State of Missouri

Gateway to Better Health Demonstration

Number 11-W-00250/7

Amended Evaluation Design

October 16, 2016

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, and again on June 16, 2016. 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 the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act (ACA);

II. Connect the uninsured to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement;

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 Myrtle Hilliard Davis Comprehensive Health Centers.

The program transitioned to a coverage model pilot on July 1, 2012. The goal of the Gateway to Better Health Pilot Program is to provide a bridge to sustainable health care for safety net providers and their uninsured patients in St. Louis City and St. Louis County until coverage options are available through federal health care reform.

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 December 31, 2013.

The Missouri legislature did not expand Medicaid eligibility during its 2013-2016 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, or until Missouri's Medicaid eligibility is expanded to include the waiver population. At this time, it is not known if the Missouri legislature will expand Medicaid eligibility during its 2017 legislative session.

Section XII, item 48 of the amended Special Terms and Conditions (STCs), issued in June 2016, requires the State to submit to CMS for approval an amended draft evaluation design. This document is intended to meet this term of the Demonstration.

[1] To be considered to be "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.

Historical Background

The current funding provided by this Demonstration Project (Number: 11-W-00250/7) builds on and maintains the success of the "St. Louis Model," which was first implemented through the "Health Care for the Indigent of St. Louis" amendment to the Medicaid Section 1115 Demonstration Project (Number: 11-W00122/7). This amendment authorized the diversion of 6.27 percent of the Statewide DSH cash distributions, previously allocated to St. Louis Regional Hospital, to a "St. Louis Safety Net Funding Pool," which funded primary and specialty care for the uninsured. The downsizing and ultimate closure of St. Louis Regional Hospital in 1997 led to the "St. Louis Model." Under this model, the DSH funds were distributed directly to the legacy clinics of St. Louis Regional Hospital, which were operated by St. Louis ConnectCare[2], Affinia Healthcare (formerly known as Grace Hill Health Centers) and Myrtle Hilliard Davis Comprehensive Health Centers. The funds were distributed directly to these organizations through June 30, 2012. As of July 1, 2012, this funding was converted to a "coverage model" per the conditions of the Demonstration.

The SLRHC was established under this waiver to coordinate, monitor and report on the safety net network's activities and to make recommendations as to the allocation of these funds. Today, the SLRHC is charged with improving health care access and delivery to the uninsured and underinsured in the St. Louis region, and is the fiscal agent for this Demonstration.

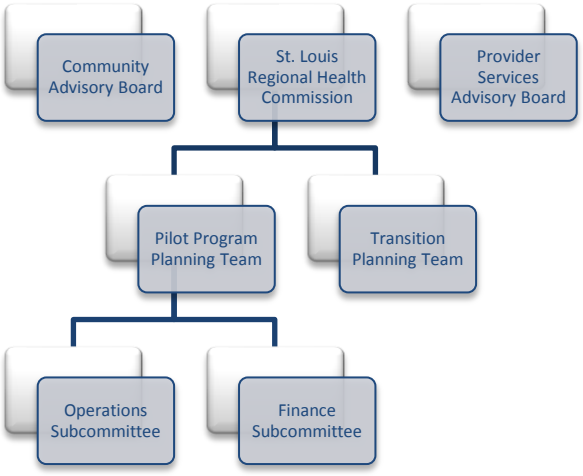
The Commission works within a large network that includes St. Louis County and its public health department, area Federally Qualified Health Centers (FQHCs), the St. Louis City health department, as well as area hospitals and medical schools.

St. Louis ConnectCare was not able to demonstrate financial sustainability under a coverage model during the Demonstration period and closed its operations in late 2013. After its closure, other contracted health care providers in the Gateway to Better Health network continued to provide services to Gateway patients. Access levels and continuity of care for these patients have been maintained through a managed transition process. Because of the approval of the Gateway extension through 2014, a seamless transition of care was possible despite ConnectCare's closure.

[2] St. Louis ConnectCare was not able to demonstrate financial sustainability under a coverage model during the Demonstration period, and closed its operations in late 2013.

II. Organizational Structure

The following structure, in consultation with the State of Missouri, has been designed to meet the objectives of the Demonstration:



The organizational structure is described below. Other sub-teams may be established during the planning process as needed.

St. Louis Regional Health Commission

The St. Louis Regional Health Commission (RHC) is a not-for-profit, public/private partnership created to improve access to health care and to reduce health disparities in St. Louis City and County. The RHC was founded in 2001 in response to a health care crisis precipitated by the closing of the area's last remaining public hospital. The RHC serves as the body that oversees the activities of the Demonstration and approves deliverables for submission to MO HealthNet Division.

Roles for the RHC under the Demonstration include:

- Serving as the Fiscal Agent for diverted DSH funds (July 2010 – December 2017);
- Creating a transition plan for implementation of a pilot coverage program (submitted June 27, 2012, and again on June 25, 2014);
- Creating an operational plan to implement the pilot program (submitted December 30, 2011);
- Collecting data and making funding recommendations for $24 million allocation to Affiliation Partners in spring 2011;
- Developing a pilot program planning team and staffing team to meet deliverable timeline; and
- Providing the operational infrastructure to operate the pilot program as described in the Memorandum of Understanding between the RHC and the State of Missouri.

Additional key roles related to both the RHC's mission and the Demonstration activities include:

- Initiating dialogue, seeking input and engaging the community on the issues of the health care safety net in the St. Louis region;
- Filtering and analyzing data, facts and various points-of-view;
- Proposing and recommending changes to the current system and developing priorities and coordinating areas of focus for action;
- Building support for change through communication, education and organization support and commitment;
- Mobilizing and coordinating resources for achieving progress towards improving the regional safety net and implementing the Demonstration; and
- Developing vehicles for measurement and communication of success on a long-term basis.

The RHC also has two Advisory Boards of approximately 30 individuals per board. One Advisory Board represents community organizations, citizens and users of the safety net system (the "Community Advisory Board"); the other Advisory Board represents health service providers in the region (the "Provider Services Advisory Board").

The Advisory Boards support the work of the RHC in three critical ways: (1) providing direct input to the Commission and the RHC's Workgroups concerning the work being completed; (2) creating and managing the engagement of the broader community into the planning process of the Commission, including the planning and oversight of the Demonstration Project Pilot Program; and (3) serving as a primary conduit of information from the Commission out to the broader community.

Both the Community Advisory Board and the Provider Services Advisory Board receive regular updates about the Demonstration planning and activities and provide input into the planning and ongoing operations of the Demonstration.

Pilot Program Planning Team

Given the complex analysis and planning necessary to meet the milestones of the Demonstration and to successfully implement and operate a pilot program, the Commission formed a "Pilot Program Planning Team" with the following charge:

- Develop recommendations for a pilot program to enroll low-income, uninsured individuals who are not currently eligible for Medicaid into a defined health coverage benefit model to operate beginning July 1, 2012 (implemented July 1, 2012); and
- Ensure all milestones of the "Gateway to Better Health" Demonstration Project are completed and submitted on time.

The team is composed of the following members:

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

Kate Becker
President, SSM Health St. Louis University Hospital

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

Johnetta Craig, MD, MBA
Chief Medical Officer, Family Care Health Centers

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

Angela Clabon
Chief Executive Officer, Myrtle Hilliard Davis Comprehensive Health Centers

Joe Yancey
Executive Director, Places for People

Faisal Khan, MBBS, MPH
Director, St. Louis County Department of Public Health

Suzanne LeLaurin, LCSW
Senior Vice-President for Individuals and Families, International Institute of St. Louis

Joe Parks
Director, MO HealthNet Division, Department of Social Services, State of Missouri

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

Jennifer Brinkmann (ex officio)
Chief of Staff, St. Louis Regional Health Commission

Operations Subcommittee

Reporting to the Pilot Program Planning Team, the Operations subcommittee has a charge to monitor and recommend necessary adjustments to Gateway operational functions, including but not limited to:

- Specialty care referral process
- Pay for performance metrics
- Performance and utilization management data from participating providers
- Enrollment and outreach efforts
- Patient and provider engagement activities

The Operations Subcommittee is composed of the following members:

Suzanne LeLaurin, LCSW (Chair)
Senior Vice President for Programs
International Institute St. Louis

Antoinette (Tonie) Briguglio-Mays
Program Development Specialist
Family Support Division

Deneen Busby
Director of Operations
Myrtle Hilliard Davis Health Centers

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

Debbie Haasis
Nursing Supervisor
South County Health Center

Amy Yost-Hansel
Director of Managed Care Contracting
SLUCare

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

Danielle Landers
Community Referral Coordinator
St. Louis Integrated Health Network

Antonie Mitrev
Director of Operations
Family Care Health Centers

Yvonne Buhlinger
Vice President, Development and Community Relations
Affinia Healthcare

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

Peggy Clemens
Practice Manager
Mercy Clinic Digestive Diseases

Cindy Fears
Director, Patient Financial Services
Affinia Healthcare

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

Linda Hickey
Practice Manager
Mercy Clinic Heart & Vascular

Lynn Kersting
Chief Operating Officer
Family Care Health Centers

Joan McGinnis
St. Louis Diabetes Coalition
Director of Education

Harold Mueller
Director, Planning and Development
Barnes-Jewish Hospital

Samantha Neal
Nursing Supervisor
John C. Murphy Health Center

Jacqueline Randolph
Director, Ambulatory Services
BJH Center for Outpatient Health

Dr. James Paine
Chief Operating Officer
Myrtle Hilliard Davis Health Centers

Finance Subcommittee

Reporting to the Pilot Program Planning Team, the Finance Subcommittee has a charge to monitor financial results of the Pilot Program and recommend adjustments in order to achieve financial goals.

The Finance Subcommittee is composed of the following members:

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

John Atkinson
Chief Financial Officer, Myrtle Hilliard Davis Comprehensive Health Centers

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

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

Dennis Kruse
Chief Financial Officer, Family Care Health Centers

Connie Sutter
Senior Auditor, MO HealthNet Division, Missouri Department of Social Services

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

Transition Planning Team

Reporting to the Commission, the Transition Planning Team has a charge to develop a Transition Plan for ensuring access to primary and specialty care services for the low-income population of St. Louis City and County after the scheduled conclusion of the Gateway to Better Health Demonstration Project on December 31, 2017. In particular, the plan will discuss how the state plans to coordinate the transition of Demonstration enrollees to a coverage option available under the Affordable Care Act. The interim Transition Plan was submitted to CMS on June 27, 2012, and again on June 25, 2014.

The Transition Planning Team is composed of the following members:

Cheryl Walker (Chair)
Attorney, Bryan Cave, LLP

Kate Becker
President, SSM Health St. Louis University Hospital

James Buford
Civic Leader

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

Faisal Khan, MBBS, MPH
Director, St. Louis County Public Health Department

Robert Hughes, Ph.D.,
President and Chief Executive Officer, Missouri Foundation for Health

Betty Sims
Former State Senator

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

Steven Lipstein
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

Melba Moore
Director, St. Louis City Department of Health

III. Planned Evaluation Approach

The Gateway to Better Health Demonstration Project will be evaluated to determine if the project meets the established objectives as well as to gain knowledge about the challenges, opportunities and benefits of a coverage model designed for low-income uninsured adult patients who do not qualify for Medicaid or Medicare. From July 1, 2012, through December 31, 2013, the Demonstration Pilot Program provided primary and specialty care for patients up to 133% of the Federal Poverty Level (FPL), and specialty care only for patients up to 200% of the FPL through a coverage model known as Gateway to Better Health. As of January 1, 2014, the Pilot Program provides primary, urgent and specialty care coverage to uninsured[3] adults in St. Louis City and St. Louis County, aged 19-64, with income at or below 100% of the (FPL).

Because this demonstration project includes a pilot program designed to provide a bridge for patients to health care reform under the Affordable Care Act, the evaluation will not merely report metrics against objectives. It also will explore some of the contributing factors that led to the pilot program's outcomes, enabling other regions to learn from the experience in St. Louis.

The evaluation will weave together multiple data sources, including but not limited to UDS reported data, utilization data from organizations participating in the pilot project, annual survey data reported to the St. Louis Regional Health Commission, as well as data from patient and physician/medical professional focus groups and surveys.

Determination of Evaluator

In 2010, with cooperation from MO HealthNet staff, the St. Louis Regional Health Commission selected Mercer Government Human Services Consulting to perform the final evaluation of the Gateway to Better Health Demonstration Project. As the program continues, additional evaluation efforts for interim evaluation results may utilize other resources, as needed.

Populations Evaluated

The demonstration project is designed to maintain and increase access to primary and specialty care for the uninsured in St. Louis City and County. As a result, the evaluation will focus on uninsured patients who are served by the health care safety net in St. Louis. For the extension period, the evaluation will examine clinical activities for uninsured adults, aged 19-64, in St. Louis City and St. Louis County, as defined by the STCs issued in June 2016.

The St. Louis health care safety net is comprised of the five St. Louis area community health centers, including Betty Jean Kerr People's Health Centers, Family Care Health Centers, Affinia Healthcare (formerly known as Grace Hill), Myrtle Hilliard Davis Comprehensive Health Centers and St. Louis County Department of Public Health. The St. Louis safety net also includes area academic medical institutions (Washington University School of Medicine and St. Louis University School of Medicine). These

[3] To be considered to be "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.

organizations are members of the St. Louis Integrated Health Network (IHN). The IHN is a 501(c)(3) comprised of primary and specialty medical care providers in the St. Louis region. The goal of the IHN is to ensure access to health care for the uninsured and underinsured through increased integration and coordination of a safety net of health care providers.

Over the last decade, the work of the safety net providers in the St. Louis region has focused on helping patients establish a medical home in one of the community health centers in an effort to reduce health disparities and increase the effective utilization of the community's health care resources. The Demonstration Project is intended to continue these efforts while preparing patients and safety net provider organizations for an effective transition to coverage that will be available under health care reform, upon expansion of Medicaid eligibility in Missouri.

Isolation of Outcomes

Because the program serves uninsured patients of a select provider network within St. Louis City and St. Louis County, the program will be able to track outcomes for safety net delivery systems, provider organizations and patients. The patients targeted by this program have very little access to health care services beyond those available from the provider organizations who are members of the St. Louis Integrated Health Network. This fact makes it easier to isolate the outcomes of this program. Furthermore, the "coverage model" provides utilization data and quality metrics for the population enrolled in the Pilot Program, enabling the project team to isolate outcomes to the targeted population. Performance and health indicator outcomes will be compared with averages of other community health centers in the State.

IV. Demonstration Project Evaluation

The Gateway to Better Health Demonstration Project includes the following main objectives:

I. Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act (ACA);

II. Connect the uninsured to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement;

III. Maintain and enhance quality service delivery strategies to reduce health disparities.

Through these objectives, the Gateway to Better Health Pilot Program expects to evaluate the following hypotheses:

I. By preserving health care services at safety net providers, services will be maintained in the urban core where the greatest health disparities exist, enabling low-income patients to receive preventive, specialty and primary care under the coverage model.

II. Patients who have access to affordable coverage will demonstrate quality outcomes comparable to other insured populations within community health centers.

III. For those patients aging out of Medicaid who need a coverage option, the pilot project provides a transition to coverage available under the Affordable Care Act, providing an effective bridge for these patients.

Described below is the recommended approach to evaluating and analyzing outcomes against the three main objectives of the program.

I. Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act (ACA).

The funding provided by the Gateway to Better Health Demonstration Project is critical to maintaining access to primary and specialty care services for the uninsured in the St. Louis region, particularly for those who live in the urban core where few options exist for health care services. Without the Pilot Program or Medicaid expansion in Missouri, much of the region's safety net would not be financially sustainable. As such, maintaining funds from the Demonstration project leads to the overall stability of the safety net and ensures access for those uninsured and underinsured patients. The evaluation will highlight pay-for-performance payments as well as total revenue for the community health centers which serve as primary care homes for Gateway patients.

Ensuring that services remain available and accessible to patients in these communities will be important in evaluating the success of the demonstration project. To measure this, the project team will report on any change in health center locations and significant changes in hours of operation during the period of the demonstration. The rationale for tracking health

center locations is to consider whether geographically dispersed access points were maintained throughout the community. The rationale for measuring hours of operation is to consider whether health centers maintained hours of operation that offered sufficient access to patients, including weekend and evening hours.

It is also important to track utilization of these services on an annual basis by payor and by service line at each provider. The rationale for measuring encounters is to analyze changes in the amount and types of services provided to different patient payor groups (particularly the uninsured) at each Gateway provider throughout the Demonstration. This data will assist evaluators in assessing changes in access to services during the Demonstration.

In addition, patients rely on health centers for a range of services from annual exams, tests and diagnostics to nutrition education and mental health. During each year of the Demonstration, the service offerings available at each provider organization will be documented in order to provide analysis of any changes in service availability.

II. Connect the uninsured to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement.

The Gateway to Better Health Demonstration Project is a medical home initiative. Enrolled patients are assigned a primary care medical home that provides comprehensive primary care services; continuous preventive, chronic care and medication management; self-care support and community resources; and care coordination for tests, referrals and transitions of care; along with a payor source that covers the cost of outpatient health care services. The Gateway providers are committed to using performance data for continuous quality improvement. Appendix III provides the pay-for-performance incentive measures upon which a set percentage of Demonstration payments are based. Appendix II provides health indicator baselines and goals for quality measurement. In addition, the Gateway primary care providers participate in the State of Missouri's medical home initiative and are working with the Missouri Primary Care Association (MPCA) to achieve official recognition from the NCQA as Patient-Centered Medical Homes.

The Demonstration project regularly assesses patient and provider satisfaction of the Pilot Program. Satisfaction is measured through surveys and focus groups performed by either the SLRHC and the community health centers or through a contracted vendor. From this evaluation, feedback and input is gathered to improve program experience for both providers and patients. Results from these surveys will be included in the overall evaluation of the Gateway to Better Health Demonstration project.

Enrollment trends by health center, zip code, age, gender and race/ethnicity are also monitored throughout the Demonstration

III. Maintain and enhance quality service delivery strategies to reduce health disparities.

The region's Federally Qualified Health Centers and health departments are continually focused on reducing the health disparities that exist in the St. Louis region. The St. Louis

Regional Health Commission studied this issue in depth in 2003, when it released *Building a Healthier St. Louis*. This report served as the foundation for the ongoing collaborative work of the members of the RHC to improve the health care safety net in St. Louis.

For the Demonstration Project, the participating Gateway primary care provider organizations will track those health disparity measures reported annually in UDS reports. The project team will use the Missouri Primary Care Association (MPCA) data warehouse to report health disparity measures. Tobacco use and cessation, cervical cancer screening, adult weight screening and follow up, blood pressure and diabetes control have been selected as health disparity measures. The project team will compare these measures of Gateway providers with the average of community health centers in the State of Missouri. It is anticipated that the participating organizations will perform at or above the average performance of all FQHCs in the State. In addition, the evaluation metrics will be reported by age, gender and race/ethnicity for each of the proposed health indicators in Appendix II, as available. All Gateway patients are residents of St. Louis City and St. Louis County. The State does not anticipate reporting health disparity measures by geography.

The St. Louis Regional Health Commission also leads the Alive and Well STL initiative, which focuses on the impact of trauma and toxic stress on physical and emotional health. During the evaluation period, the SLRHC seeks to intersect the Gateway to Better Heath program and Alive and Well STL through collaborative learning sessions where Gateway providers and organizations can become trained in providing trauma informed care to their patients, including those Gateway to Better Health patients. The impact of this training will be measured through ongoing assessments of each provider organization's adoption of trauma informed practices. Providers will determine which quality or process measures they seek to improve within their organizations through this work. Results from these evaluations will be reported in the evaluation for the demonstration project.

The Pilot Program Planning team and its subcommittees (comprised of representatives from participating provider organizations) monitor utilization and quality outcomes of the Gateway to Better Health program. The teams meet regularly to discuss solutions and innovative techniques to improve quality and consumer issues related to the program. Participating providers work together to implement new strategies aimed at improving care coordination and quality.

Overview of Demonstration Project Evaluation

The following table summarizes the key questions and areas of analysis by Demonstration objective. Baselines and Goals are provided in Appendices I and II[4].

[4] Only baseline data, as of 2009 and 2010 for those affiliation partners and as of 2011 for all other primary care providers included in the coverage model, is provided in the evaluation design.

Demonstration Questions and Areas of Analysis by Objective

Demonstration Objective	**Key Questions**	**Key Measures/Data Sources**	**Analysis**
I. Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act (ACA).	Were primary health care services maintained in the neighborhoods where they existed at the beginning of the demonstration project (July 2010)? Did St. Louis City and St. Louis County uninsured individuals maintain access to specialty care services at a level provided at the beginning of the demonstration project? Did the types of services available (i.e. nutrition education, lab tests, radiology) in July 2010 remain available throughout the Demonstration project?	Health center locations and hours of operation. Primary care encounters by payor and by service line at safety net primary care organizations on an annual basis. Urgent care encounters at Gateway urgent care sites on an annual basis. Specialty care encounters and diagnostic services provided by safety net specialty care providers on an annual basis. Services available at Gateway provider organizations on an annual basis. Provider revenue data by federal fiscal year.	Description of changes in service and impact of changes on the patient community.
II. Connect the uninsured to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement.	How many uninsured patients had a medical home at Gateway primary care organizations each year of the Demonstration project? How did Gateway patients and providers rate overall coordination, quality and delivery of healthcare services?	Number of primary care patients seen by Gateway providers who are uninsured on an annual basis. Pay for performance quality results by reporting period. Number of new enrollees in the program on an annual basis.	Description of trends in connecting the uninsured to a primary care home and the impact of having a primary care home on the uninsured.

Demonstration Objective	Key Questions	Key Measures/Data Sources	Analysis
		Number of enrollees in the program by primary care home, zip code, age, gender, race/ethnicity. Results from patient and provider satisfaction surveys.	
III. Maintain and enhance quality service delivery strategies to reduce health disparities.	By race and ethnicity, what percentage of patients met health disparities metrics (tobacco use and cessation, cervical cancer screening, adult weight screening and follow up, blood pressure and diabetes control)? Did providers implement new programs with the aim to maintain and enhance quality as well as reduce health disparities?	UDS quality measures for each year of the demonstration project from participating organizations. Number of participating primary and specialty care provider organizations that are actively implementing trauma informed practices and/or other quality initiatives. Wait times at safety net primary and specialty care providers.	Description of trends presented in UDS data, including how that data compares to state and national averages for other community health centers. Description of how trauma informed care has improved quality of care and/or reduced disparities.

In addition to the stated objectives of the demonstration project, CMS' special terms and conditions specify that the draft evaluation design shall address the following evaluation questions and topics:

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

As addressed in the description of Objective I, the following information will be tracked throughout the demonstration:

- Health center locations and hours of operation;
- Primary care encounters by payor and by service line at safety net primary care organizations on an annual basis;
- Urgent care encounters provided by Gateway urgent care sites;
- Specialty care encounters and diagnostic services by payor and by service line at medical schools, hospitals and community specialist providers on an annual basis on;

In addition to the information mentioned above, the Demonstration will also track the following:

- Number of transportation rides to medical appointments funded through Gateway

This information will provide insights about where and what services have been maintained or enhanced throughout the Demonstration Project.

II. How successful is the Demonstration in expanding coverage to the region's uninsured by 2% each year?

The following information will be tracked throughout the Demonstration:

- Primary care (including urgent care) encounters among the uninsured and the Medicaid population at community health centers;
- Number of uninsured individuals in St. Louis and County on an annual basis;
- Number of individuals covered by Medicaid in St. Louis and County on an annual basis.

The annual number of uninsured encounters and patients will be tracked for each of the primary care provider organizations that receive funding throughout the Demonstration.

Coinciding with the time period of the Demonstration, community health centers led organization-wide outreach efforts to enroll eligible patients into available coverage, including Gateway to Better Health, Medicaid programs and private insurance available through the federal exchange. Trends in enrollment into coverage will be monitored and reported in the evaluation of the demonstration program.

With enrollment efforts among safety net providers in the St. Louis region, the number of encounters and unique patients served among these populations will also be an important factor in determining the success of expanding coverage to the region's uninsured. As a result, utilization trends within safety net providers among those covered through Gateway, Medicaid and private insurance will be monitored and reported in evaluation efforts for the demonstration project.

III. To what extent has the Demonstration improved the health status of the population served in the Demonstration?

Health status of the population will be tracked through the annual analysis of certain measures, which are reported on annual UDS reports or are HITECH Meaningful Use measures. In addition, the Incentive Payment Protocol (originally submitted to CMS on August 16, 2012, and subsequently amended on April 24, 2014, and August 11, 2014, and discussed in item IV below) aligns health status measures with the provider payment methodologies to provide further incentives for the delivery of quality healthcare services for the duration of the pilot program. For a complete list of proposed quality measures, see Appendix II.

IV. Describe provider incentives and activities.

Beginning July 1, 2012, with the implementation of the pilot program, the project team instituted new provider incentives and activities. The Incentive Payment Protocol (provided as Appendix III) was originally submitted to CMS on August 16, 2012, and subsequently amended on April 24, 2014, and August 11, 2014.

The Incentive Payment Protocol requires 7% of provider funding to be withheld from the Gateway providers. The 7% withheld is tracked on a monthly basis. The St. Louis Regional Health Commission is responsible for monitoring the participating organizations' performance against the pay-for-performance metrics in the Incentive Payment Protocol. Effective January 1, 2014, the Incentive Payment Protocol was only applicable to primary care organizations.

The evaluation will provide an analysis of provider performance against the performance incentive criteria and discuss provider payment. The evaluation will also compare outcomes with data from health centers statewide as described in Item V below.

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

As described in item IV above, the St. Louis Regional Health Commission is responsible for monitoring the health centers' performance against the pay-for-performance metrics in the Incentive Payment Protocol. The Incentive Payment Protocol is provided in Appendix III.

The evaluation will also provide an analysis of provider performance outcomes as compared to statewide health center performance data for the following UDS measures:

- Percentage of adults age 18 and older assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy at least once within 24 months;
- Proportion of patients 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;
- Percentage of women 24 to 64 years of age who received one or more Pap tests to screen for cervical cancer during the measurement year or during the 2 calendar years prior to the measurement year or for women who were 30 years of age or older at the time of the test who choose to also have an HPV test performed simultaneously, during the measurement year or during the 4 calendar years prior to the measurement year;
- 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;
- 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 and if the most recent BMI is outside parameters, a follow-up plan is documented.

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

Beginning January 1, 2016, the pilot program began providing for brand name insulin and inhalers, as there are no generic alternatives to these medications at this time. To measure the success of this new benefit on beneficiaries, the STLRHC will track the number of these prescriptions provided to patients.

To measure the impact of providing coverage for brand name insulin and inhalers, the pilot program already tracks a number of quality indicators relevant to patients who may utilize this new benefit through incentives payments and UDS reporting. Changes in the quality measures specific to patients utilizing this benefit are listed below and will be reported in the evaluation:

- Number of patients with chronic diseases with at least two office visits within one year as measured through the Incentive Payment Protocol in six month reporting periods;
- Number of patients with diabetes with one HgbA1c test within six months as measured through the Incentive Payment Protocol in six month reporting periods;
- Number of patients with diabetes with a HgbA1c less than or equal to 9% as measured through both the Incentive Payment Protocol in six month reporting periods as well as through annual UDS health status reporting.

Appendix I
Demonstration Objectives, Baselines and Goals

Appendix I provides baselines and goals for each Demonstration objective. Unless otherwise noted, data is collected by the SLRHC by written provider survey on an annual basis. The data is self-reported by each provider organization. Only baseline data, as of 2009 and 2010 for those Affiliation Partners and as of 2011 for all other primary care providers included in the coverage model, is provided below.

<u>Demonstration Objective I</u>: Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage Is available under the Affordable Care Act (ACA).

- Hours of Operation by Site

All Primary and Specialty Care Sites: Hours of Operation

Partner Site	***2011***	***2010***	***2009***
Affinia Healthcare			
North Florissant	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm	NA
Lemp	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm
South Broadway	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm	NA	NA
Biddle	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm	NA	M,T,TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm
BJC Behavioral Health	M-F-8:30am-5pm	NA	NA
St. Patrick	M-F-8am-4:30pm	NA	NA
Myrtle Hilliard Davis Comprehensive Health Centers			
Homer G. Phillips	M, T, W, F-8am-5pm; Th-8am-8pm	M, T, W, F - 8am-5pm; TH- 8am-8pm	M, T, W, F - 8:00am-5:00pm; TH-8am-8pm
Florence Hill	M-8am-8pm; T, W, Th, F-8am-5pm	M-8am-8pm; T, W, TH, F-8am-5pm	M-8am-8pm, T, W, TH, F-8am-5pm
Comp I	M, T, Th, F-8am-5pm; W-8am-8pm	NA	NA
Betty Jean Kerr People's Health Centers			
Central	M-F-8:30am-5:30pm; Sa (When Scheduled)	NA	NA
North	M, T, Th, F-8:30am-5:30pm; W-11:30am-8:30pm; Sa (When Scheduled)	NA	NA
West	M, T, W, F-8:30am-5:30pm; Th-11:30am-8:30pm; Sa (When Scheduled)	NA	NA
Family Care Health Centers			
Carondelet	M, W, F-8am-4:30pm; T, Th-8am-8pm; Sa-8am-1pm	NA	NA

Partner Site	*2011*	*2010*	*2009*
Forest Park	M, W, Th, F-8am-4:30pm; T-8am-7pm; Sa-9am-2pm	NA	NA
St. Louis County Health Centers			
North Central	M, T, F-8am-5pm; W, Th-8am-9pm	NA	NA
South County	M, T-8am-9pm; W, Th, F-8am-5pm	NA	NA
St. Louis ConnectCare	M-F-8am-7pm; Sa/Su-8am-5pm (Urgent Care and General X-ray); M-F- 8am-4:30pm (All other services)	M-F 8am-7pm; Sa/Su-8am- 5pm (Urgent Care and General X-ray); M-F-8am-5pm (All other services)	M-F 8am-7pm; Sa/Su-8am-5pm (Urgent Care and General X-ray); M-F-8am-5pm (All other services)

Goal will be to maintain or improve hours of operation by site throughout the Demonstration.

- Primary care encounters by payor and by service line for primary care legacy sites and all Gateway primary care provider organizations on an annual basis. Specialty care, urgent care and diagnostic services encounters by payor and by service line at St. Louis ConnectCare on an annual basis.

Affinia Healthcare: Encounters by Service Line, 2009-2011

Year	*Service Line*	*All Affinia Sites*	*Murphy O'Fallon**	*Soulard Benton**
2011	Primary Medical Care	106,421	32,146	24,110
	Dental	22,261	7,431	6,974
	Mental Health	6,474	4,298	1,489
	Substance Abuse	10,422	0	0
	Enabling Services	13,009	4,553	348
	Other (podiatry and optometry)	4,237	2,151	802
	Total	162,824	50,579	33,723
2010	Primary Medical Care	99,008	28,993	24,158
	Dental	19,967	7,017	6,802
	Mental Health	6,200	4,117	1,103
	Substance Abuse	8,657	0	0
	Enabling Services	11,819	4,106	112
	Other (podiatry and optometry)	3,777	1,721	957
	Total	149,428	45,954	33,132
2009	Primary Medical Care	96,796	27,752	23,657
	Dental	16,273	6,274	5,663
	Mental Health	6,609	4,359	944
	Substance Abuse	7,959	0	0
	Enabling Services	26,087	9,063	5,653
	Other (podiatry and optometry)	3,046	2,693	166
	Total	156,770	50,141	36,083

**Denotes legacy sites of St. Louis Regional Hospital*

Affinia Healthcare: Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***All Affinia Sites***
2011	Uninsured	92,570
	Medicaid	59,156
	Medicare	4,913
	Private Insurance	6,185
	Total	162,824
2010	Uninsured	89,658
	Medicaid	50,805
	Medicare	5,977
	Private Insurance	2,988
	Total	149,428
2009	Uninsured	94,062
	Medicaid	53,302
	Medicare	6,271
	Private Insurance	3,135
	Total	156,770

Myrtle Hilliard Davis Comprehensive Health Centers: Encounters by Service Line, 2009-2011

Year	***Service Line***	***All Myrtle Hilliard Davis Sites***	***Homer G. Philips****	***Florence Hill****
2011	Primary Medical Care	75,204	14,460	14,692
	Dental	22,248	4,983	4,852
	Mental Health	0	0	0
	Substance Abuse	0	0	0
	Enabling Services	2,620	940	661
	Other (podiatry and optometry)	537	41	17
	Total	100,609	20,424	20,222
2010	Primary Medical Care	74,491	14,271	14,555
	Dental	22,033	4,914	4,798
	Mental Health	0	0	0
	Substance Abuse	0	0	0
	Enabling Services	2,544	929	602
	Other (podiatry and optometry)	573	54	2
	Total	99,641	20,168	19,957
2009	Primary Medical Care	77,990	15,852	14,411
	Dental	18,107	3,922	4,220
	Mental Health	0	0	0
	Substance Abuse	0	0	0
	Enabling Services	3,032	968	457
	Other (podiatry and optometry)	428	38	18
	Total	99,557	20,780	19,106

**Denotes legacy sites of St. Louis Regional Hospital*

Myrtle Hilliard Davis Comprehensive Health Centers: Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***All Myrtle Hilliard Davis Sites***
2011	Uninsured	66,076
	Medicaid	22,977
	Medicare	3,700
	Private Insurance	7,856
	Total	100,609
2010	Uninsured	40,853
	Medicaid	31,885
	Medicare	15,943
	Private Insurance	10,960
	Total	99,641
2009	Uninsured	47,848
	Medicaid	36,265
	Medicare	6,757
	Private Insurance	8,687
	Total	99,557

All Other Primary Care Gateway Participants: Encounters by Service Line, 2011

Year	***Service Line***	***BJK People's, All Sites***	***Family Care, All Sites***	***STL County, All Sites***
2011	Primary Medical Care	91,955	50,222	52,562
	Dental	13,843	7,468	8,480
	Mental Health	1,630	4,475	281
	Substance Abuse	0	0	0
	Enabling Services	0	2,483	0
	Other (podiatry and optometry)	12,146	2,043	7,665
	Total	119,574	66,691	68,988

All Other Primary Care Gateway Participants: Encounters by Payor Mix, 2011

Year	***Payor Category***	***BJK People's, All Sites***	***Family Care, All Sites***	***STL County, All Sites***
2011	Uninsured	47,739	24,009	39,553
	Medicaid	54,740	29,344	23,828
	Medicare	4,686	4,668	4,933
	Private Insurance	12,409	8,670	674
	Total	119,574	66,691	68,988

St. Louis ConnectCare: Encounters by Service Line, 2009-2011

Year	***Service Line***	***St. Louis ConnectCare***
2011	Urgent Care	12,716
	Specialty Care	
	Cardiology	2,130
	Dermatology	1,176
	Endocrinology	1,015
	Other	0
	General Surgery	1,621
	Gastroenterology	2,878
	Urology	957
	Infectious Disease	0
	Nephrology	1,606
	Neurology	1,726
	Gynecology (Surgical)	0
	Orthopedics	1,148
	Otolaryngology	1,136
	Pulmonary	554
	Rheumatology	0
	Total Specialty Care Encounters	15,947
	Diagnostic Services	
	Endoscopy	1,132
	Radiology	8,330
	Total Diagnostic Services Encounters	9,462
	STD Clinic Encounters	5,753
	Total	43,878
2010	Urgent Care	13,269
	Specialty Care	
	Cardiology	2,201
	Dermatology	1,122
	Endocrinology	1,130
	Other	35
	General Surgery	11,625
	Gastroenterology	3,585
	Urology	1,043
	Infectious Disease	0
	Nephrology	1,850
	Neurology	1,702
	Gynecology (Surgical)	50
	Orthopedics	1,707
	Otolaryngology	1,202
	Pulmonary	579
	Rheumatology	295
	Total Specialty Care Encounters	18,126
	Diagnostic Services	
	Endoscopy	1,434
	Radiology	10,801
	Total Diagnostic Services Encounters	12,235
	STD Clinic Encounters	5,898

Year	*Service Line*	*St. Louis ConnectCare*
	Total	49,528
2009	Urgent Care	15,502
	Specialty Care	
	Cardiology	2,749
	Dermatology	1,203
	Endocrinology	1,105
	Other	169
	General Surgery	1,923
	Gastroenterology	3,906
	Urology	1,032
	Infectious Disease	0
	Nephrology	1,864
	Neurology	1,690
	Gynecology (Surgical)	633
	Orthopedics	1,933
	Otolaryngology	1,291
	Pulmonary	622
	Rheumatology	1,601
	Total Specialty Care Encounters	21,721
	Diagnostic Services	
	Endoscopy	1,306
	Radiology	8,961
	Total Diagnostic Services Encounters	10,267
	STD Clinic Encounters	6,153
	Total	53,643

St. Louis ConnectCare: Specialty Clinic Encounters by Payor Mix, 2009-2011

Year	*Payor Category*	*St. Louis ConnectCare Specialty Clinics*
2011	Uninsured	9,472
	Medicaid	3,498
	Medicare	2,174
	Private Insurance	803
	Total	15,947
2010	Uninsured	11,248
	Medicaid	3,922
	Medicare	2,500
	Private Insurance	456
	Total	18,126
2009	Uninsured	13,240
	Medicaid	4,724
	Medicare	2,619
	Private Insurance	1,138
	Total	21,721

St. Louis ConnectCare: Urgent Care Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***St. Louis ConnectCare Specialty Clinics***
2011	Uninsured	7,132
	Medicaid	2,981
	Medicare	892
	Private Insurance	1,711
	Total	12,716
2010	Uninsured	7,530
	Medicaid	2,917
	Medicare	1,013
	Private Insurance	1,809
	Total	13,269
2009	Uninsured	9,512
	Medicaid	2,848
	Medicare	1,041
	Private Insurance	2,101
	Total	15,502

St. Louis ConnectCare: Diagnostic Service Care Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***Diagnostic Service Care***
2011	Uninsured	6,425
	Medicaid	1,649
	Medicare	733
	Private Insurance	655
	Total	9,462
2010	*Uninsured*	*8,375*
	Medicaid	*1,976*
	Medicare	*1,080*
	Private Insurance	*804*
	Total	*12,235*
2009	Uninsured	6,956
	Medicaid	1,557
	Medicare	841
	Private Insurance	913
	Total	10,267

Goal will be to increase uninsured encounters by 2% at Gateway primary care organizations.

- Baseline Services

Services Available at Affinia Healthcare, Myrtle Hilliard Davis and St. Louis ConnectCare, 2009-2011

Affiliation Partner Organization	***2011***	***2010***	***2009***
Affinia Healthcare (formerly known as Grace Hill)	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care.	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care.	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care.
Myrtle Hilliard Davis Comprehensive Health Centers	Primary medical care, podiatry, ophthalmology, dental care, behavioral health, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.	Primary medical care, podiatry, ophthalmology, dental care, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.	Primary medical care, podiatry, ophthalmology, dental care, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.
St. Louis ConnectCare	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology,	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics,	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics,

Affiliation Partner Organization	*2011*	*2010*	*2009*
	pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.

2011 Services Available at Other Gateway Primary Care Providers

Betty Jean Kerr People's Health Centers	*Family Care Health Centers*	*St. Louis County Health Centers*
Primary medical care, women's health, pediatrics, dental, podiatry, optometry, WIC, enabling services (social services, mental health, substance abuse counseling, HIV/AIDS counseling and testing), outreach (school-linked programs, abstinence education, community health nursing, health education, mobile health services), laboratory/x-ray, and referral for specialty services.	Primary medical care, dental, optometry, behavioral health, nutrition, WIC, pharmacy, laboratory, HIV/AIDS counseling and testing, and referral for specialty services.	Primary medical care, women's health, pediatrics, dental, podiatry, ophthalmology, WIC, health education classes (childbirth and diabetes), immunization clinic, lead screening and treatment services, nutrition counseling, public health nursing, STD testing and counseling, teen care, and referral for specialty services.

Goal will be to maintain or expand current services available at primary care organizations throughout the Demonstration. Benefits offered through the pilot program may impact service offerings at primary care organizations.

<u>Demonstration Objective II</u>: Connect the uninsured to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement.

- Number of patients who are uninsured or covered by Medicaid

Gateway Primary Care Providers: Uninsured and Medicaid Users, 2009-2011

Provider	*Payor Category*	*2011*	*2010*	*2009*
Affinia Healthcare (formerly known as Grace Hill)	Uninsured	26,088	24,886	24,867
	Medicaid	16,885	13,757	13,736
	Total	42,973	38,643	38,603
Myrtle Hilliard Davis Comprehensive Health Centers	Uninsured	11,306	14,460	12,767
	Medicaid	12,109	9,017	9,411
	Total	23,415	23,477	22,178
Betty Jean Kerr People's Health Centers	Uninsured	15,493	Not applicable. Betty Jean Kerr People's Health Centers, Family Care Health Centers, and St. Louis County Health Centers	
	Medicaid	17,765		
	Total	33,258		
Family Care Health Centers	Uninsured	6,825		

	Medicaid	8,342	began receiving funding through the Demonstration in July 2012. Data from 2011 is provided as a baseline.
	Total	15,167	
St. Louis County Department of Health	Uninsured	21,756	
	Medicaid	10,066	
	Total	31,822	

Goal will be to increase uninsured encounters by 2% at Gateway primary care organizations.

<u>Demonstration Objective III:</u> Maintain and enhance quality service delivery strategies to reduce health disparities.

- *(Data Source: UDS reports)*

<u>Diabetes by Race and Hispanic/Latino Identity - All Federally Qualified Health Centers</u>						
Proportion of adult patients born between January 1, 1937, and December 31, 1993, with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was less than or equal to 9% at the time of the last reading in the measurement year. Results in four categories.						
Hispanic/Latino	Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c< 7% (3c)	Patients with 7%≤HbA1c<8% (3d)	Patients with 8%≤HbA1c≤9% (3e)	Patients with HbA1c>9% or No Test During Year (3f)
1a. Asian	-	-	-	-	-	-
1b1. Native Hawaiian	-	-	-	-	-	-
1b2. Pacific Islander	4	-	-	-	-	-
1c. Black/African American	6	1	-	-	-	1
1d. American Indian/ Alaska Native	4	2	2	-	-	-
1e. White	50	2	1	-	1	-
1f. More Than One Race	-	-	-	-	-	-
1g. Unreported/Refused to Report Race	145	6	2	1	1	2
Subtotal Hispanic/Latino	209	11	5	1	2	3
Non-Hispanic Latino						
2a. Asian	91	2	1	1	-	-
2b1. Native Hawaiian	-	-	-	-	-	-
2b2. Pacific Islander	14	1	1	-	-	-
2c. Black/African American	5,364	193	78	35	19	61
2d. American Indian/ Alaska Native	10	-	-	-	-	-
2e. White	1,102	69	29	13	10	17
2f. More Than One Race	6	-	-	-	-	-
2g. Unreported/Refused to Report Race	201	-	-	-	-	-
Subtotal Hispanic/Latino	6,788	265	109	49	29	78
Unreported/ Refused to Report Ethnicity						
h. Unreported/Refused to Report Race and Ethnicity	61	4	-	1	1	2
i. Total	7,058	280	114	51	32	83
Percent			41%	18%	11%	30%

2011 Baseline – Percentage of patients with HbA1c less than or equal to nine percent: 70%
2017 Goal: Percentage of patients with HbA1c less than or equal to nine percent: 75%

Hypertension by Race and Hispanic/Latino Identity - All Federally Qualified Health Centers				
Proportion of patients born between January 1, 1927, and December 31, 1993, with diagnosed hypertension whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading				
Hispanic/Latino	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)	% Patients with HTN Controlled
1a. Asian	-	-	-	
1b1. Native Hawaiian	-	-	-	
1b2. Pacific Islander	4	3	2	
1c. Black/African American	21	-	-	
1d. American Indian/ Alaska Native	5	-	-	
1e. White	70	5	3	
1f. More Than One Race	1	-	-	
1g. Unreported/Refused to Report Race	191	183	120	
Subtotal Hispanic/Latino	292	191	125	65%
Non-Hispanic Latino				
2a. Asian	203	63	43	
2b1. Native Hawaiian	-	-	-	
2b2. Pacific Islander	22	10	9	
2c. Black/African American	15,416	5,411	2,725	
2d. American Indian/ Alaska Native	29	24	13	
2e. White	2,684	923	539	
2f. More Than One Race	8	1	1	
2g. Unreported/Refused to Report Race	563	14	6	
Subtotal Hispanic/Latino	18,925	6,446	3,336	52%
Unreported/ Refused to Report Ethnicity				
h. Unreported/Refused to Report Race and Ethnicity	134	134	83	
i. **Total**	19,351	6,637	3,461	52%

2011 Baseline – Percentage of patients with hypertension controlled: 52%
2017 Goal – Percentage of patients with hypertension controlled: 64%

APPENDIX II
Proposed Health Indicators

The Proposed Health Indicators in this appendix are for evaluation of the Demonstration and general reporting; as such, they are not related to provider incentive payments. Baselines are provided using data from calendar year 2011.

The state will use the Missouri Primary Care Association (MPCA) data warehouse as the data source for the health indicators in this appendix. The health indicators were selected because they are UDS/HITECH measures reported on a standard basis by each Gateway primary care provider.

The metrics will be reported for the population group receiving primary and specialty care through the Demonstration by age, gender and race/ethnicity, as data is available.

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
1. Tobacco Use Assessment & Cessation Intervention[5] Percentage of adults age 18 and older assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy	Number of patients for whom documentation demonstrates that patients were queried about their tobacco use at least once within 24 months of their last visit (during measurement year) about any and all forms of tobacco use AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user	Number of patients who were 18 years of age or older during the measurement year with at least one medical visit during the reporting year, and with at least two medical visits ever, or a statistically valid sample of these patients	NA	TBD	UDS
2. Hypertension: Blood Pressure Control Proportion of patients 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	Number of patients whose last systolic blood pressure measurement was less than 140 mm Hg and whose diastolic blood pressure was less than 90 mm Hg	All patients 18 to 85 years of age as of December 31 of the measurement year: with a diagnosis of hypertension (HTN); who were first diagnosed by the health center as hypertensive at some point before June 30 of the measurement year, and; who have been seen for medical services at least twice during the reporting year; or a statistically valid sample of these patients	59%	64%	UDS

[5] Tobacco use assessment and cessation intervention were measured separately until 2014, when the metrics were combined. Data from baseline reflect tobacco use assessment and tobacco cessation intervention separately; historic data for the new combined measure is not available.

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
3. Hypertension: Blood Pressure Measurement Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, or a statistically valid sample of these patients	54%	59%	HITECH Meaningful Use
4. Cervical Cancer Screening Percentage of women 24 to 64 years of age who received one or more Pap tests to screen for cervical cancer	Number of female patients 24–64 years of age receiving one or more documented Pap tests during the measurement year or during the 2 calendar years prior to the measurement year among those women included in the denominator; OR, for women who were 30 years of age or older at the time of the test who choose to also have an HPV test performed simultaneously, during the measurement year or during the 4 calendar years prior to the measurement year	Number of all female patients age 24-64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sample of these women	61%	66%	UDS
5. 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. Results are reported in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9% or untested	Number of adult patients whose most recent hemoglobin A1c level during the measurement year is less than or equal to 9%	Number of adult patients aged 18 to 75 as of December 31 of the measurement year with a diagnosis of Type I or II diabetes and; who have been seen in the clinic for medical services at least twice during the reporting year; or a statistically valid sample of these patients	70%	75%	UDS

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
6. 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	Number of patients who had their BMI (not just height and weight) documented during their most recent visit or within 6 months of the most recent visit and if the most recent BMI is outside parameters, a follow-up plan is documented	Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, or a statistically valid sample of these patients	19%	24%	UDS
7. Flu Shot for Patients 6 Months of Age and Older 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	The number of patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	All patients aged 6 months and older seen for a visit between October 1 and March 31 of the measurement year	NA	TBD	HITECH Meaningful Use
8. Breast Cancer Screening Percentage of female patients 42 to 69 years of age that received a mammogram to screen for breast cancer	The number of female patients 42-69 years of age who received one or more mammograms during the measurement year or the year prior to the measurement year	Number of all female patients 42-69 years of age as of December 31 of the measurement year or the year prior to the measurement year who had at least one medical visit during the reporting year, or a statistically valid sample of these patients	NA	TBD	HITECH Meaningful Use
9. Chlamydia Screening in Women Ages 21 to 24 Percentage of female patients 21 to 24 years of age that were identified as sexually active and that had at least one test for Chlamydia during the measurement year	The number of female patients 21-24 years of age that have had at least one Chlamydia test during the measurement year	Number of all female patients 21-24 years of age as of December 31 of the measurement year who were dispensed prescription contraceptives or had at least one medical visit during the reporting year, or a statistically valid sample of these patients	NA	TBD	HITECH Meaningful Use

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
10. Primary Care Visits for Patients with Chronic Diseases Percentage of enrolled patients with diabetes, hypertension, CHF or COPD with 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	The number of chronic disease patients that have had two or more office visits within the first 6 months following initial program enrollment or diagnosis during the measurement year	Number of chronic disease patients enrolled in the program during the reporting year	TBD	80%	Pay-for-Performance Reporting
11. Primary Care Follow-Up After Hospitalization 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 of hospital discharge.	The number of patients contacted by a clinical staff member at the patient's established primary care home within 7 days of hospital discharge	Number of patients whose primary care home was notified of their hospitalization by the gateway Call Center during the reporting year	TBD	50%	Pay-for-Performance Reporting

APPENDIX III
Incentive Payment Protocol

Incentive Payments

The state will withhold 7% from payments made to the primary care health centers (PCHC) through December 31, 2017, 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 of the Pilot Program based on performance during the reporting period.

Reporting Periods:

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

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 Affinia Healthcare (formerly known as 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.

STEP 3

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

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

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

Step 6

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

** 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	$ 40,000	$ 10,000
St. Louis County	$ 50,000	$ 45,000	$ 5,000
Total	$ 420,000	$380,000	**$ 40,000**

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

Table 2C - Computes the remaining primary care incentive fund payment (RPCIFP) for each PCHC assuming that some providers did not meet 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.