonstration Year 9 (July 1, 2018 – September 30, 2018).

Enrollment Information:

As of October 1, 2018, 13,507 unique individuals were enrolled in the Gateway to Better Health. The Gateway enrollment cap is set at 21,423, which leaves room for approximately 7,946 new members under 100% FPL. There were no program wait lists during this quarter of the Pilot Program.

Table 1. Gateway to Better Health Pilot Program Enrollment by Health Center*

Health Center	Unique Individuals Enrolled as of October 1, 2018	Member Months July – September 2018
BJK People's Health Centers	2,268	7,418
Family Care Health Centers	1,265	4,077
Affinia Healthcare	5,491	18,354
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)	2,620	8,550
St. Louis County Dept. of Health	1,863	5,866
Total	**13,507**	**44,265**

**Enrollment numbers are based on MO HealthNet enrollment data as of October 1, 2018.*

Outreach/Innovation Activities:

Each month, the SLRHC shares information and gathers input about the Demonstration from its 20-member board, and its 30-member Community and Provider Services Advisory boards. Full rosters of these boards may be found at www.stlrhc.org.

The SLRHC shares monthly financial, enrollment, and customer service reports about the Pilot Program with these advisory boards in addition to the Pilot Program Planning Team and the committees that report to this team; these committees include the Operations and Finance subcommittees. Members of the community, health center leadership, health center medical staff and representatives from other

medical providers in the St. Louis region are represented on these committees. (Full rosters can be found in Appendix II of this report).

The SLRHC conducts orientation sessions for members of the Pilot Program on a regular basis. The sessions are open to all members, but targeted towards those members newly enrolled in the program during the last six months. To date, more than 1,376 members have attended orientation sessions since its implementation in March 2015. Member orientations provide an avenue for the SLRHC to explain the program to new Gateway members and to gather feedback from patients. As of January 2017, member orientations are held twice a year at each site. There were no orientation sessions held during the fourth quarter (July – September 2018).

In addition, the SLRHC regularly uses the infrastructure of its public Advisory Boards and Gateway Team meetings to gather input about the Demonstration. Public meetings held during the fourth quarter are listed below:

Team	Meeting Date
Gateway Operations Team Meeting	July 12, 2018
Provider Services Advisory Board and Community Advisory Board Meeting	July 17, 2018
RHC Commission Meeting	July 18, 2018
Provider Services Advisory Board Meeting	August 7, 2018
RHC Commission Meeting	August 15, 2018
Community Advisory Board Meeting	August 21, 2018
Provider Services Advisory Board Meeting	September 4, 2018

Through ongoing outreach initiatives by the community health centers to enroll patients into coverage, the Gateway program accepted 889 applications on average each month during the quarter. With the eligibility review process for Gateway members and other factors, the program experienced a total net loss of 260 members each month during this quarter.

Operational/Policy Development/Issues:

There are no operational or policy issues to report for this quarter.

Financial/Budget Neutrality Development/Issues:

The State continues to monitor budget neutrality for this quarter as claims are processed. The program remained budget neutral for the fourth quarter of the federal fiscal year.

Consumer Issues:

Individuals enrolled in the Gateway to Better Health Pilot Program have access to a call center, available Monday through Friday, 8:00AM to 5:00PM central standard time. When the call center is not open, callers may leave messages that are returned the next business day.

From July – September 2018, the call center answered 3,136 calls, averaging approximately 50 calls per day. Of calls answered during this time, 12 (<1%) resulted in a consumer complaint. The 12 consumer issues were resolved directly with the patient and associated provider(s). The most common source of complaints for this quarter were related to transportation. The type and number of complaints received during this period of time are outlined below:

Table 2. Summary of Consumer Complaints, July 1, 2018 – September 30, 2018*

Type of Complaint	Number of Complaints	Nature of Complaints/Resolution
Member Services	1	Patient reported dissatisfaction with treatment received at the health center. The patient opted to change health centers.
Access to Care	5	Patients (2) reported difficulty scheduling urgent dental appointments. The patients were scheduled for dental appointments. Patients (2) reported difficulty getting prescriptions filled. The health center filled the prescription and made it ready for pick up. Patient reported difficulty obtaining the correct diabetes testing supplies. The patient was able to get the correct testing supplies.
Transportation	6	Patient (1) reported transportation showed up late for a scheduled pick-up. Logisticare reached out to the patient. Patients (2) reported that transportation did not show for a scheduled pick-up. Logisticare reached out to the patient. In one case, a future appointment was monitored by the Director of Operations to ensure an on-time pick up. Patients (3) reported difficulty scheduling transportation through the health center. The health center staff reached out to the patients and helped schedule transportation.

**Reported consumer complaints are based on Automated Health Systems data as of October 22, 2018.*

Action Plans for Addressing Any Policy, Administration, or Budget Issues Identified:

There are no policy, administrative, or budget issues to report this quarter.

Quality Assurance/Monitoring Activity:

The State and SLRHC are continually monitoring the performance of the program to ensure it is providing access to quality health care for the population it serves. Representatives from the provider organizations meet regularly to evaluate clinical, consumer, and financial issues related to the program.

The SLRHC conducts satisfaction surveys with referring physicians (including support staff) and Gateway to Better Health enrollees on a regular basis. The results from the Patient and Provider Satisfaction Surveys conducted in summer 2018 are reported in future sections of this annual report.

In addition, the State and SLRHC continually monitor call center performance, access to medical referrals (including referrals for diagnostic care, specialty care and surgical procedures) and wait times for medical appointments. Recent available outcomes for these measures are detailed in the sections below:

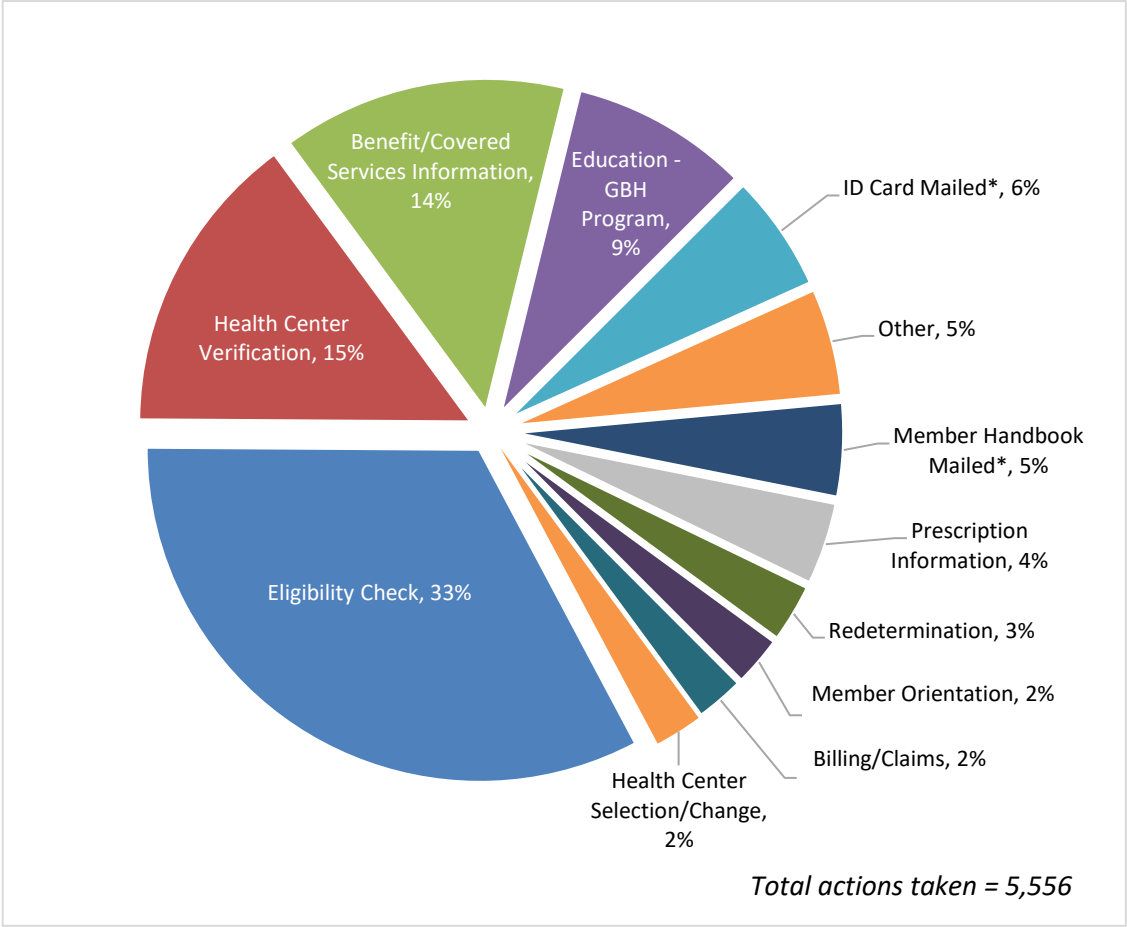
Call Center Performance

Table 3. Call Center Performance, July - September 2018

Performance Measure	**Outcome**
Calls received	3,238
Calls answered	3,136
Abandonment rate	3.15%
Average answer speed (*seconds*)	26
Average length of time per call (*minutes: seconds*)	4:04

**Call center performance metrics are based on Automated Health Systems data as of October 22, 2018.*

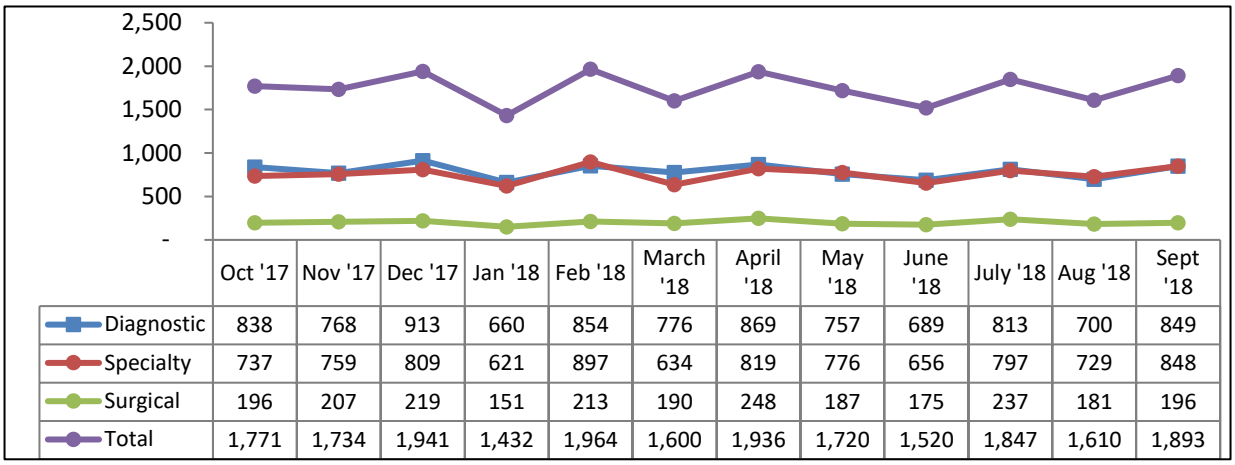
Figure 1. Call Center Actions, July - September 2018



**Reported call center actions are based on Automated Health Systems data as of October 22, 2018.*

Access to Medical Referrals

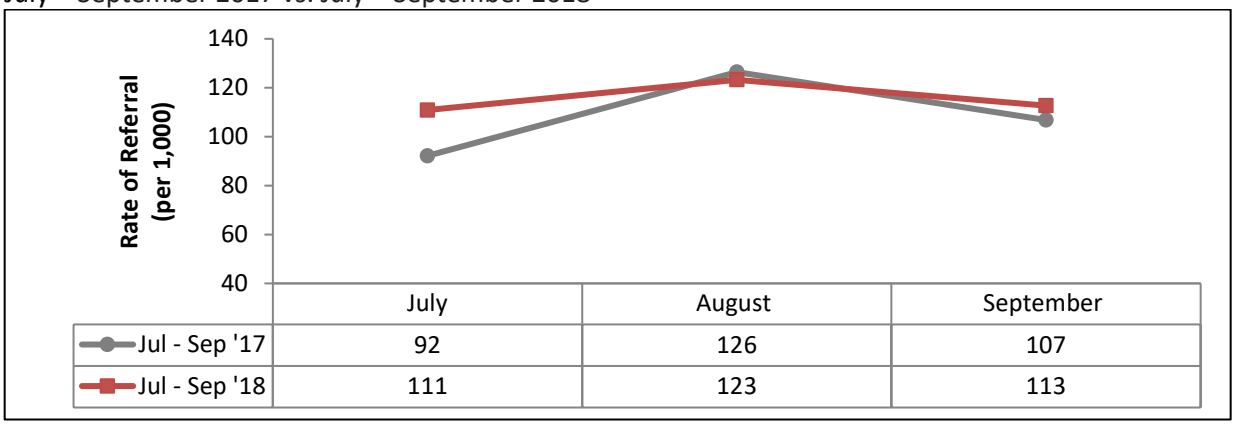
Figure 2. Medical Referrals by Type and Pilot Program Month, October 2017 – September 2018*



	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18	March '18	April '18	May '18	June '18	July '18	Aug '18	Sept '18
Diagnostic	838	768	913	660	854	776	869	757	689	813	700	849
Specialty	737	759	809	621	897	634	819	776	656	797	729	848
Surgical	196	207	219	151	213	190	248	187	175	237	181	196
Total	1,771	1,734	1,941	1,432	1,964	1,600	1,936	1,720	1,520	1,847	1,610	1,893

**Reported medical referrals are based on Automated Health Systems data as of October 22, 2018.*

Figure 3. Comparison of Rate of Referral to Specialist by Pilot Program Month (per 1,000 Members Enrolled), July – September 2017 vs. July – September 2018*

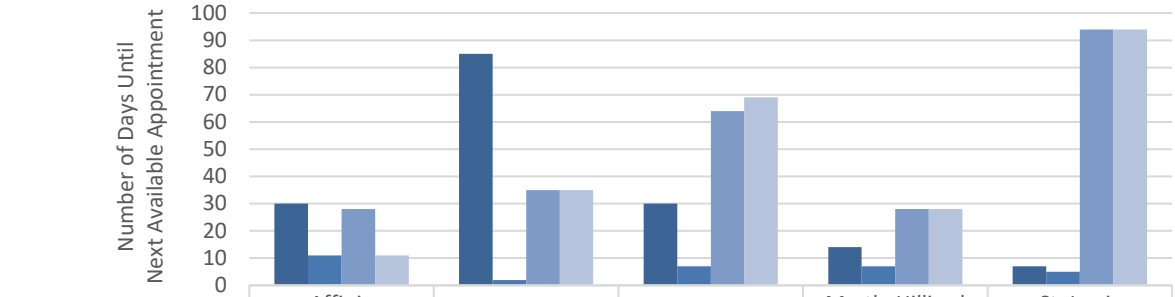


	July	August	September
Jul - Sep '17	92	126	107
Jul - Sep '18	111	123	113

**Reported rates of medical referrals are based on Automated Health Systems data as of October 22, 2018. Referral types include diagnostic, specialty and surgical procedures. Rate of referral is determined by using the total referrals divided by the average monthly enrollment.*

Primary Care Appointment Wait Times

Figure 4. Primary Care Wait Times (Non-Urgent Appointments in Days), as of September 30, 2018*



	Affinia Healthcare	BJK People's	Family Care	Myrtle Hilliard Davis	St. Louis County
Adult Patient - New	30	85	30	14	7
Adult Patient - Return	11	2	7	7	5
Adult Dental - New	28	35	64	28	94
Adult Dental - Return	11	35	69	28	94

**Wait times self-reported by individual health center as of September 30, 2018, and are calculated for Gateway patients only.*

Updates on Provider Incentive Payments:

Table 4. Summary of Provider Payments and Withholds, July 2018 – September 2018*

Providers	Provider Payments Withheld	Provider Payments Earned**
BJK People's Health Centers	33,085	534,811
Family Care Health Centers	18,268	293,796
Affinia Health Centers	81,165	1,247,775
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)	37,897	596,842
St. Louis County Department of Public Health	26,047	419,955
Voucher Providers	N/A	1,930,638
Total for All Providers	**196,463**	**5,023,816**

**Payments in the table above are subject to change as additional claims are submitted by providers.*
Reported provider payments and withholds are based on data as of October 5, 2018 for reporting period July - September 2018.

***Amount represents payments made during the quarter, inclusive of payouts from previous quarters.*

As documented in previous quarterly reports, the Incentive Payment Protocol requires 7% of provider funding to be withheld from Gateway providers. The 7% withhold is tracked and managed on a monthly basis. The SLRHC is responsible for monitoring the health centers' performance against the pay-for-performance metrics in the Incentive Payment Protocol.

Pay-for-performance incentive payments are paid out at six-month intervals of the Pilot Program based on performance during the following reporting periods:

- July 1, 2012 – December 31, 2012
- January 1, 2013 – June 30, 2013
- July 1, 2013 – December 31, 2013
- January 1, 2014 – June 30, 2014
- July 1, 2014 – December 31, 2014
- January 1, 2015 – June 30, 2015
- July 1, 2015 – December 31, 2015
- January 1, 2016 – June 30, 2016
- July 1, 2016 – December 31, 2016
- January 1, 2017 – June 30, 2017
- July 1, 2017 – December 31, 2017
- January 1, 2018 – June 30, 2018
- July 1, 2018 – December 31, 2018

Community health centers continue to perform well in the pay-for-performance criteria measures. During the January 2018 – June 2018 reporting period, each community health centers met at least four of the six clinical quality measures. Three health centers, Betty Jean Kerr People's Health Centers, Family Care Health Centers, and St. Louis County Department of Public Health, achieved all six of the measures.

For this reporting period, the community health centers collectively exceeded the thresholds in five of the six measures (same as prior period): 92% of patients with chronic diabetes had two primary care visits (threshold 80%); 94% of patients with diabetes had their HgbA1C drawn within 6 months (threshold 85%); 63% of patients with diabetes had a HgbA1c measure <9% (threshold 60%); 68% of hospitalized patients received follow-up within 7 days of discharge (threshold 50%); and the referral rate for specialists was 391/1000 (threshold 680/1000). Also, 73% of patients had a primary care visit during this period, with a threshold of 80%.

Pay for performance results remained approximately the same (within five percentage points) as those reported in the previous period, July 2017 – December 2017. The only metric with a decrease of more than five percentage points was the percentage of hospitalized patients who received follow-up within 7 days of discharge. While this metric decreased by seven percentage points (from 75% from the last period to 68% this period), all health centers still exceeded the threshold for this measure.

See Appendix V for a comprehensive review of pay-for-performance results for the January 2018 – June 2018 reporting period.

Updates on Budget Neutrality Worksheets:

Please see attached worksheets (Appendix III).

Evaluation Activities and Interim Findings:

The final evaluation design was submitted on August 31, 2018. Interim findings to date have been provided on page 19.

Updates on the State's Success in Meeting the Milestones Outlined in Section XI:

Date – Specific	Milestone	STC Reference	Date Submitted
12/1/2017	Procure external vendor for evaluation services	Section XI (#39)	Ongoing
12/30/2017	Submit Amended Evaluation Design	Section XI (#40)	12/30/2017
12/30/2017	Submit Draft Annual Report for DY8 (October 2016-September 2017)		12/30/2017
5/31/2018	Finalize Evaluation Design	Section XI, (#41)	8/31/2018
Ongoing – due 60 days at the end of each quarter	Submit Quarterly Reports	Section IX (#34)	Ongoing
12/30/2018	Submit Draft Annual Report for DY9 (October 2017 – September 2018)	Section IX (#34/#35)	12/30/2018
12/30/2019	Submit Draft Annual Report for DY10 (October 2018 – September 2019)	Section IX (#34/#35)	
12/31/2021	Submit Interim Evaluation	Section XI (#47)	
12/30/2020	Submit Draft Annual Report for DY11 (October 2019 – September 2020)	Section IX (#34/#35)	
12/30/2021	Submit Draft Annual Report for DY12 (October 2020 – September 2021)	Section IX (#34/#35)	
12/30/2022	Submit Draft Annual Report for DY13 (October 2021 – September 2022)	Section IX (#34/#35)	
6/30/2024	Submit Summative Evaluation Report	Section XI (#48)	
9/1/2022	Submit Draft Final Operational Report	Section IX (#34/#35)	

State Contact(s):

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APPENDIX II: Gateway Team Rosters

Pilot Program Planning Team

James Crane, MD (Chair)
Associate Vice Chancellor for Clinical Affairs
Washington University School of Medicine

Dwayne Butler
President and Chief Executive Officer
BJK People's Health Centers

Angela Clabon
Chief Executive Officer
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)

Caroline Day, MD, MPH
Chief Medical Officer
Family Care Health Centers

Ken Griffin
Clinical Operations Director
St. Louis County Department of Health

Alan Freeman, PhD
President and Chief Executive Officer
Affinia Healthcare (formerly known as Grace Hill)

Todd Richardson
Director
MO HealthNet Division, Department of Social Services, State of Missouri

Joe Yancey
Executive Director
Places for People

Robert Fruend (ex officio)
Chief Executive Officer
St. Louis Regional Health Commission

Angela Brown (ex officio)
Chief of Staff
St. Louis Regional Health Commission

Operations Subcommittee

Gretchen Leiterman (Chair)
Chief Operating Officer
SSM Health Saint Louis University Hospital

Tony Amato
Assistant Director, Managed Care
SLUCare

Yvonne Buhlinger
Vice President, Development and Community Relations
Affinia Healthcare (formerly known as Grace Hill)

Felecia Cooper
Nursing Supervisor
North Central Health Center

Kitty Famous
Manager, CH Orthopedic & Spine Surgeons
BJC Medical Group

Bernard Ceasor
GBH Section Supervisor
Family Support Division

Peggy Clemens
Practice Manager
Mercy Clinic Digestive Diseases

Cindy Fears
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Affinia Healthcare (formerly known as Grace Hill)

Linda Hickey
Practice Manager
Mercy Clinic Heart & Vascular

Gina Ivanovic
Manager, Referral Programs
Washington University School of Medicine

Andrew Johnson
Senior Director, A/R Management
Washington University School of Medicine

Lynn Kersting
Chief Operating Officer
Family Care Health Centers

Danielle Landers
Community Referral Coordinator
St. Louis Integrated Health Network

Antonie Mitrev
Director of Operations
Family Care Health Centers

Harold Mueller
Director, Planning and Development
Barnes-Jewish Hospital

Dr. James Paine
Chief Operating Officer
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)

Jacqueline Randolph
Director, Ambulatory Services
BJH Center for Outpatient Health

Renee Riley
Managed Care Operations Manager
MO HealthNet Division (MHD)

Vickie Wade
Vice President of Clinical Services
Betty Jean Kerr People's Health Centers

Jody Wilkins
Nursing Supervisor
South Count Health Center

Finance Subcommittee

Mark Barry/Denise Lewis-Wilson
Fiscal Director/Patient Accounts Manager
St. Louis County Department of Health

Andrew Johnson
Senior Director of A/R Management
Washington University School of Medicine

Dennis Kruse
Chief Financial Officer
Family Care Health Centers

Thomas Vu
Chief Financial Officer
CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers)

Connie Sutter
Fiscal and Administrative Manager
MO HealthNet Division, Missouri Department of Social Services

Hewart Tillett
Chief Financial Officer
Betty Jean Kerr People's Health Centers

Janet Voss
Vice President and Chief Financial Officer
Affinia Healthcare (formerly known as Grace Hill)

Transition Planning Team

Cheryl Walker (Chair)
Attorney
Riley Safer Holmes & Cancila LLP

James Buford
Civic Leader

Alan Freeman, PhD
Chief Executive Officer, Affinia Healthcare (formerly known as Grace Hill)

Ken Griffin
Clinical Operations Director
St. Louis County Department of Health

Robert Hughes, PhD
President and Chief Executive Officer
Missouri Foundation for Health

Bethany Johnson-Javois
Chief Executive Officer
St. Louis Integrated Health Network

Richard Liekweg
President and Chief Executive Officer
BJC HealthCare

Robert K. Massie, D.D.S.
Chief Executive Officer
Family Care Health Centers

Will Ross, M.D
Associate Dean and Director of the Office of Diversity
Washington University School of Medicine

Jeanine Arrighi
Interim Director
St. Louis City Department of Health

APPENDIX III: See Appendix III Attachment

Appendix IV: Incentive Payment Protocol

Incentive Payments

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

Pay-for-performance incentive payments will be paid out at six-month intervals (January – June and July – December) of the Pilot Program based on performance during the reporting period.

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

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

TABLE 1

Pay-for-Performance Incentive Criteria	**Threshold**	**Weighting**	**Source**
All Newly Enrolled Patients- Minimum of at least 1 office visit within 1 year (6 months before/after enrollment date)	80%	20%	EHR Data
Patients with Diabetes, Hypertension, CHF or COPD – Minimum of at least 2 office visits within 1 year (6 months before/after reporting period start date)	80%	20%	EHR Data
Patients with Diabetes - Have one HgbA1c test within 6 months of reporting period start date	85%	20%	EHR Data
Patients with Diabetes – Have a HgbA1c less than or equal to 9% on most recent HgbA1c test within the reporting period	60%	20%	EHR Data
Hospitalized Patients - Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days after hospital discharge.	50%	20%	Self-reported by health centers and AHS Call Center Data
TOTAL POSSIBLE SCORE		**100%**	

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

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

TABLE 2

Pay-for-Performance Incentive Criteria	**Threshold**	**Weighting**	**Source**
Rate of Referral to Specialist among Tier 1/Tier 2 Enrollees	680/1000	100%	Referral data

The primary care providers will be eligible for the remaining funds based on the percentage of patients enrolled at their health centers. For example, if Grace Hill has 60% of the primary care patients and Myrtle Hilliard Davis 40%, they would each qualify up to that percentage of the remaining funds. Funds not distributed will be used to create additional enrollment slots where demand and capacity exist. Payments will not be redirected for administrative or infrastructure payments.
Within the first quarter following the end of the reporting period, the state will issue incentive payments to the health centers. Incentive payments will be calculated based on the data received and the methodology described below.

Primary Care Health Center (PCHC) Calculations

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

- IP = PCHC Payments Earned x 7%

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

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

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

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

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

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

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

- PS = RPCIF x (CMM/TMM)

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

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

IPW = 30% + 70% = 100% (effective 7/1/12 - 12/31/13)

IPW = 100% (effective 1/1/14 – 12/31/14)

- RPCIFP = PS x IPW

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

SCENARIO 1

Key assumptions:

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

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

	7% Withheld	Earned	***STEP 3*** Remaining (Unearned)
Grace Hill	$ 200,000	$200,000	$ -
Myrtle Hilliard	$ 100,000	$ 75,000	$ 25,000
Family Care	$ 20,000	$ 20,000	$ -
BJK People's	$ 50,000	$ 40,000	$ 10,000
St. Louis County	$ 50,000	$ 45,000	$ 5,000
Total	$ 420,000	$380,000	**$ 40,000**

Remaining Primary Care Incentive Funds

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

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

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

Step 6

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

** Effective 1/1/14, IPW will either be 100% or 0% due to elimination of emergency department services.

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

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

SCENARIO 2

Key assumptions:

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

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

STEP 3

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

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

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

Step 6

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

** Effective 1/1/14, IPW will either be 100% or 0% due to elimination of emergency department services.

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

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

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

APPENDIX V: Pay-for-Performance Results

GATEWAY TO BETTER HEALTH

Pay-for-Performance Incentive Payment Results

Reporting Period: January – June 2018

Background

The State withholds 7% from payments made to the primary care health centers. The amount withheld is tracked on a monthly basis. Primary care health centers provided self-reported data to SLRHC within 30 days of the end of the reporting period for those patients who were enrolled for the entire reporting period. SLRHC validated the data by taking a random sample of the self-reported data and comparing it to the claims data. SLRHC has calculated the funds due to the providers based on the criteria and methodologies described in the Incentive Protocol, approved by CMS. Results for the sixth reporting period, January – June 2018, are summarized below.

Primary Care Health Center Pay-for-Performance Results

The potential incentive payment amount totaled $407,031.38 and 100% will be paid to primary care providers. The following table outlines the pay-for-performance thresholds in comparison to the actual results of each metric.

Table 1		*Actual Outcomes Achieved*					
Pay-for-Performance Criteria	**Threshold**	**AH**	**MHD**	**FC**	**BJKP**	**County**	**Total**
1 - All Patients (1 visit)	80%	74%	58%	84%	81%	82%	73%
2 - Patients with Chronic Disease (2 visits)	80%	90%	93%	96%	99%	92%	92%
3 - Patients with Diabetes HgbA1c Tested	85%	97%	94%	94%	100%	86%	94%
4 - Patients with Diabetes HgbA1c < 9%	60%	55%	61%	76%	77%	61%	63%
5 - Hospitalized Patients	50%	88%	54%	88%	52%	65%	68%

The number of metrics met by each health center for the first round of metrics is depicted by the green highlighted fields in Table 1 above. The health centers earned $322,860.54 of the initial incentive pool leaving a remaining balance of $84,170.84.

According to the Protocol, each health center is eligible for the remaining funds based on their percentage of patients enrolled provided that the specialist referral rate criteria is met. The outcome for referral rates to specialty care was compared to the thresholds and the results are summarized as follows:

Table 2		*Actual Outcomes Achieved*					
Pay-for-Performance Criteria	**Threshold**	**AH**	**MHD**	**FC**	**BJKP**	**County**	**Total**
Referral Rate to Specialists	680/1000	333	289	595	365	621	391

As noted by the green highlights in Table 2, all health centers met the performance criteria for the second round of metrics related to the rate of referrals to specialty care. The following table summarizes the incentive earnings for each health center based on the metrics achieved.

Table 3 - Amount Due to Each Health Center

Health Center	Incentive Pool	First Round Earnings	Second Round Earnings	Total Due to Providers
AH	$ 171,307.40	$ 102,784.44	$ 35,425.00	$ 138,209.44
MHD	$ 78,239.39	$ 62,591.51	$ 16,179.28	$ 78,770.79
FC	$ 36,444.60	$ 36,444.60	$ 7,536.45	$ 43,981.05
BJKP	$ 68,374.72	$ 68,374.72	$ 14,139.35	$ 82,514.07
County	$ 52,665.27	$ 52,665.27	$ 10,890.76	$ 63,556.03
Total	**$ 407,031.38**	**$ 322,860.54**	**$ 84,170.84**	**$ 407,031.38**

APPENDIX A: SUMMARY OF CALCULATIONS

The following process was followed to determine the payout for each of the primary care providers.

Step 1: Determine the initial pool amount.

Step 2: Determine which of the following first-tier performance metrics were achieved for each organization:

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
All Newly Enrolled Patients- Minimum of at least 1 office visit within 1 year (6 months before/after enrollment date)	80%	20%	EHR Data
Patients with Diabetes, Hypertension, CHF or COPD – Minimum of at least 2 office visits within 1 year (6 months before/after reporting period start date)	80%	20%	EHR Data
Patients with Diabetes - Have one HgbA1c test 6 months after reporting period start date	85%	20%	EHR Data
Patients with Diabetes – Have a HgbA1c less than or equal to 9% on most recent HgbA1c test within the reporting period	60%	20%	EHR Data
Hospitalized Patients - Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days after hospital discharge.	50%	20%	Self-reported by health centers and AHS Call Center Data
TOTAL POSSIBLE SCORE		**100%**	

Step 3: Calculate the earnings for the initial pool based on the number of first-tier metrics achieved.

Step 4: Determine the second pool amount, which is unearned amount from the initial pool.

Step 5: Calculate health center's share of available earnings based on enrollment.

Step 6: Determine which of the following second-tier performance metrics were achieved:

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
Rate of Referral to Specialist among Enrollees	680/1000	100%	Claims data

Step 7: Calculate the earnings for the second pool based on the number of second-tier metrics achieved.

Step 8: Calculate the total payment to the health center by summing the earnings from both pool.

APPENDIX B:
PRIMARY CARE TRENDING REPORT

Pay-for-Performance Criteria	Threshold	Affinia												Myrtle											
		Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jan-Jun 16	Jul-Dec 16	Jan-Jun 17	Jul-Dec 17	Jan-Jun 18	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jan-Jun 16	Jul-Dec 16	Jan-Jun 17	Jul-Dec 17	Jan-Jun 18
TIER 1 OUTCOMES																									
1 - New patients (1 visit)	80%	68%	52%	75%	67%	65%	74%	70%	72%	72%	75%	77%	74%	56%	58%	86%	71%	75%	83%	80%	66%	53%	70%	62%	58%
2 - Patients with chronic diseases (2 visits)	80%	73%	81%	80%	83%	80%	86%	84%	87%	86%	87%	87%	90%	82%	87%	95%	87%	92%	94%	96%	93%	83%	86%	87%	93%
3 - Patients with diabetes HgbA1c tested	85%	62%	91%	88%	87%	91%	92%	95%	90%	97%	89%	98%	97%	67%	78%	72%	48%	91%	86%	100%	92%	93%	85%	96%	94%
4 - Patients with diabetes HgbA1c <9%	60%	61%	60%	61%	60%	61%	60%	70%	73%	68%	65%	65%	55%	50%	48%	50%	58%	77%	47%	63%	63%	57%	65%	50%	61%
5 - Hospitalized Patients	50%	100%	83%	71%	87%	83%	85%	96%	95%	75%	91%	91%	88%	100%	59%	37%	73%	88%	64%	83%	93%	44%	44%	50%	54%
TIER 2 OUTCOMES																									
1 - Emergency Department Utilization	28/1000	34	13	12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	28	10	27	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2 - Referral Rate to Specialists	680/1000	447	427	315	277	272	280	281	308	316	394	321	333	454	353	309	345	287	322	272	277	233	250	265	289

Pay-for-Performance Criteria	Threshold	Family Care												BJK People's											
		Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jan-Jun 16	Jul-Dec 16	Jan-Jun 17	Jul-Dec 17	Jan-Jun 18	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jan-Jun 16	Jul-Dec 16	Jan-Jun 17	Jul-Dec 17	Jan-Jun 18
TIER 1 OUTCOMES																									
1 - New patients (1 visit)	80%	70%	73%	74%	80%	81%	78%	80%	89%	85%	88%	82%	84%	75%	61%	80%	72%	80%	58%	60%	66%	62%	72%	75%	81%
2 - Patients with chronic diseases (2 visits)	80%	75%	18%	14%	89%	96%	85%	95%	93%	96%	94%	94%	96%	50%	68%	81%	92%	82%	90%	96%	84%	86%	91%	88%	99%
3 - Patients with diabetes HgbA1c tested	85%	68%	70%	81%	100%	100%	89%	100%	94%	90%	85%	100%	94%	71%	57%	85%	89%	81%	90%	89%	74%	97%	85%	100%	100%
4 - Patients with diabetes HgbA1c <9%	60%	54%	53%	64%	75%	71%	68%	68%	83%	95%	69%	81%	76%	46%	37%	55%	56%	62%	61%	67%	60%	60%	52%	69%	77%
5 - Hospitalized Patients	50%	100%	100%	38%	64%	50%	67%	75%	75%	100%	80%	100%	88%	100%	77%	28%	67%	62%	60%	87%	77%	70%	50%	57%	52%
TIER 2 OUTCOMES																									
1 - Emergency Department Utilization	28/1000	12	11	20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	24	16	17	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2 - Referral Rate to Specialists	680/1000	656	647	567	599	518	528	521	506	497	553	565	595	598	440	363	425	346	337	348	370	360	375	354	365

Pay-for-Performance Criteria	Threshold	St. Louis County												Total											
		Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jan-Jun 16	Jul-Dec 16	Jan-Jun 17	Jul-Dec 17	Jan-Jun 18	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jan-Jun 16	Jul-Dec 16	Jan-Jun 17	Jul-Dec 17	Jan-Jun 18
TIER 1 OUTCOMES																									
1 - New patients (1 visit)	80%	69%	75%	77%	87%	88%	89%	95%	81%	81%	80%	80%	82%	65%	62%	79%	72%	74%	74%	74%	72%	68%	75%	75%	73%
2 - Patients with chronic diseases (2 visits)	80%	89%	95%	82%	92%	97%	97%	92%	88%	86%	81%	84%	92%	74%	73%	77%	86%	86%	90%	91%	88%	86%	87%	87%	92%
3 - Patients with diabetes HgbA1c tested	85%	71%	83%	85%	89%	92%	89%	77%	85%	87%	67%	88%	86%	66%	77%	83%	80%	90%	90%	91%	87%	94%	85%	97%	94%
4 - Patients with diabetes HgbA1c <9%	60%	39%	64%	63%	68%	80%	65%	61%	73%	40%	42%	71%	61%	54%	53%	59%	63%	68%	60%	66%	69%	65%	60%	66%	63%
5 - Hospitalized Patients	50%	100%	100%	52%	83%	65%	80%	100%	62%	100%	61%	64%	65%	100%	78%	54%	81%	78%	78%	91%	88%	71%	71%	75%	68%
TIER 2 OUTCOMES																									
1 - Emergency Department Utilization	28/1000	9	7	14	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	26	12	12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2 - Referral Rate to Specialists	680/1000	547	510	487	484	506	536	559	580	501	538	578	621	496	443	365	363	338	351	349	366	346	395	370	391

Note: The threshold for emergency room (ER) utilization for the July 2012 through June 2013 was 36 per 1000. As of January 1, 2014, Gateway to Better Health no longer funded any portion of ER visits and thus no longer captured data for ER utilization.

Budget Neutrality

Gateway to Better Health (Total Computable)

	DY 1 FFY 2010 07/28/2010 - 09/30/2010	DY 2 FFY 2011 10/01/2010 - 09/30/2011	DY 3 FFY 2012 10/01/2011- 9/30/2012	DY 4 FFY 2013 10/01/2012- 09/30/2013	DY 5 FFY 2014 10/01/2013- 9/30/2014	DY 6 FFY 2015 10/01/2014- 09/30/15	DY 7 FFY 2016 10/01/2015- 9/30/2016	DY 8 FFY 2017 10/01/2016- 9/30/2017	DY 9 FFY 2018 10/01/2017- 09/30/2018	DY 10 FFY 2019 10/01/2018- 12/31/2018
No. of months in DY	**3 months**	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**3 months**
No. of months of direct payments to facilities	**3 months**	**12 months**	**9 months**	**0 months**	**0 months**	**0 months**	**0 months**	**0 months**	**0 months**	**0 months**
No. of months of Pilot Program (will be implemented on 07/01/2012)	**0 months**	**0 months**	**3 months**	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**3 months**
Without Waiver Projections										
Estimated DSH Allotment**	$189,681,265	$748,599,611	*$766,126,399*	*$811,102,775*	$814,509,721	*$809,021,633*	*$812,093,381*	$812,093,381	$801,292,456	$801,292,456
Without Waiver Total	**$189,681,265**	**$748,599,611**	**$766,126,399**	**$811,102,775**	**$814,509,721**	**$809,021,633**	**$812,093,381**	**$812,093,381**	**$801,292,456**	**$801,292,456**
With Waiver Projections										
Residual DSH	$167,785,998	$679,083,062	*$675,602,811*	*$735,329,474*	*$713,152,789*	*$714,046,801*	*$787,095,768*	*$789,017,419*	*$774,502,111*	*$779,480,569*
St. Louis ConnectCare	$4,850,000	$18,150,000	$14,879,909	*$3,148,648*	$118,489	$0	$0	$0	$0	
Grace Hill Neighborhood Health Centers	$1,462,500	$5,850,000	*$5,071,706*	*$5,016,507*	*$6,073,656*	$5,648,970	*$4,805,114*	*$4,669,814*	*$4,871,549*	*$4,143,815*
Myrtle Davis Comprehensive Health Centers	$937,500	$3,750,000	*$3,097,841*	*$2,108,161*	*$1,838,040*	$2,157,443	*$2,098,142*	*$2,063,214*	*$2,259,440*	*$1,921,915*
Contingency Provider Network	$0	$0	*$379,372*	*$4,254,902*	*$5,469,199*	$3,937,955	*$5,035,278*	*$4,480,512*	*$4,874,848*	*$4,155,754*
Voucher	$0	$0	$0	*$4,541,262*	*$6,358,786*	$6,926,811	*$6,649,760*	*$5,712,142*	*$8,169,693*	*$7,838,797*
Infrastructure	$0	$0	$975,000	*$1,925,000*	*$0*	$0	$0	$0	$0	
SLRHC Administrative Costs	$75,000	$300,000	$300,000	*$300,000*	*$75,000*	*$0*	*$0*	*$0*	*$0*	
SLRHC Administrative Costs Coverage Model			$584,155	*$4,328,950*	*$3,692,463*	$3,098,002	*$3,477,955*	*$3,377,876*	*$3,659,960*	*$3,751,606*
CRC Program Administrative Costs	$91,684	$700,000	$700,000	*$700,000*	*$175,000*	*$0*	$ -	$ -	$ -	
Actual expenditures for DY3 DOS				$2,670,607	*$33,308*	*$0*	$ *(82.81)*	$ -	$ -	
Actual expenditures for DY4 DOS				$0	*$2,540,653*	*$6,559*	$ *229.36*	$ *(324.80)*		
Actual expenditures for DY5 DOS						*$2,402,336*	$ *267,821.04*	$ *(11,643.87)*		
Actual expenditures for DY6 DOS							$ *2,663,396.70*	$ *(21,117.45)*		
Actual expenditures for DY7 DOS								*$2,805,489*	$ *30,539.40*	
Actual expenditures for DY8 DOS									$ *2,924,315.43*	
Total With Waiver Expenditures	**$175,202,682**	**$707,833,062**	**$701,590,793**	**$764,323,513**	**$739,527,383**	**$738,224,877**	**$812,093,381**	**$812,093,381**	**$801,292,456**	**$801,292,456**
Amount under (over) the annual waiver cap	$14,478,583	$40,766,549	$64,535,605	$46,779,262	$74,982,338	$70,796,756	$0	$0	$0	$0
Annual expenditure by DY Payment Date as reported on CMS 64s (Demo expenses NOT including residual DSH)			$25,987,982	$28,994,039	$26,374,594	$24,178,076	$24,997,613	$23,075,962	$26,790,345	$21,811,887
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$7,416,684	$28,750,000	$28,691,815	$28,870,549	$26,459,146	$24,411,460	$24,902,277.87	$23,227,874	$23,835,490	$21,811,887

*Amount anticipated to be reported in Demonstration Years that should apply to a previous demonstration period.

**FFY 2012 through FY 2014 DSH allotments have not been finalized. FFY 2012 through FFY 2015 DSH allotments are based on actual CMS-64 reported expenditures. DSH allotment is shown as (total computable) above. For reference, DSH allotment in Federal share is shown below:

	FFY 2010
FFY 2010 Allotment (Federal share)	$465,868,922
FFY 2010 Increased Allotment (Federal share)	$23,584,614
Total Allotment (Federal share)	$489,453,536

Note: FFY 2010 FMAP for MO = 64.51%; FFY 2011 FMAP for MO = 63.29%; FFY 2013 FMAP = 61.37%. FFY 2014 FMAP = 62.03; FFY 2015 FMAP= 63.45; FFY 2016 FMAP=63.28; FFY 2017 FMAP=63.21; FFY 2018 FMAP=64.61; FFY 2019 FMAP=6