GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
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November 9, 2016

The Honorable Sylvia Mathews Burwell
Secretary of the United States Department of
Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

SUBMITTED ELECTRONICALLY AND VIA REGULAR MAIL

Dear Madam Secretary:

The State of Missouri, Department of Social Services is requesting to extend its Section 1115 demonstration project, "Gateway to Better Health," which is currently scheduled to expire December 31, 2017. Missouri requests that the demonstration be extended for one year, to December 31, 2018, or until such time as Missouri's Medicaid eligibility is expanded to include the waiver population, whichever is sooner.

This updated demonstration extension application is being submitted in partnership with the St. Louis Regional Health Commission. Through administering the demonstration, the Commission works to preserve and improve primary and specialty care access for uninsured residents of St. Louis City and St. Louis County.

Public notice requirements under 42 CFR 431.408 have been met. Two public hearings were held and a newspaper notice was published with a 30-day comment period.

We look forward to working with the federal review team in the months to come. If additional information is needed, please contact Dr. Joseph Parks, Director, MO HealthNet Division, Missouri Department of Social Services, at 573-751-6922.

Thank you for your continued support of this critical health care demonstration project.

Sincerely,

[redacted]

Jeremiah W. (Jay) Nixon
Governor

Enclosure

c: James G. Scott, CMS Region VII
Eliot Fishman
Julia Hinckley
Juliana Sharp

Gateway to Better Health Demonstration

Demonstration Extension Application

November 9, 2016

Number: 11-W-00250/7

Gateway to Better Health Demonstration: Extension Request

The State of Missouri, Department of Social Services is requesting an extension of the Section 1115 Demonstration project "Gateway to Better Health" which is currently scheduled to expire December 31, 2017. The beginning date of the most recent Demonstration extension period is January 1, 2017. The State requests an extension of this waiver until such time as Missouri's Medicaid eligibility is expanded to include the waiver population, or up to one year, whichever is first.

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Section I: Summary and Objectives

On July 28, 2010, CMS approved the State of Missouri's "Gateway to Better Health" Demonstration, which preserves 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 care 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 an extension of the Demonstration for patients up to 100% FPL, for up to one-year or until Missouri's Medicaid eligibility is expanded to include the waiver population.

Extension of the Gateway Demonstration

At this time, it is not known if the Missouri legislature will expand Medicaid eligibility during its 2017 legislative session. If not, beginning January 1, 2018, Gateway patients will no longer have access to coverage, since all Gateway patients are under 100% of the FPL. The providers serving the Gateway

[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.

population will also experience a significant reduction in revenue, preventing them from maintaining their current staffing or service levels.

Without Medicaid expansion and without the Gateway Demonstration, the Gateway population will have limited options for accessing outpatient health care services. As of June 30, 2016, the Gateway program provides outpatient coverage for nearly 19,000 individuals, which is nearly 45 percent of all uninsured residents under 100 percent of the federal poverty level in St. Louis City and County *(source: 2014 American Community Survey)*. Previous studies have indicated that the care provided through this Demonstration prevents more than 50,000 emergency department visits per year.

The State of Missouri proposes that the Gateway Demonstration be extended until Missouri's Medicaid eligibility is expanded to include the waiver population, or for a period up to one year, whichever is first. This extension will enable the uninsured population to continue to access preventive and other ambulatory health care services.

During this extension of the Demonstration, the State, SLRHC and providers will continue to demonstrate how coverage and access to preventive care cost-effectively improves the health of a low-income population.

The proposed objectives for the extension period are:

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.

With these objectives, the St. Louis community can continue to improve the health of those individuals who are not eligible for Medicaid or Medicare.

This application requests the extension of two current expenditure authorities with a total annual computable budget of $30,000,000 in lieu of spending that amount of statutorily authorized funding on payments to disproportionate share hospitals (DSHs) for one additional year, or when Medicaid eligibility expands in Missouri, whichever is first:

- **Demonstration Population:** Effective January 1, 2014, expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between the ages of 19-64 years of age with income up to 100 percent of the FPL to pay for primary care provided by a designated primary care provider or specialty care provider when referred by a designated primary care provider.
- **Expenditure for Managing the Coverage Model:** Effective January 1, 2014, expenditures pursuant to a memorandum of understanding and not to exceed $4,500,000 for costs incurred by the SLRHC to activities related to the continued administration of the coverage model during the extension period.

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 the "Health Care for the Indigent of St. Louis" 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, a seamless transition of care was possible despite ConnectCare's closure.

Demonstration Summary

Beneficiaries and Eligibility Criteria

Gateway to Better Health will continue to provide access to primary care, specialty care and urgent care services for individuals who meet the following requirements:

- A citizen of the United States; legal immigrant who has met the requirements for the five-year waiting period for Medicaid benefits; refugee or asylee under same immigrant eligibility requirements that apply to the Medicaid program
- A resident of St. Louis City or St. Louis County
- Ages 19 through 64
- Uninsured

[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.

- At or below the federal poverty level of 100 percent
- Not eligible for coverage under the federal Medicare program or Missouri Medicaid
- Patients with a primary care home at one of the network primary care sites

Delivery System

Gateway to Better Health services will continue to be delivered through a limited provider network. Beneficiaries choose a primary care home in which to enroll. Primary care homes in the network include:

- BJK People's Health Centers
- Family Care Health Centers
- Affinia Healthcare *(formerly known as Grace Hill Health Centers)*
- Myrtle Hilliard Davis Comprehensive Health Centers
- St. Louis County Department of Public Health

Primary care provider organizations will continue to be paid under an alternative payment methodology.

Beneficiaries may be referred by their primary care physician for specialty care at participating hospitals, medical schools and community specialist practices contracted with the State and Gateway to Better Health.

Benefits

Beneficiaries will continue to receive the following benefits:

> Preventive; well care; dental (diagnostic and preventive); internal and family practice medicine (including five urgent care visits); gynecology; podiatry, generic prescriptions dispensed at primary care clinics as well as brand name insulin and inhalers; cardiology; DME (crutches, walkers, wound vac, and wound vac supplies); endocrinology; ENT; gastroenterology; neurology; oncology, radiation therapy, rheumatology, laboratory/pathology services; ophthalmology; orthopedics; outpatient surgery; physical, occupational or speech therapy (on a limited basis); pulmonology; radiology (x-ray, MRI, PET/CT scans); renal; urology; and non-emergency medical transportation.

This application proposes that all the benefits approved for the Gateway to Better Health Demonstration continue during the proposed extension period. The final actuarial rates for the extension period will be established in 2017.

Cost Sharing

There will be no premium for Gateway to Better Health. Beneficiary co-pays are the same as those for patients of the Missouri Medicaid program, MO HealthNet.

Section II: Progress to Date

Through the Gateway to Better Health Demonstration, the State of Missouri and the St. Louis region have transitioned patients and providers to an environment where otherwise uninsured individuals access outpatient health care services via coverage. Eligible individuals are enrolled in the Demonstration and are eligible for primary care available at a limited network of safety net providers, including Affinia Healthcare (formerly known as Grace Hill Health Centers), Myrtle Hilliard Davis Comprehensive Health Centers, BJK People's Health Centers, Family Care Health Centers, and the health centers of the St. Louis County Department of Public Health. Beneficiaries may be referred by their primary care physician for specialty care at participating hospitals, medical schools and community specialist practices.

Throughout the Demonstration, access to primary care has been maintained in the areas of highest need, and access to specialty care has been maintained for an otherwise uninsured population. Summarized below are the key results to date:

1. ***Gateway has maintained access to primary and specialty care for uninsured individuals living in poverty in St. Louis City and St. Louis County.***
2. ***Providers are consistently earning their incentive payments by meeting quality metrics, including ensuring access for those with chronic conditions and helping them to manage their disease better.***
3. ***Gateway has enabled care coordination for low-income populations among community health centers, specialists and hospitals.***
4. ***Gateway continues to engage and assist members with care navigation, and members are highly satisfied with services.***

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1. ***Gateway has maintained access to primary and specialty care for uninsured individuals living in poverty in St. Louis City and St. Louis County.***

    - Nearly 19,000 individuals are enrolled in Gateway to Better Health, which is approximately 45 percent of those uninsured and living below the federal poverty level in St. Louis City and County. Over the life of the program, more than 49,000 unique individuals have received services from the program.
    - Nearly 100,000 medical visits (primary care/urgent care, dental, specialty care, diagnostic services and outpatient hospital services) and more than 225,000 prescriptions are funded each year through Gateway to Better Health. Previous studies have indicated that the care provided through this Demonstration prevents more than 50,000 emergency department visits per year.

2. ***Providers are consistently earning their incentive payments by meeting quality metrics, including ensuring access for those with chronic conditions and helping them to manage their disease better.***

- As of January 1, 2016, Gateway provides coverage for brand name insulins and inhalers, where a generic alternative is otherwise unavailable. From January – June 2016, Gateway providers filled 7,486 of these prescriptions to help patients managed their chronic diseases.
- Ninety-one percent of newly enrolled or newly diagnosed diabetic patients had their HgbA1c tested within six months during the most recent incentive period, compared to 66% at the beginning of the Demonstration.
- Sixty-six percent of patients with diabetes had an HgbA1c of less than 9% within six months of diagnosis or enrollment during the most recent incentive period, compared to 54% at the beginning of the program.
- Ninety-one percent of newly enrolled individuals with chronic diseases or newly diagnosed patients received two office visits within six months, compared to 74% at the beginning of the Demonstration.
- Preventative health and screening services (such as tobacco use assessment and cessation intervention, adult weight screening and follow up, flu shots, breast cancer screening, chlamydia screening, and office visits for patients with chronic diseases) improved on average by 6% from year one (7/1/12-6/30/13) to year three (7/1/14-6/30/15), with more patients utilizing these services.
- Management of chronic conditions, such as hypertension and diabetes, has been maintained throughout the life of the program.
- All community health centers have joined the Alive and Well STL Health Learning Collaborative, which guides organizations on how they can implement trauma informed practices in their work and how they interact with the patients they serve. Through this training, health centers will be able to provide better care management to patients.

3. ***Gateway has enabled care coordination for low-income populations among community health centers, specialists and hospitals.***

- As part of their pay-for-performance measures, health centers are required to follow up with hospital patients within seven days of discharge, when they are notified of the admission via the Gateway call center. During the last incentive period, this follow up occurred 91% of the time.
- Of the members who attended member orientations, 85% felt very confident or somewhat confident that they can navigate receiving health care service at their health center.
- A survey conducted by Princeton Survey Research Associates International (PSRAI) in 2014 found that, of those who have visited a specialist, more than 70% report that they received help from someone at their health center coordinating their care, and of those, 80% report being “very satisfied” with the help they received. Respondents who reported that they received help coordinating care are more likely to report that their health has improved throughout the demonstration, are more likely to report ease in obtaining a visit with a specialist and consistently rate specialist staff more positively.
- As part of Gateway’s commitment to remove barriers to care and ensure access to health care services for the safety net population, the program covers transportation for members

to and from medical appointments through a contracted transportation provider, Logisticare. From January – June 2016, the program provided more than 3,600 rides to members for their primary and specialty care appointments.

4. ***Gateway continues to engage and assist members with care navigation, and members are highly satisfied with services.***

   - On a quarterly basis, Gateway hosts voluntary member orientations to educate new members about the Gateway program. As of June 2016, more than 700 members have attended member orientations.
   - As a result of attending member orientations, 86% of attendees felt very confident or somewhat confident that they understood how to use their benefits and 85% felt very confident or somewhat confident that they can navigate receiving health care services at their health center.
   - On a recent satisfaction survey, 98% of respondents indicate they would recommend their health center to others. On a 5-point scale, respondents rated the quality of service received as a 4.61 on average and how well the doctor listened and explained things as a 4.63 on average (5.0 represents "very good").

The State, SLRHC and safety net providers have been working to achieve the following objectives over the life of the Demonstration:

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;

To date, all Demonstration objectives have been met or significant progress can be demonstrated.

Section VII: Interim Evaluation Findings provides further evidence to support the progress toward the Demonstration Objectives. Outlined below are the critical success factors for each objective.

Objective 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).

To date, the Demonstration has shown that the St. Louis region can continue to provide access to ambulatory health care for the uninsured in the St. Louis region under a coverage model. The Safety Net Pilot Program has provided access to outpatient health services for more than 49,000 unique individuals over the life of the program.

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

In 2014, more than 75,000 uninsured[3] patients received care at Gateway primary care providers. More than 49,000 unique individuals have been enrolled into Gateway since the implementation of the pilot program in July 2012. Gateway primary care sites have also successfully enrolled more than 32,500 individuals into MO HealthNet programs including:

- More than 16,500 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- More than 9,200 adults approved for Uninsured Women's Health Services;
- 3,444 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 3,505 adults approved for MO HealthNet for Families.

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

The continuation of the funding for the St. Louis safety net of health care providers through this Demonstration helps ensure access to health care for those living in traditionally underserved communities. 73% of all members of the pilot coverage model are African-American, 19% are Caucasian, less than 1% are members of other races, and 8% did not report their race. (Other races and ethnicities – reporting as one race -- make up 4.5% of individuals in St. Louis City and County.)

Recent patient surveys conducted by Princeton Survey Research Associates International (PSRAI) in 2014 indicate that patients are receiving quality care across racial and ethnic groups. When looking at the survey results by race, African-Americans (76% of survey respondents) tend to be more satisfied than other enrollees with the care they have received from medical staff at health centers and specialty providers.

As measured through pay-for-performance metrics, outcomes for African Americans enrolled in the Pilot Program are comparable to those of Whites enrolled in the program:

- 90% of African Americans with chronic conditions had at least two office visits within 1 year, as compared to 93% of Whites.
- 89% of African Americans with diabetes had at least one HgbA1c test within 6 months, which is the same as that of Whites.

Quality of care, as measured by the program's pay-for-performance measures, continues to improve. Providers are consistently earning their incentive payments by meeting quality metrics, including ensuring access for those with chronic conditions and helping them to manage their disease better.

- Ninety-one percent of newly enrolled or newly diagnosed diabetic patients had their HgbA1c tested within six months during the most recent incentive period, compared to 66% at the beginning of the Demonstration.

[3] Individuals with coverage through Gateway to Better Health are considered uninsured, as this is a limited coverage program. All reported data for uninsured populations are inclusive of Gateway patients, as applicable.

- Sixty-six percent of patients with diabetes had an HgbA1c of less than 9% within six months of diagnosis or enrollment during the most recent incentive period, compared to 54% at the beginning of the program.

- Ninety-one percent of newly enrolled individuals with chronic diseases or newly diagnosed patients received two office visits within six months, compared to 74% at the beginning of the Demonstration.

Research demonstrates that adverse events and stress- especially persistent, toxic stress or traumatic incidents- lead to disease. In order to truly impact health disparities, a public health perspective is warranted to address health issues and focus on an individual's mental, emotional and physical well-being. The SLRHC, through its other programming, has engaged in an initiative called Alive & Well STL in response to this research. Alive and Well STL is a community-wide effort focused on reducing the impact of toxic stress and trauma on our health and wellbeing. More information on the initiative can be found at http://aliveandwellstl.com/.

During the evaluation period, the Gateway to Better Heath program has intersected with Alive and Well STL through a Health Learning Collaborative where Gateway providers and organizations become trained on how to provide trauma informed care to their patients, including Gateway to Better Health patients. The impact of this training will be measured through ongoing assessments of each 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 provided in future reports for the Demonstration project.

Section III: Compliance with Each of the STCs

The State of Missouri has been compliant with each of the STCs throughout the duration of this Demonstration. The deadline for each deliverable has been met. The State does not anticipate any difficulty maintaining compliance with each STC throughout the remainder of the existing Demonstration or the extension of the Demonstration.

Through ongoing dialogue, program monitoring and regular and extensive reporting, the State is able to maintain compliance. Throughout the negotiations for the STCs, the State and CMS developed several monitoring and reporting mechanisms to ensure compliance. These include but are not limited to the STCs listed below:

Table I: STC's Related to Monitoring and Reporting

IX.	**General Reporting Requirements**
29.	General Financial Requirements
30.	Reporting Requirements Related to Budget Neutrality
31.	Quarterly Calls
32.	Quarterly Progress Reports
33.	Annual Report
34.	Final Report
X.	**General Financial Requirements**
35.	Quarterly Expenditure Reports
36.	Expenditures Subject to Title XIX Budget Neutrality Expenditure Limit
37.	Reporting Expenditures Subject to Title XIX Budget Neutrality Expenditure Limit
38.	Standard Medicaid Funding Process
39.	Extent of Federal Financial Participation for the Demonstration
40.	Sources of Non-Federal Share
41.	Monitoring the Demonstration
42.	Program Integrity
XI.	**Monitoring Budget Neutrality for the Demonstration**
43.	Limit on Title XIX Funding
44.	Risk
45.	Budget Neutrality Expenditure Limit
46.	Future Adjustments to the Budget Neutrality Expenditure Limit
47.	Enforcement of Budget Neutrality
XII.	**Evaluation**
48.	Submission of Draft Evaluation Design
49.	Interim Evaluation Reports
50.	Final Evaluation Design and Implementation
51.	Cooperation with Federal Evaluators
XIII.	**Schedule of State Deliverables During the Demonstration**

Furthermore, the State reviews the status of the program monthly as part of its own administrative functions and also as participants in the board meetings of the SLRHC and its planning committees. Through these efforts, the State maintains a close working relationship with the SLRHC, its vendors and the providers. The State reviews and approves any information distributed by the SLRHC or its

enrollment broker to patients, issues all payments to providers via the SLRHC based on the State's enrollment and claims data, reviews monthly financial data from the SLRHC related to the Demonstration and reviews the monthly call center report from the SLRHC's enrollment broker.

CMS assesses State compliance with the STCs in numerous ways. Conference calls are conducted as needed to discuss any outstanding items as well as any significant actual or anticipated developments related to the Demonstration. The State submits to CMS both quarterly and annual reports as well as the quarterly CMS 64 reports.

Section IV: Waiver and Expenditure Authorities

The waiver and expenditure authorities would remain the same for the extension period. No additional waivers or expenditure authorities are requested.

It is anticipated the Waiver and Expenditure Authorities would include:

- **Demonstration Population 1:** Expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between the ages of 19-64 years of age with income at or below 100 percent of the FPL to pay for primary care provided by a designated primary care providers or specialty care providers when referred by a designated primary care provider.
- **Expenditure for Managing the Coverage Model:** Expenditures pursuant to a memorandum of understanding and not to exceed $4,500,000 annually for costs incurred by the SLRHC to activities related to the continued administration of the coverage model during the extension period.

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

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

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary, to enable the State to establish an enrollment target and maintain waiting lists for the Demonstration population.

Amount, Duration and Scope **Section 1902(a)(10)(B)**

To the extent necessary, to permit the State to offer benefits that differ among the Demonstration population and that differ from the benefits offered under the Medicaid state plan.

Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary, to enable the State to mandatorily enroll the Demonstration population into a delivery system that restricts free choice of provider.

Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary, to enable the State to not provide medical assistance to the Demonstration population prior to the date of application for the Demonstration benefits.

Payment for Services by Federally Qualified Health Centers (FQHCs) **Section 1902(a)(15)**

To the extent necessary, to enable the State to make payments to participating FQHCs for services provided to Demonstration Population using reimbursement methodologies other than those required by section 1902(bb) of the Act to the limited nature of the benefits.

Section V: Quality

Clinical Quality

The Demonstration was designed to measure and improve health outcomes for the patients of the safety net providers in the St. Louis region. During the extension period, the primary care providers will continue to be subject to a 7 percent withhold from their payments to incent them to achieve certain clinical measures. These measures were developed by the community's clinicians and determined to be the community's priorities. They include:

Primary Care Pay-for-Performance Incentive Measures

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%**	

Progress on pay-for-performance metrics are measured at six month intervals. 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:

Pay-for-Performance Measures for Distribution of Remaining Funds

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

**Based on actuarial analysis: the thresholds for rate of referral to specialists is 680 referrals per 1,000 members enrolled at each health center. Thresholds may change for the subsequent reporting periods, pending additional actuarial analysis. Please refer to Appendix III for a complete review of pay-for-performance outcomes to date.*

Primary care providers will be eligible for the remaining funds based on the percentage of patients enrolled at their health centers. 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 approved methodology.

Program Quality

In addition to these clinical measures, the State and SLRHC will continue to monitor the performance of the Safety Net Pilot Program to ensure it is providing access to quality health care for the population it serves.

Representatives from the provider organizations meet bi-monthly to evaluate clinical, consumer and financial issues related to the program. SLRHC is monitoring appointment wait times and conducting surveys with referring physicians on an annual basis. SLRHC is also conducting surveys with program participants annually.

The most recent results from these surveys are reviewed in other sections of this application.

SECTION VI: Compliance with the Budget Neutrality Cap

To date, there have been no issues maintaining budget neutrality during the Gateway Demonstration. The State works closely with CMS to complete the budget neutrality reports and to monitor the program's budget compliance.

See Appendix IV for a completed budget neutrality worksheet.

SECTION VII: Interim Evaluation Findings

This section provides a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The section reports on hypotheses being tested and preliminary evaluation results.

Evaluation Design Summary

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 and Medicaid populations 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.

From July 1, 2012, when the pilot coverage model went into effect, through December 31, 2013, the Demonstration: (1) provided primary, urgent and specialty care coverage to uninsured[4] adults in St. Louis City and St. Louis County, aged 19-64, who are below 133% of the Federal Poverty Level (FPL) through a coverage model known as Gateway to Better Health Blue; and (2) provided individuals otherwise meeting the same requirements but with income up to 200% of the FPL with urgent and specialty care services, excluding the primary care benefit, through a coverage model known as Gateway to Better Health Silver.

On September 27, 2013, CMS approved a one-year extension of the Gateway Demonstration program until December 31, 2014, or until Missouri's Medicaid eligibility is expanded to include the waiver population. As of January 1, 2014, the coverage model provides primary, urgent and specialty care coverage to one population: uninsured adults, aged 19-64, in St. Louis City and St. Louis County with incomes up to 100% FPL.

[4] 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.

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.

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 Special Terms and Conditions (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 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.

Overview of Demonstration Project Evaluation

The following table summarizes the key questions and areas of analysis by Demonstration objective. Interim evaluation findings are provided later in this report section.

Demonstration Questions and Areas of Analysis by 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 primary care 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.

	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.

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; and
- 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 I.

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 II) 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 II.

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 coverage 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 SLRHC 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.

Evaluation Activities

Evaluation activities to date include the following:

- Collection and reporting of baseline data for all Demonstration objectives for 2009-2015 as applicable
- Collection and reporting of proposed health indicator data baselines (see Appendix I)
- Analysis of interim progress in meeting Demonstration objectives comparing 2009-2015 data as provided in this report section
- Analysis and reporting of enrollment data for the eighteen months of the Pilot Program (7/01/12-12/31/13) and the extension periods (1/1/14-6/30/16), as provided in this report section.
- Analysis and reporting of financial data for the Demonstration (07/01/2012 – 6/30/2016) as provided in this report section.
- Analysis and reporting of claims-based utilization data for the Demonstration (07/01/2012–6/30/2016) as provided in this report section.
- Analysis and reporting of preliminary quality data for the Demonstration (07/01/2012–9/30/2015) as provided in this report section.

Data collection and analysis will continue throughout the Demonstration project. Additional interim evaluation findings will be provided in future reports as detailed in the STCs.

Interim Evaluation Findings for Demonstration Objectives

Based on data gathered to date, all Demonstration objectives have been met or significant progress can be demonstrated. Provided below are interim evaluation findings for each Demonstration objective. Unless otherwise noted, findings are based on reported data through calendar year 2015 as available.

The Demonstration objectives are as follows:

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 primary care homes 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.

Objective 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)

Key questions for this demonstration objective include:

- 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?

Findings to Date

The Demonstration has met Objective I, as evidenced by:

A. The St. Louis safety net providers funded by Gateway were able to increase primary care encounters for uninsured patients at their locations by 13.6% during the pilot coverage model.

B. Primary care health centers have maintained or expanded hours of operation and have maintained their locations throughout the demonstration.

C. Primary care services were maintained or expanded at Gateway providers through 2015.

D. Access to specialty care has been maintained throughout the demonstration.

E. Access to urgent care locations for the safety-net population has been expanded throughout the demonstration.

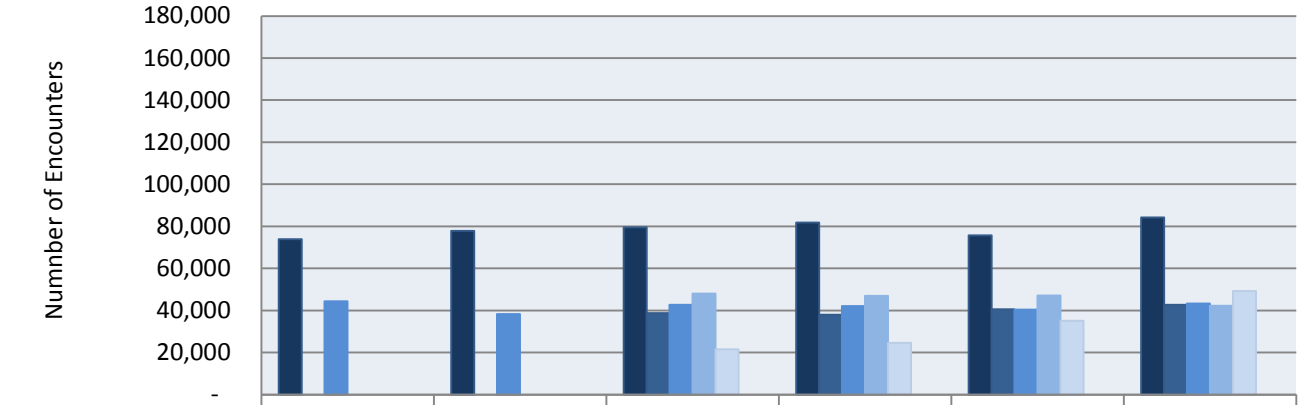
F. Funding provided by the Demonstration project maintains access to primary and specialty care services for the uninsured.

Each of these findings is reviewed in detail below:

A. The St. Louis safety net providers funded by Gateway were able to increase primary care encounters for uninsured patients at their locations by 13.6% during the pilot coverage model.

Uninsured primary care encounters at primary care affiliation sites increased (+3.2%) from 118,327 in 2009 (baseline) to 122,114 in 2011 (the year before the coverage model was implemented). Additional safety net providers funded by Gateway were added to the primary care network of the coverage model in 2012. Uninsured encounters at Gateway primary care providers increased (+13.6%) from 230,455 in 2011 (coverage model baseline) to 261,816 in 2014. Data for uninsured encounters at Gateway primary care providers in 2015 is not yet available. Updated data will be provided in the 2016 annual report.

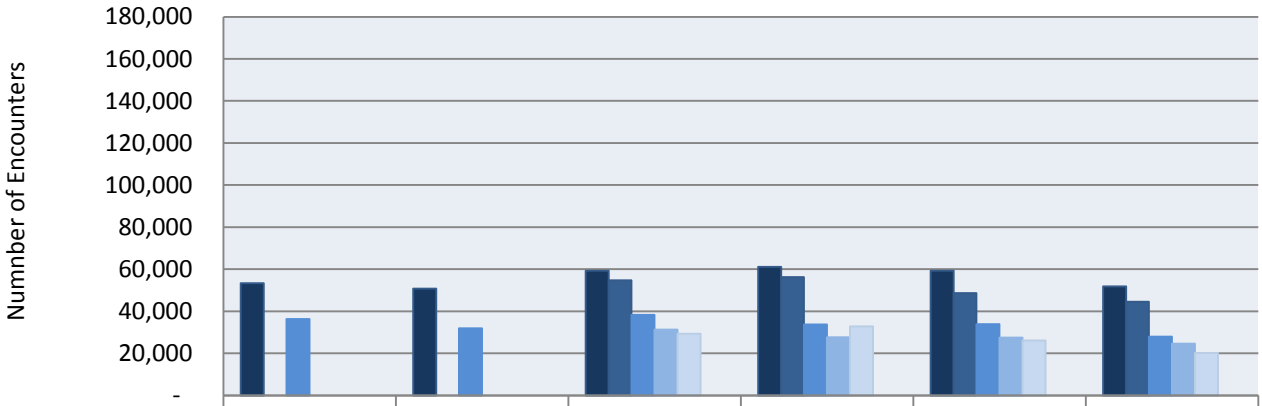
Uninsured Encounters Provided by Gateway Primary Care Providers, 2009-2014



	2009	2010	2011	2012	2013	2014
Affinia	73,939	77,839	79,460	81,808	75,764	84,254
BJK People's	-	-	38,763	38,020	40,513	42,704
Myrtle Hilliard Davis	44,388	38,309	42,654	42,055	40,406	43,321
St. Louis County	-	-	48,052	46,939	47,092	42,263
Family Care	-	-	21,526	24,637	35,027	49,274
Total	118,327	116,148	230,455	233,459	238,802	261,816

Medicaid primary care encounters at primary care affiliation sites increased (+8.8%) from 89,567 in 2009 (baseline) to 97,449 in 2011 (the year before the coverage model was implemented). Additional safety net providers funded by Gateway were added to the primary care network of the coverage model in 2012. Medicaid encounters at Gateway primary care providers decreased from 212,870 in 2011 (coverage model baseline) to 169,190 in 2014. Data for Medicaid encounters at Gateway primary care providers in 2015 is not yet available. Updated data will be provided in the 2016 annual report.

Medicaid Encounters Provided by Gateway Primary Care Providers, 2009-2014



	2009	2010	2011	2012	2013	2014
Affinia	53,302	50,805	59,218	61,177	59,357	51,869
BJK People's	-	-	54,740	56,278	48,600	44,468
Myrtle Hilliard Davis	36,265	31,885	38,231	33,680	33,921	27,953
St. Louis County	-	-	31,337	27,679	27,494	24,651
Family Care	-	-	29,344	32,866	26,139	20,249
Total	89,567	82,690	212,870	211,680	195,511	169,190

B. Primary care providers have maintained or expanded hours of operation, and have maintained their locations throughout the demonstration.

Primary care providers' locations and hours of operation were maintained in the neighborhoods where they were located in from 2009 through 2015.

Hours of Operation at Gateway Primary Provider Locations

Partner Site	***2015***	***2014***	***2013***	***2012***	***2011***	***2010***	***2009***
Affinia Healthcare (formerly known as Grace Hill Health Centers)							
North Florissant	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	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	NA	NA

Partner Site	*2015*	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*
Lemp	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-9am-1pm Urgent Care: M, T, W, TH, F 9am – 7pm; Sa-9am-5pm; Su-9am-1pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-9am-1pm Urgent Care: M, T, W, TH, F 9am – 7pm; Sa-9am-5pm; Su-9am-1pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa- 9am-1pm Urgent Care: M, T, W, TH, F 9am – 7pm; Sa-9am-5pm; Su-9am-1pm	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	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	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	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	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M,T,TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm
St. Louis Dental Education and Oral Health Clinic	M-F-8:30am-5:30mpm	NA	NA	NA	NA	NA	NA
BJC Behavioral Health	T-8:30am-4:30pm	T-8:30am-3pm	M-8:30am-4:30pm	M-F-8:30am-5pm	M-F-8:30am-5pm	NA	NA
Myrtle Hilliard Davis Comprehensive Health Centers							
Homer G. Phillips	M, T, W, TH, F-8am-5pm	M, T, W, TH, F-8am-5pm	M, T, W, TH, F-8am-5pm	M, T, W, F-8am-5pm; Th-8am-8pm	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, T, W, TH, F-8am-5pm	M, T, W, TH, F-8am-5pm	M, T, W, TH, F-8am-5pm	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	M-8am-8pm, T, W, TH, F-8am-5pm

Partner Site	*2015*	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*
Comp I	M, T, W, TH, F- 8am-5pm Urgent Care: M, T, W, TH, F- 10am-7pm; Sa-9am-5pm; Su-1pm-5pm	M, T, W, TH, F-8am-5pm Urgent Care: M, T, W, TH, F- 10am-7pm; Sa-9am-5pm; Su-1pm-5pm	M, T, W, TH, F-8am-5pm; Sa 10am-2pm Urgent Care: M, T, W, TH, F- 10a-7pm; Sa- 9am-5pm; Su-1pm-5pm	M, T, Th, F-8am-5pm; W-8am-8pm	M, T, Th, F-8am-5pm; W-8am-8pm	NA	NA
Pope	M, T, W, TH, F-8am-5pm	NA	NA	NA	NA	NA	NA
BJK People's Health Centers							
Central	M T, W, TH-9am-7pm; F-9am-5pm; Sa-10am-4pm	M, W, TH, F-8am-5:30pm; T-8am-8:30pm	M, W, TH, F-8am-5:30pm; T-8am-8:30pm	M-F-8:30am-5:30pm; Sa (When Scheduled)	M-F-8:30am-5:30pm; Sa (When Scheduled)	NA	NA
North	M, T, TH, F-8am-5:30pm; W-9am-8:30pm	M, T, TH, F-8am-5:30pm; W-9am-8:30pm	M, T, TH, F-8am-5:30pm; W-9am-8:30pm	M, T, Th, F-8:30am-5:30pm; W-11:30am-8:30pm; Sa (When Scheduled)	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-5:00pm; TH-11:30am-7:30pm	M, T, W, F-8am-5:30pm; TH-11am-8pm	M, T, W, F-8am-5:30pm; TH-11am-8pm	M, T, W, F-8:30am-5:30pm; Th-11:30am-8:30pm; Sa (When Scheduled)	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-5pm; T, TH-8am-8pm; Sa-8am-1pm	M, W, F-8am-5pm; T, TH- 8am-8pm; Sa-8am-1pm	M, W, F- 8am-5pm; T, TH- 8am-8pm; Sa-8am-1pm	M, W, F-8am-4:30pm; T, Th-8am-8pm; Sa-8am-1pm	M, W, F-8am-4:30pm; T, Th-8am-8pm; Sa-8am-1pm	NA	NA
Forest Park	M, W, TH, F-8:30am-5pm; T-8:30am-7pm; Sa-9am-1pm	M, W, TH, F-8:30am-5pm; T-8:30am-7pm; Sa-9am-1pm	M, W, TH, F-8:30am-5pm; T- 8:30am-7pm; Sa-9am-1pm	M, W, Th, F-8am-4:30pm; T-8am-7pm; Sa-9am-2pm	M, W, Th, F-8am-4:30pm; T-8am-7pm; Sa-9am-2pm	NA	NA
Places for People	M, W-10am-2pm	NA	NA	NA	NA	NA	NA
St. Louis County Department of Public Health Centers							

Partner Site	*2015*	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*
North Central	M, T, W, TH, F-8am-5pm	M, T, TH, F-8am-5pm; W-8am-6pm	-	M, T, F-8am-5pm; W, Th-8am-9pm	M, T, F-8am-5pm; W, Th-8am-9pm	NA	NA
South County	M, T, W, TH, F-8am-5pm	M, W, TH, F-8am-5pm; T-8am-6pm	-	M, T-8am-9pm; W, Th, F-8am-5pm	M, T-8am-9pm; W, Th, F-8am-5pm	NA	NA
John C. Murphy	M, T, W, TH, F-8am-5pm	M, T, W, F-8am-5pm; TH-8am-6pm	NA	NA	NA	NA	NA

C. Primary care services were maintained or expanded at Gateway provider sites through 2015.

Primary care services at the Gateway primary care sites have been maintained or expanded from 2009 to 2015, ensuring patients in areas of highest need maintained access to the breadth of services available from community health centers. In 2015, Affinia Healthcare opened a clinic for dental students which expanded access to dental services for the safety net population, Myrtle Hilliard Davis Comprehensive Health Centers opened a new location available for general access and Family Care open a limited access site at Places for People (a community behavioral health organization).

Primary Care Sites	*2015*	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*
Affinia Healthcare	Added: Expanded dental services	Added: Urgent Care services	No change	No change	No change	No change	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.

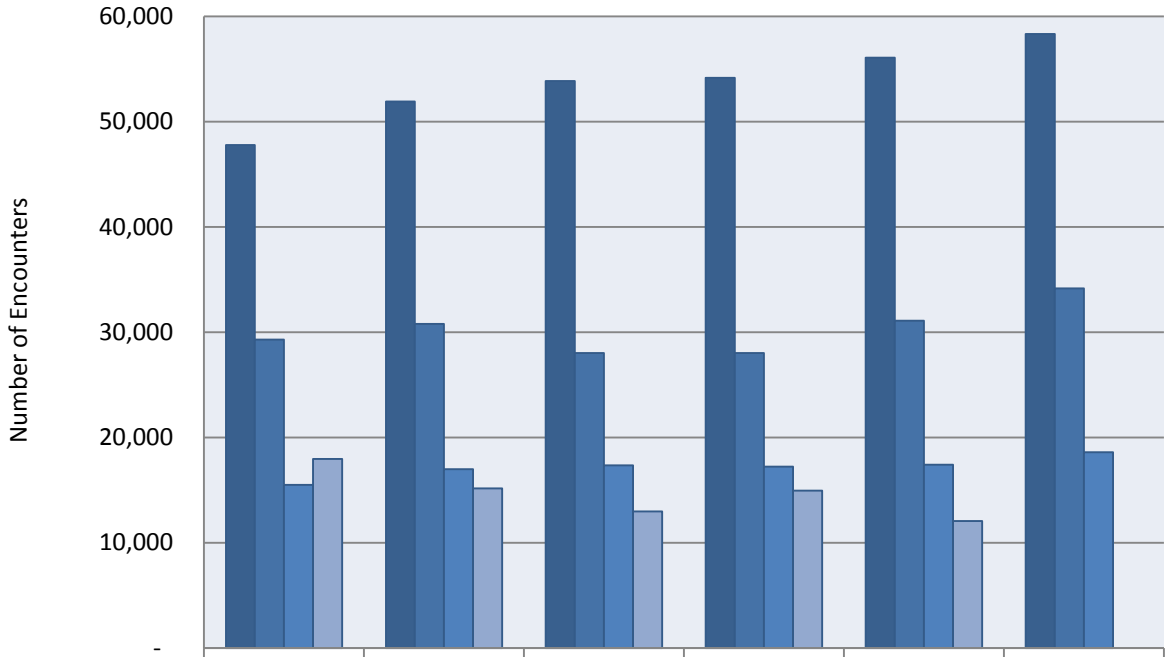
Primary Care Sites	***2015***	***2014***	***2013***	***2012***	***2011***	***2010***	***2009***
Myrtle Hilliard Davis Comprehensive Health Centers	Added: New location	Added: Urgent Care services	Added: health insurance coverage enrollment assistance.	No change	No change	No change	Primary medical care, 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.
Family Care Health Centers	Added: New location	No change	No change	No change	Primary medical care, podiatry, ophthalmology, dental care, behavioral health, nutrition, pharmacy, laboratory services, and enabling services (Community outreach services, community and patient health education), case management (for pregnant women), social services, assistance, referral for specialty services, and HIV counseling and testing.	N/A	N/A

Primary Care Sites	*2015*	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*
Betty Jean Kerr Peoples Health Centers	No change	No change	No change	No change	Primary medical care, podiatry, ophthalmology, dental care, behavioral health, nutrition, pharmacy, laboratory services, and enabling services (Community outreach services, community and patient health education, WIC services (lactation and nutrition), and HIV/AIDS counseling and testing.)	N/A	N/A
St. Louis County Department of Public Health	No change	No change	No change	No change	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	N/A	N/A

D. Access to specialty care has been maintained throughout the Demonstration.

The St. Louis safety net providers funded by Gateway were able to increase specialty care encounters for all uninsured and Medicaid patients at their locations by 2% during the Demonstration from 2009-2014. Gateway specialty care providers provided 112,870 specialty care encounters to uninsured and Medicaid patients in 2014, compared to 110,540 in 2009, an increase of 2,330 encounters. Gateway to Better Health's specialty care provider network includes medical schools, hospitals, and some community specialist providers. Data for uninsured and Medicaid encounters at Gateway specialty care providers in 2015 is not yet available. Updated data will be provided in the 2016 annual report.

Uninsured and Medicaid Encounters by Gateway Specialty Care Providers, 2009-2014



	2009	2010	2011	2012	2013	2014
Washington University - Adult	47,791	51,904	53,864	54,162	56,083	58,322
SLUCare	29,290	30,778	28,035	28,035	31,084	34,172
Barnes-Jewish	15,495	16,989	17,349	17,250	17,434	18,598
St. Louis ConnectCare*	17,964	15,170	12,970	14,947	12,084	-
Total	110,540	114,841	112,218	114,394	116,685	112,870

*St. Louis ConnectCare could not demonstrate financial sustainability throughout the demonstration and closed operations in October 2013.

E. Access to urgent care locations for the safety net population has been expanded throughout the demonstration

After the closure of St. Louis ConnectCare (including its urgent care facility) in late 2013, it was decided that primary care providers should provide urgent care services for their Gateway patients to ensure the coordination of care with the primary care provider. As a result, Myrtle Hilliard Davis and Affinia Healthcare (formerly known as Grace Hill Health Centers) started offering urgent care services in 2014, and the other Gateway primary care providers contracted with SSM Urgent Care to provide urgent care services for their Gateway patients. To date, Affinia Healthcare and Myrtle Hilliard Davis have provided 18,699 urgent care visits to Gateway patients, showing urgent care services have successfully been maintained during ConnectCare's closure. An additional 2,234 urgent care visits were provided by SSM Urgent Care.

F. Funding provided by the Demonstration project maintains access to primary and specialty care services for the uninsured.

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. Outlined below are the financial results of Demonstration, as of July 7, 2016:

*Summary of Medical Payments through the Demonstration (July 2012 – June 2016)**

Payment Type	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016*
Primary Care	$ 2,272,716	$ 12,243,427	$ 14,437,742	$ 13,703,784	$ 9,141,638
Specialty Care	$ 2,373,722	$ 11,124,482	$ 8,040,940	$ 8,276,692	$ 5,124,158
Transportation	$ -	$ -	$ 333,745	$ 326,810	$ 224,238
Total	$ 4,646,438	$ 23,367,210	$ 22,812,428	$ 22,307,286	$ 14,490,034

*The data above is as of 7/7/16 and is subject to change as additional claims are submitted and recoupments occur.

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

Key questions for this objective include:

- 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?

Findings to Date:

The Demonstration has met Objective II, evidenced by:

A. Primary care providers funded by the Gateway Demonstration served as medical homes for more than 75,000 uninsured patients in 2014.

B. As of June 30, 2016, there were 18,994 individuals enrolled in the Demonstration project, receiving care at Gateway primary care homes.

C. Increasing quality of care as measured by the program's pay-for-performance measures.

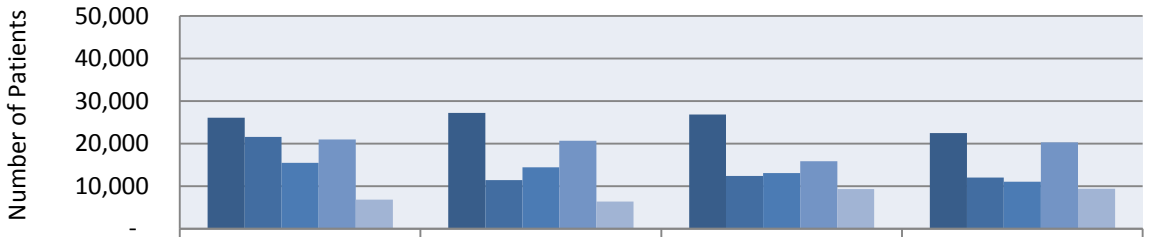
D. Patients and providers regularly express satisfaction with Gateway and the benefits the program provides to enrollees.

Each of these findings is reviewed in detail below:

A. *Primary care providers funded by the Gateway Demonstration served as medical homes for more than 75,000 uninsured patients in 2014.*

Gateway primary care providers served as a medical home to a total of 75,216 uninsured patients in 2014. Data for uninsured patients at Gateway primary care providers in 2015 is not yet available. Updated data will be provided in the 2016 annual report.

Uninsured Patients Served by Gateway Primary Care Providers, 2011-2014



	2011	2012	2013	2014
Affinia	26,088	27,262	26,838	22,473
Myrtle Hilliard	21,549	11,425	12,361	12,005
BJK People's	15,493	14,456	13,106	11,073
St. Louis County	20,969	20,704	15,883	20,278
Family Care	6,825	6,346	9,333	9,387
Total	90,924	80,193	77,521	75,216

B. *As of June 30, 2016, there were 18,994 individuals enrolled in the Demonstration project, receiving care at Gateway primary care homes.*

More than 14,500 individuals were enrolled in the Blue Plan and 399 in the Silver Plan as of July 1, 2012. Since then, enrollment has continued to increase. On October 31, 2012, the State submitted a Notification of Change to the Enrollment Target, which notified CMS that the State was raising the enrollment target to 20,500 as of January 1, 2013. In January 2013, the State submitted an additional Notification of Change to the enrollment target, notifying CMS that the State will increase the target to 22,600 in April 2013. The State raised the enrollment target due higher than anticipated demand for Blue Plan services and lower than expected demand for services from Populations 2 and 3.

As of January 1, 2014, 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. Individuals with incomes between 100% and 200% FPL are not eligible for Gateway coverage as of January 1, 2014, and therefore making the Blue Plan the only Gateway plan. When the income requirements changed for the program, approximately 4,000 individuals lost coverage through Gateway. Significant outreach was conducted helping to enroll these individuals in other coverage options.

In the approval for 2016, CMS approved the addition of insulin and inhalers that are not available in a generic alternative to the program's benefit package. With the additional cost of this benefit, the enrollment target going forward was lowered to 21,432. As of June 30, 2016, nearly 19,000 individuals were enrolled in Gateway.

Outlined below are the key statistics related to enrollment in the demonstration at the end of each federal fiscal year, as available:

*Gateway to Better Health Enrollment by Population, 2012 – 2016**

Demonstration Populations	**Unique Individuals Enrolled as of September 30, 2012**	**Unique Individuals Enrolled as of September 30, 2013**	**Unique Individuals Enrolled as of September 30, 2014**	**Unique Individuals Enrolled as of September 30, 2015**	**Unique Individuals Enrolled as of June 30, 2016**
Population 1: Uninsured individuals receiving both Primary and Specialty Care through the Demonstration	16,441	21,061	21,743	19,780	18,994
Population 2: Uninsured individuals receiving only Specialty Care through the Demonstration	633	1,134	N/A	N/A	N/A
Population 3: Uninsured individuals receiving only Specialty Care through the Demonstration	239	1,326	N/A	N/A	N/A
Total	17,313	23,521	21,743	19,780	18,994

*Data for 2016 only available as of June 30, 2016 at the time of extension request development.

*Gateway to Better Health Member Months by Population by Federal Fiscal Year**

	Member Months				
Demonstration Populations	**Federal Fiscal Year 2012 July – September 2012**	**Federal Fiscal Year 2013 October '12 – September '13**	**Federal Fiscal Year 2014 October '13 – September '14**	**Federal Fiscal Year 2015 October '14 – September '15**	**Federal Fiscal Year 2016 October '15 – June '16**
Population 1: Uninsured individuals receiving both Primary and Specialty Care through the Demonstration	46,668	234,302	256,727	256,553	173,050
Population 2: Uninsured individuals receiving only Specialty Care through the Demonstration	1,430	11,159	3,583	N/A	N/A
Population 3: Uninsured individuals receiving only Specialty Care through the Demonstration	529	13,099	4,207	N/A	N/A
Total	48,627	258,560	264,517	256,553	173,050

*Data for 2016 only available as of June 30, 2016 at the time of extension request development.

In addition, more than 49,000 unique individuals have been enrolled into Gateway since the implementation of the pilot program in July 2012. The Gateway primary care sites have also successfully enrolled more than 32,500 individuals into MO HealthNet programs including:

- More than 16,500 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- More than 9,200 adults approved for Uninsured Women's Health Services;
- 3,444 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 3,505 adults approved for MO HealthNet for Families.

Gateway to Better Health Enrollment by Health Center, as of June 30, 2016

Health Center	**Unique Individuals Enrolled as of June 30, 2016**	**Member Months July 2012 – June 2016**
BJK People's Health Centers	3,271	142,653
Family Care Health Centers	1,393	68,508
Affinia Healthcare	8,057	435,232
Myrtle Hilliard Davis Comprehensive Health Centers	3,622	174,204
St. Louis County Dept. of Public Health	2,651	142,456
Total	18,994	963,053

**Enrollment numbers are based on MO HealthNet enrollment data as of June 30, 2016.*

Gateway to Better Health Enrollment by Gender, as of June 30, 2016

Gender	Count	Percentage
Female	9,638	50.7%
Male	9,356	49.3%
Total	***18,994***	***100.0%***

*Top 15 Zip Codes by Member Count as of June 30, 2016**

ZIP	Member Count	City or County
63136	1,510	St. Louis County (Jennings, MO)
63115	1,161	St. Louis City
63118	1,046	St. Louis City
63116	952	St. Louis City
63113	936	St. Louis City
63107	744	St. Louis City
63112	720	St. Louis City
63111	688	St. Louis City
63121	687	St. Louis County (Normandy, MO)
63106	684	St. Louis City
63103	681	St. Louis City
63104	542	St. Louis City
63120	523	St. Louis City
63137	513	St. Louis County (Bellefontaine Neighbors)
63033	511	St. Louis City
All Others	7,096	St. Louis City and St. Louis County
Total	***18,994***	-

**These 15 zip codes account for 62.6% of the total Gateway population*

Members by Age Group as of June 30, 2016

Age Groups	Members	% of Total
19-30	4,206	22.1%
31-44	5,818	30.6%
45-64	8,970	47.2%
Total	***18,994***	***100.0%***

Members by Race as of June 30, 2016

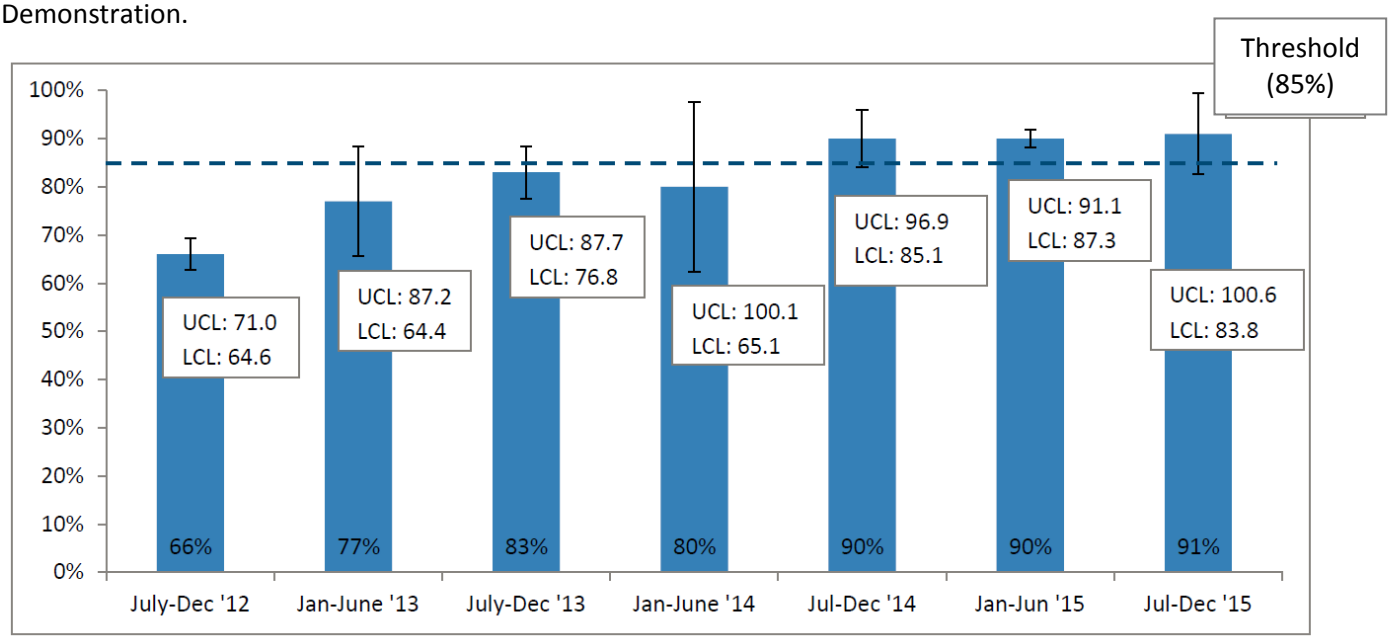
Race	Members	% of Total
African American	13,918	73.3%
Caucasian	3,534	18.6%
Other	21	<1%
Unknown	1,521	8.0%
Total	***18,994***	***100.0%***

C. Increasing quality of care as measured by the program's pay-for-performance measures.

Quality of care as measured by the program's pay-for-performance measures, continues to improve. Providers are consistently earning their incentive payments by meeting quality metrics, including ensuring access for those with chronic conditions and helping them to manage their disease better.

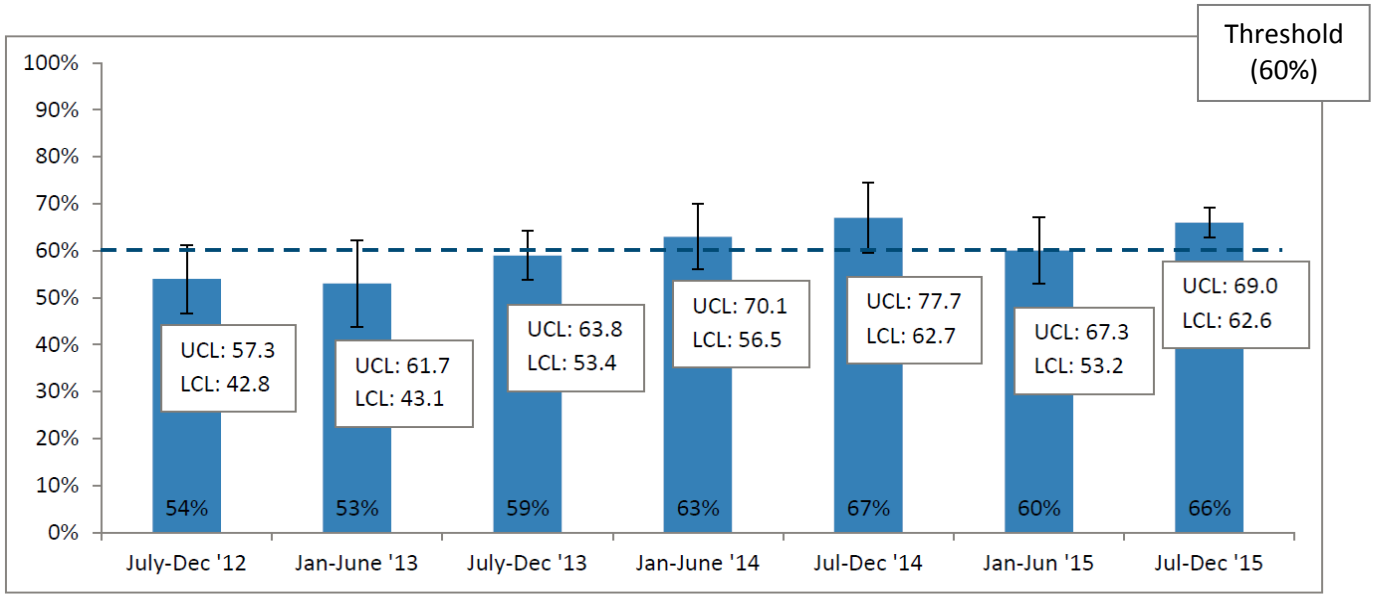
Patients with Diabetes HgbA1c: HgbA1c testing performed within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis

Ninety-one percent of newly enrolled or newly diagnosed diabetic patients had their HgbA1c tested within six months during the most recent incentive period, compared to 66% at the beginning of the Demonstration.



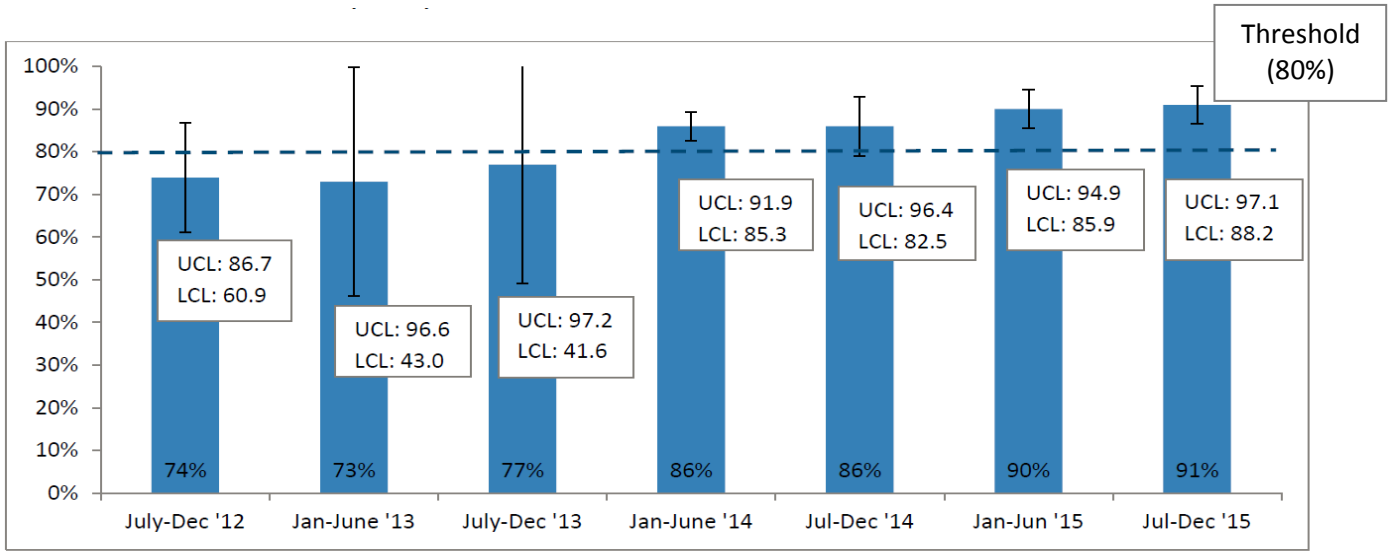
Patients with Diabetes HgbA1c <9%: Percentage of diabetics who have a HgbA1c <9% within six months following the latter of either: a) initial enrollment, or b) initial diagnosis

Sixty-six percent of patients with diabetes had an HgbA1c of less than 9% within six months of diagnosis or enrollment during the most recent incentive period, compared to 54% at the beginning of the program.



Patients with Chronic Disease (2 visit): Two office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis

- Ninety-one percent of newly enrolled individuals with chronic diseases or newly diagnosed patients received two office visits within six months, compared to 74% at the beginning of the Demonstration.



D. Patients and providers regularly express satisfaction with Gateway and the benefits the program provides to enrollees.

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

Patient Satisfaction Survey

Patient satisfaction surveys were conducted six times from July 2012 – June 2015 with Gateway to Better Health patients. In the July-September 2012 reporting period, a total of 66 patients participated in the survey; in the October-December 2012 reporting period, a total of 40 patients participated; in the January-March 2013 reporting period, a total of 98 patients participated; in the January-April 2014 reporting period, a total of 301 patients participated; in a survey conducted by Princeton Survey Research Associates International between September and October 2014, a total of 1,202 patients participated; in the January-June 2015 reporting period, a total of 32 patients participated; and in the March-June 2016 reporting period, a total of 764 patients participated. An overview of the findings have been provided below.

In general, surveyed patients reported having a good experience with receiving services at their health center. In the July-September 2012 and January-March 2013 reporting periods, the lowest scores for most patients were related to ease of getting an appointment. In the October-December 2012 reporting period, the lowest scores for most patients were related to how well provider staff listened to the patient. In the January-April 2014 and January-June 2015 reporting periods, the lowest scores were for ease of getting an appointment at your health center.

The survey was updated in February 2016, to reduce the burden on patients in completing survey. In the March – June 2016 reporting period, both questions asked "how well did the staff and doctor listened to your needs and explained things in a way that was easy to understand" and "how satisfied are you with the quality of services received" resulted in high ratings from respondents.

Overall, Gateway patients were satisfied with the primary care services, and 98% of respondents indicated that they would recommend their health center to others. Results of the patient survey are outlined below.

*Patient Satisfaction Survey Results for Primary Care Services, March - June 2016**

Survey Item	Average Ratings*
Doctor and staff listened and explained things well	4.63
Overall quality of service	4.61

**5-point rating scale (1= Poor, 2=Fair, 3=Good, 4=Very Good, 5=Excellent)*

When asked how their experience with the health centers could be improved for future visits, 53% of respondents had positive feedback for the health centers and expressed gratitude for the program. While, 21% of respondents indicated wait times to be seen once arrived for the appointment as their main issue with their experience at the health centers

Member Orientation Results

The Gateway to Better Health program enrolls 600 to 1600 new members each month. In an effort to educate these new members about program and health center processes, the Pilot Program holds member orientations on a quarterly basis at each participating health center for those members who've enrolled in the program during the last six months. Topics discussed during the sessions include program background, application process, member handbook and ID card, covered and non-covered benefits, transportation scheduling, redetermination and disenrollment, as well as health center specific policies. Member orientations are conducted at various sites for all Gateway primary care organizations: Betty Jean Kerr People's Health Center, Myrtle-Hilliard Davis Comprehensive Health Centers, Family Care Health Centers, Affinia Healthcare, and St. Louis County Department of Public Health. To date, more than 700 members have attended orientation sessions since its implementation in March 2015. Participants are asked to evaluate the effectiveness of each orientation session at its conclusion. Results from orientations conducted during the third quarter of DY7 (April – June 2016) are summarized below:

- 86% of members felt very confident or somewhat confident that they understood how to use their benefits
- 85% of members felt very confident or somewhat confident that they can navigate receiving health care service at their health center
- 90% of members felt the orientation sessions were very helpful or somewhat helpful

Provider Satisfaction Survey Results

Representatives from the provider organizations meet monthly to evaluate clinical issues, consumer issues and financial issues related to the program. SLRHC is monitoring appointment wait times and conducting satisfaction surveys with physician and support staff participants on an annual basis. Survey outcomes from July 2012 – December 2015 are detailed below:

Provider satisfaction surveys were distributed to the five primary care health centers in the Gateway provider network to assess providers' experience with the referral process for the program. In the July-September 2012 reporting period, a total of 17 surveys were collected; in the October-December 2012 reporting period, a total of 44 surveys were collected; in January-March 2013 reporting period, a total of 37 surveys were collected; in the April-June 2013 reporting period, a total of 34 surveys were collected; in the January-April 2014 reporting period, a total of 62 surveys were collected; in a survey conducted by Princeton Survey Research Associates International in October 2014, a total of 93 were collected; in the January-June 2015 reporting period, a total of 56 surveys were collected; and in the July – December 2015 reporting period, a total of 33 surveys were collected.

The lowest scores for most providers during the July-December 2015 reporting period were related to the receipt of report or notes from specialty care provider. The lowest scores for most support staff were related to the timeliness of available appointments. Results from all reporting periods are outlined below:

*Provider Satisfaction Survey Results (Support Staff), October 2012 – December 2015**

Survey Item	Oct-Dec 2012	Jan-March 2013	April - June 2013	July - Sept 2013	Oct - Dec 2013	Jan - June 2014	Jan - June 2015	July - Dec 2015
Helpfulness and courtesy of staff when scheduling	3.5	3.1	2.8	2.9	2.9	2.9	2.4	2.1
Timeliness of available appointments	3.2	2.7	2.6	2.6	3.0	2.8	2.2	1.8
Ease of contacting the rendering provider	3.4	2.9	2.6	2.5	2.9	2.9	2.3	1.9
Overall ease of scheduling a consultation	3.4	2.8	2.7	2.8	3.0	3.0	2.1	2.0
Overall satisfaction	**3.4**	**2.9**	**2.7**	**2.7**	**2.9**	**2.9**	**2.2**	**2.0**

**4-point rating scale (1= Needs Improvement, 2=Average, 3=Above Average, 4=Excellent)*

*Provider Satisfaction Survey Results (Referring Providers), October 2012 – December 2015**

Survey Item	Oct-Dec 2012	Jan-March 2013	April-June 2013	July - Sept 2013	Oct - Dec 2013	Jan - June 2014	Jan - June 2015	July - Dec 2015
Timeliness of available appointments	2.3	2.0	2.0	2.2	2.6	2.4	1.9	2.2
Receipt of report from consultation provider	2.4	2.0	2.2	2.5	2.6	2.3	1.9	2.0
Meaningfulness of report from consultation provider	2.9	2.7	2.4	2.8	2.9	2.4	2.1	3.0
Availability to speak with rendering specialist	1.9	1.9	2.3	2.8	2.9	2.0	1.9	2.4
Overall Satisfaction	**2.3**	**2.1**	**2.2**	**2.5**	**2.8**	**2.3**	**1.9**	**2.4**

**4-point rating scale (1= Needs Improvement, 2=Average, 3=Above Average, 4=Excellent)*

Overall throughout the pilot program, satisfaction among primary care providers has shown little to no change. The SLRHC regularly meets with referral staff and providers at the health centers to identify sources of dissatisfaction and have communicated trending issues to specialty care providers within the Gateway network.

With the work of the trauma informed learning collaborative, the SLRHC is seeking to help address the barriers and concerns providers face when caring for their safety net patients. Using SAMHSA's concept of trauma informed cared, organizations in the learning collaborative will work on building stronger cross sector collaboration that will help improve health outcomes for their patients. Research has shown that implementing a trauma informed approach to care can lead to improvements in not only health outcomes for patients, but also overall provider satisfaction.

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

Key questions for this objective include:

- By race and ethnicity, how many and what percentage of patients met health disparities metrics: tobacco use and cessation intervention, 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?

Findings to date:

The demonstration has met objective III, as evidenced by:

A. Successful enrollment of African-American patients, who report high satisfaction with the program and show positive health outcomes.
B. A review of standard quality measures, based on data sourced from the Missouri Primary Care Association, indicates that Gateway primary care providers have provided quality medical services to patients throughout the Demonstration.
C. Access to primary and specialty care services has been maintained throughout the Demonstration.
D. Safety net providers are being trained in trauma informed care and practices.

Each of these findings is reviewed in detail below:

A. Successful enrollment of African-American patients, who report high satisfaction with the program and show positive health outcomes.

The continuation of the funding for the St. Louis safety net of health care providers through this Demonstration helps ensure access to health care for those living in traditionally underserved communities. 73% of all members of the pilot coverage model are African-American, 19% are Caucasian, less than 1% are members of other races, and 8% did not report their race. (Other races and ethnicities – reporting as one race -- make up 4.5% of individuals in St. Louis City and County.)

Recent patient surveys conducted by Princeton Survey Research Associates International (PSRAI) in 2014 indicate that patients are receiving quality care. When looking at the survey results by race, African-Americans (76% of survey respondents) tend to be more satisfied than other enrollees with the care they have received from medical staff at health centers and specialty providers.

As measured through pay-for-performance metrics in the July – December 2015 reporting period, outcomes for African Americans and Whites enrolled in the Pilot Program are being maintained or have improved:

- 90% of African Americans with chronic conditions had at least two office visits within 1 year, as compared to 93% of Whites. In the prior reporting period, 88% of both African Americans and Whites met this metric.

- 89% of African Americans with diabetes had at least one HgbA1c test within 6 months, which is the same as that of Whites. In the prior reporting period, 87% of African Americans and 94% of Whites met this metric.

B. A review of standard quality measures, based on data sourced from the Missouri Primary Care Association, indicates that Gateway primary care providers have provided quality medical services to patients throughout the Demonstration.

Quality Measure	2013	2014	2015
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	73%	72%	78%
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	56%	76%	53%
Cervical Cancer Screening Percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer	61%	66%	59%
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%	65%	69%	64%
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	37%	46%	58%

A complete list of quality measures, as reported to UDS through 2014, is provided in Appendix I.

Many key quality metrics, such as diabetes and hypertension control, have declined throughout the program for both African Americans and Whites enrolled. These health outcomes are likely impacted by the disproportionate stress and trauma that this population faces. To address these health disparities, the work of the Alive and Well STL Health Learning Collaborative centers on reducing the burden of stress and trauma on individuals' lives to improve health and wellbeing.

Quality Measure	Year 1 (7/1/12 – 6/30/13)		Year 2 (7/1/13 – 6/30/14)		Year 3 (7/1/14 – 6/30/15)	
	Whites	African Americans	Whites	African Americans	Whites	African Americans
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	75%	73%	79%	69%	80%	73%
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	67%	52%	60%	52%	62%	50%
Cervical Cancer Screening Percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer	60%	59%	52%	56%	55%	58%
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%	64%	65%	68%	60%	61%	60%
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	31%	19%	43%	40%	54%	45%

C. Access to primary and specialty care services has been maintained throughout the Demonstration.

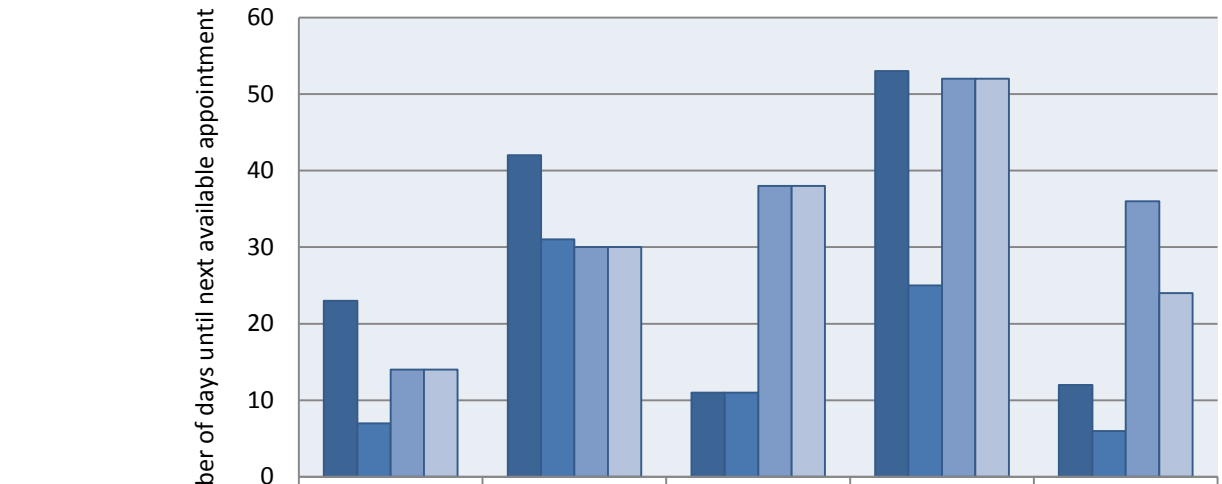
Access to Specialty and Diagnostic Care, July 2012 – June 2015

Month	Referrals to St. Louis ConnectCare*	Referrals to other Specialty Providers	Total
July 2012	1350	417	1,767
August 2012	1515	638	2,153
September 2012	1004	618	1,622
October 2012	1171	850	2,021
November 2012	984	878	1,862
December 2012	1059	803	1,862

January 2013	1357	1108	2,465
February 2013	1230	970	2,200
March 2013	1394	1347	2,741
April 2013	1616	1239	2,855
May 2013	1287	1141	2,430
June 2013	1248	1364	2,612
July 2013	1336	1202	2,538
August 2013	858	1568	2,426
September 2013	79	1662	1,741
October 2013	69	2310	2,379
November 2013	8	2041	2,049
December 2013	0	1855	1,855
January 2014	N/A	1804	1,804
February 2014	N/A	1988	1,988
March 2014	N/A	2067	2,067
April 2014	N/A	2366	2,366
May 2014	N/A	2120	2,120
June 2014	N/A	2524	2,524
July 2014	N/A	2263	2,263
August 2014	N/A	2202	2,202
September 2014	N/A	2301	2,301
October 2014	N/A	2349	2,349
November 2014	N/A	1767	1,767
December 2014	N/A	1879	1,879
January 2015	N/A	1871	1,871
February 2015	N/A	1983	1,983
March 2015	N/A	2178	2,178
April 2015	N/A	2334	2,334
May 2015	N/A	1955	1,955
June 2015	N/A	2222	2,222
July 2015	N/A	2101	2,101
August 2015	N/A	1964	1,964
September 2015	N/A	1845	1,845
October 2015	N/A	1896	1,896
November 2015	N/A	1648	1,648
December 2015	N/A	1886	1,886
January 2016	N/A	1913	1,913
February 2016	N/A	1818	1,818
March 2016	N/A	2146	2,146
April 2016	N/A	2181	2,181
May 2016	N/A	2084	2,084
June 2016	N/A	1895	1,895

*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.

Primary Care Wait Times for Regular (Non-Urgent) Appointments as of 6/30/16*



	Affinia Healthcare	St. Louis County	Family Care	BJK People's	Myrtle Hilliard Davis
Adult Patient-New	23	42	11	53	12
Adult Patient-Returning	7	31	11	25	6
Adult Dental-New	14	30	38	52	36
Adult Dental-Return	14	30	38	52	24

**Wait times self-reported by individual health centers as of June 30, 2016 and are calculated for Gateway patients only.*

*Adult Wait Times by Specialty, CY2014**

	# of Days Until the Next Available Appointment	
Appointment Type	**New Patient**	**Return Patient**
Cardiology	9.3	18.6
Dermatology	24.5	16.3
Endocrinology	35.3	29.3
Endoscopy	7.0	7.0
ENT/Otolaryngology	14.8	9.5
Gastroenterology (GI)	32.0	40.3
Gynecology	30.5	15.5
Hematology	28.5	23.5
Hepatology	66.0	37.0
Infectious Disease	29.5	20.0
Mental/Behavioral Health	33.6	20.3
Nephrology	24.0	21.0
Neurology	31.3	16.5
Neurosurgery	27.5	15.8
Obstetrics/Prenatal Care	9.0	10.6

Oncology	12.0	12.6
Ophthalmology/Eye Care	49.6	31.6
Orthopedics	13.3	19.3
Pain Management	27.0	25.0
Pathology	0.0	0.0
Physical Therapy	1.0	8.0
Podiatry	79.0	79.0
Pulmonology	27.5	21.0
Rheumatology	47.0	30.3
Surgery -- General	8.6	9.6
Urology	27.3	18.8

*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). Specialty care wait time data not yet available for calendar year 2015 and will be provided in future reports.

D. Safety net providers are being trained in trauma informed care and practices.

Each Gateway primary care provider is participating in an 18-month learning collaborative where organizations receive expert consultation to develop an organizational work plan to implement trauma-informed practices. Consultation will be based on the Missouri Model, a guide for the stages of trauma integration within an organization. Key components of each learning collaborative include:

- Introductory training/meetings for staff and leadership, as needed
- Advanced trauma training for the trauma committees within each organization
- Monthly webinars/trainings for trauma committees to provide technical assistance in specific areas based on SAMHSA's 10 domains of trauma, which include: governance and leadership; policy; physical environment; engagement and involvement; cross-sector collaboration; screening; assessment and treatment services; training and workforce development; progress monitoring and quality assurance; financing; and evaluation.
- Monthly coaching calls and limited on-site support for each organization to provide guidance on implementation

The learning collaborative offers organizations two membership options: full membership and participating membership. All Gateway primary care providers have signed on as full members of the collaborative and will receive free training, monthly webinars and coaching calls, and onsite consultation with expert consultants. Area hospitals, academic medical institutions, specialty care providers and other healthcare organizations are participating members and will receive free training and consultation.

Additional Demonstration Evaluation Questions and Topics

In addition to the stated objectives of the Demonstration project, CMS' special terms and conditions specify that the evaluation shall address the evaluation questions and topics as listed below. Interim evaluation findings for these topics are provided.

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

The Gateway to Better Health Demonstration has improved access to care for low-income individuals, as discussed in the description of interim evaluation findings for Objective I. Key findings to date include the following:

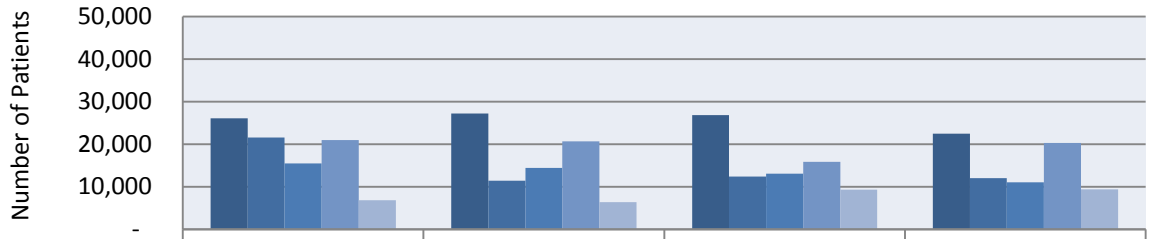
- Nearly 19,000 individuals are enrolled in Gateway to Better Health, which is approximately 45 percent of those uninsured and living below the federal poverty level in St. Louis City and County. Over the life of the program, more than 49,000 unique individuals have received services from the program.
- Nearly 100,000 medical visits (primary care/urgent care, dental, specialty care, diagnostic services and outpatient hospital services) and more than 225,000 prescriptions are funded each year through Gateway to Better Health. Previous studies have indicated that the care provided through this Demonstration prevents more than 50,000 emergency department visits per year.
- More than 6,600 transportation rides to medical appointments for primary and specialty care services are funded through the Demonstration project each year.
- Uninsured encounters at Gateway primary care providers increased by 13.6% (+31,361 encounters) from 2011 (coverage model baseline) to 2014. Data for uninsured encounters at Gateway primary care providers in 2015 is not yet available. Updated data will be provided in the 2016 annual report.

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

As discussed in the interim evaluation findings for Objective II, the Demonstration has expanded coverage in the St. Louis region. Key findings to date include the following:

Gateway primary care providers served as a medical home to a total of 75,216 uninsured patients in 2014. Data for uninsured patients at Gateway primary care providers in 2015 is not yet available. Updated data will be provided in the 2016 annual report.

Uninsured Patients Served by Gateway Primary Care Providers, 2011-2014

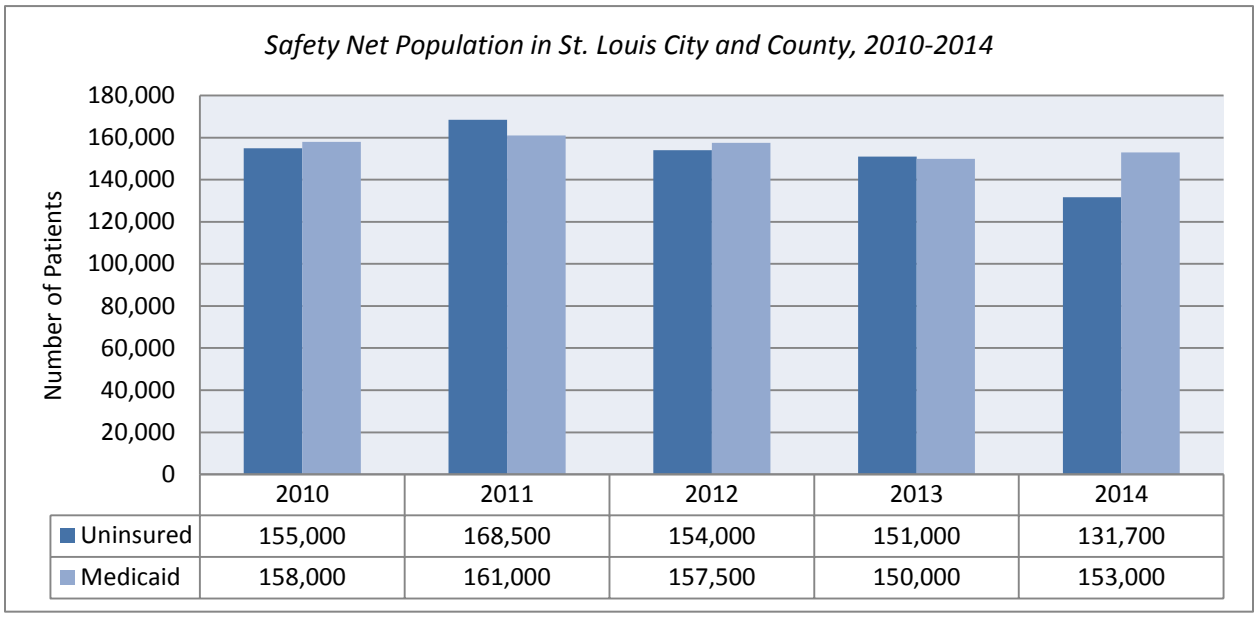


	2011	2012	2013	2014
Affinia	26,088	27,262	26,838	22,473
Myrtle Hilliard	21,549	11,425	12,361	12,005
BJK People's	15,493	14,456	13,106	11,073
St. Louis County	20,969	20,704	15,883	20,278
Family Care	6,825	6,346	9,333	9,387
Total	90,924	80,193	77,521	75,216

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. To date, Gateway primary care sites have successfully enrolled more than 32,500 individuals into MO HealthNet programs including:

- More than 16,500 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- More than 9,200 adults approved for Uninsured Women's Health Services;
- 3,444 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 3,505 adults approved for MO HealthNet for Families.

Since the implementation of the Demonstration project in 2010, the safety net population in St. Louis City and County has decreased by 9% and the number of individuals without health insurance coverage has decreased by 15%. Data for safety net users in 2015 is not yet available. Updated data will be provided in the 2016 annual report.



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

Quality of care as measured by the program's pay-for-performance measures, continues to improve. Providers are consistently earning their incentive payments by meeting quality metrics, including ensuring access for those with chronic conditions and helping them to manage their disease better.

- Ninety-one percent of newly enrolled or newly diagnosed diabetic patients had their HgbA1c tested within six months during the most recent incentive period, compared to 66% at the beginning of the Demonstration.

- Sixty-six percent of patients with diabetes had an HgbA1c of less than 9% within six months of diagnosis or enrollment during the most recent incentive period, compared to 54% at the beginning of the program.

- Ninety-one percent of newly enrolled individuals with chronic diseases or newly diagnosed patients received two office visits within six months, compared to 74% at the beginning of the Demonstration.

Progress has been seen in key health indicators since the start of the Pilot Program, as measured using data sourced from the Missouri Primary Care Association and Gateway safety net provider electronic health records.

- Preventative health and screening services (such as tobacco use assessment and cessation intervention, adult weight screening and following up, flu shots, breast cancer screening, chlamydia screening, and office visits for patients with chronic diseases) improved on

average by 6% from year one (7/1/12-6/30/13) to year three (7/1/14-6/30/15), with more patients utilizing these services.

- Management of chronic conditions, such as hypertension and diabetes, has been maintained throughout the life of the program.

IV. Describe provider incentives and activities.

The primary care organizations are working to achieve quality metrics developed by the SLRHC's community planning committee for the Demonstration – the Pilot Program Planning Team. Seven percent of provider payments are withheld and are paid out semi-annually based on the attainment of six performance metrics.

The seventh pay-for-performance reporting period ended on December 31, 2015. The complete results are provided in Appendix III. In general, the providers continued to build off gains from the first reporting period and made great strides in attaining the clinical quality measures. It is expected that the participating providers will continue to improve results as the program continues. As of January 2014, pay-for-performance measures only apply to the participating primary care providers.

In the seventh reporting period, individually, all primary care providers achieved at least five of the six clinical quality measures. Family Care Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers achieved all six measures. Across all primary providers, 74% of patients enrolled for six months had a primary care visit during that time, with a threshold of 80%. 91% of patients with chronic conditions enrolled six months had two primary care visits during that time, with a threshold of 80%. In addition, 66% of the patients with diabetes had HgbA1c measures <9%, with a threshold of 60%. Of all newly diagnosed or enrolled diabetic patients, 91% had their HgbA1c drawn within six months. Among enrollees whose primary care home was notified of a recent hospitalization, 91% were contacted by their primary care home's staff within (7) days after hospital discharge.

In the seventh pay-for-performance period, the providers successfully attained the measure related to rate of referrals to specialists. Tracking these measures has enabled the providers to address operational and clinical improvements to help them achieve better outcomes over the life of the program.

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

- **Tobacco Use Assessment & Cessation Intervention**: the percentage of patients aged 18 and over who were queried about tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy at health centers participating in the Gateway Pilot Program improved by 5% throughout the life of the program. In 2015, the Gateway health centers rate of screening was comparable to the 2014 state average (77% state average vs. 78% Gateway average). Statewide UDS data for CY 2015 not yet available.
- **Controlling High Blood Pressure**: the proportion of hypertension patients whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading slightly

declined by 3% at health centers participating in the Gateway Pilot Program. This measure also slightly declined across the state from 61% in 2011 to 59% in 2014. Statewide UDS data for CY 2015 not yet available.

- **Cervical Cancer Screening**: the 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 at health centers participating in the Gateway Pilot Program slightly declined by 2% throughout the program. This measure remained relatively stable statewide from 2012 to 2014. Statewide UDS data for CY 2015 not yet available.
- **Diabetes HbA1c Control (<9%)**: the proportion of adult patients 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 at health centers participating in the Gateway Pilot Program remained relatively stable from 2011 to 2015. The percent of adult diabetes patients with HbA1c readings less than 9% at health centers statewide improved slightly by 2% from 2012 to 2014. Statewide UDS data for CY 2015 not yet available.
- **Adult Weight Screening and Follow-Up**: the percentage of patients 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 improved by 21% from 2013 to 2015 at health centers participating in the Gateway Pilot Program. This measure improved by 13% among health centers across the state from 2012 to 2014. Statewide UDS data for CY 2015 not yet available.

The Safety Net Pilot Program will continue to evaluate the impact of performance incentives on population metrics as additional information becomes available. Outcomes isolated to the Gateway population, using data sourced from Missouri Primary Care Association, are provided below:

- Preventative health and screening services (such as tobacco use assessment and cessation intervention, adult weight screening and follow up, flu shots, breast cancer screening, chlamydia screening, and office visits for patients with chronic diseases) improved on average by 6% from year one (7/1/12-6/30/13) to year three (7/1/14-6/30/15), with more patients utilizing these services.

- Management of chronic conditions, such as hypertension and diabetes, has been maintained throughout the life of the program.

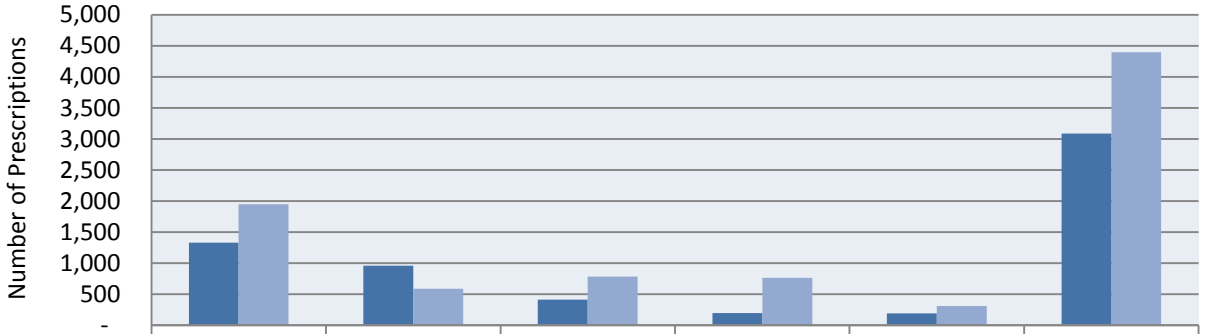
See Appendix I for more information regarding progress on quality indicators.

VII. 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 Demonstration project began providing coverage for brand name insulin and inhalers, as there are no generic alternatives to these medications. As of June

30, 2016, a total of 7,486 prescriptions for brand name insulin and inhalers have been filled through Gateway funding.

Brand Name Insulin and Inhalers filled by Gateway Primary Care Providers, as of June 30, 2016



	Affinia	Myrtle Hilliard	BJK People's	St. Louis County	Family Care	Total
Insulin	1,331	958	414	195	191	3089
Inhalers	1,948	591	783	763	312	4397

To measure the effect of providing coverage for brand name insulin and inhalers, the pilot program tracks a number of quality indicators relevant to patients who may utilize this new benefit through incentives payments and UDS reporting:

- 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.

Data for these metrics, since the benefit of brand name insulin and inhalers became available for program enrollees, is not yet available. Trends for metrics, prior to and after the new benefit, will be provided in the 2016 annual report.

Section VIII: Compliance with Public Notice Process

The State has taken multiple steps to inform the public and solicit public input about its Demonstration extension application. These public notice and public input procedures comply with 42 C.F.R. Part 431.

In compliance with 42 C.F.R. § 431.408, The State's public notice and comment period began on September 28, 2016 and ran for 30 days, until October 27, 2016. On September 23, 2016, the State published the full public notice document (See Appendix VIII) in a prominent location on its website at http://dss.mo.gov/mhd/ and on September 24, 2016, published the abbreviated public notice (see Appendix VII) in the newspapers of widest circulation in each city in Missouri with a population of 50,000 or more. In addition, the SLRHC notified via email past participants of community meetings regarding Gateway to Better Health.

The public was invited to review and comment on the State's proposed waiver extension request from September 28th – October 27th, 2016. Comments concerning the State's plan to submit a waiver extension request were accepted at:

Department of Social Services, MO HealthNet Division
Attention: Gateway Comments
P.O. Box 6500
Jefferson City, MO 65102-6500
Ask.MHD@dss.mo.gov

The public was permitted to view a hard copy of the complete Gateway to Better Health Waiver Extension document and public notice by appointment by calling, 314-446-6454, ext. 1011. Appointments were scheduled during regular business hours, 8 a.m. – 4:30 p.m., Monday through Friday at 1113 Mississippi Avenue, St. Louis, MO 63104.

The public hearings were held more than 20 days prior to submission of the extension application:

Monday, October 3, 2016, 9-10AM*
St. Louis County Department of Public Health
6121 N. Hanley Road
Berkley MO 63134

Wednesday, October 5, 2016, 3:30-4:30PM*
Forest Park Visitor and Education Center, Voyagers Room
595 Grand Drive
St. Louis, MO 63112

**Individuals wanting to participate in the public hearing via conference call may dial 888-808-6929, access code: 9158702.*

The State and the St. Louis Regional Health Commission accepted verbal and written comments at the public hearings regarding the extension application. Participants expressed their gratitude for the work of the program, citing the new benefits of insulin and inhalers as impactful to members. Attendees commented about how to increase enrollment and outreach efforts, particularly to men and young

adults aging out of Medicaid. Questions around transportation benefits and how those services are accessed were also addressed. Additionally, attendees discussed how the efforts to improve physical health through Gateway were positively impacting behavior health even though budget does not allow for coverage of a mental health benefit. Participants unanimously supported continuing the program.

On June 21, 2016, a post-award public input session was held to inform the public on the progress of the Gateway demonstration during the current extension period, in compliance with 42 C.F.R. § 431.420(c). This meeting was held as part of the regularly scheduled Community Advisory Board of the St. Louis Regional Health Commission. Approximately, 22 people attended the meeting. 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 success to date. Attendees expressed their satisfaction with the progress of the Demonstration to date and their support for the continued work of the Demonstration, including the implementation of trauma-informed practices within the health centers.

NOTE: The most current extension period is set to begin January 1, 2017 and expire on December 31, 2017. Given the date of submission for the 2018 extension application, the post award public hearing for 2017 has not yet been scheduled. The hearing will be held within six months of implementation or before June 30, 2017. The date of the post award public notice hearing will be provided in future reports to CMS.

Gateway to Better Health Demonstration

Demonstration Extension Application Appendices

November 9, 2016

Number: 11-W-00250/7

Appendix I

Quality Measures

Baselines are provided using data from calendar year 2011. These quality measures will be reviewed for evaluation purposes. Data below represents data reported to UDS from those Gateway primary care providers with the Federal Qualified Health Center (FQHC) designation and excludes St. Louis County Department of Public Health. UDS data for 2015 is not yet available and will be provided in future reports.

Quality Measures

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
1. Tobacco Use Assessment[1] Percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months	Number of patients for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit or within 24 months of their most recent visit	Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least two medical visits ever, or a sample of these patients.	82%	82%	73%	84%	76%	86%	NA	NA	87%	UDS
2. Tobacco Cessation Intervention[1] Percentage of patients aged 18 and over who were identified as users of any and all forms of tobacco during the program year or the prior year who received tobacco use intervention (cessation counseling and/or pharmacological intervention)	Number of patients who received tobacco cessation counseling or smoking cessation agents during their most recent visit or within 24 months of the most recent visit	Number of patient who were 18 years of age or older during the measurement year, seen after their 18th birthday, who were identified as a tobacco user at some point during the prior twenty-four months who had at least one medical visit during the reporting period, and at least two medical visits ever, or a sample of these patients	57%	42%	63%	53%	66%	60%	NA	NA	62%	UDS

[1] As of 2014, this metric is no longer measured by UDS. Data for this metric will not be captured going forward.

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
3. Tobacco Use Assessment & Cessation Intervention[2] 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 Pharmaco-therapy if identified as a tobacco user	Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least two medical visits ever, or a sample of these patients.	-	-	-	-	-	-	72%	77%	TBD	UDS

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

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
2. 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	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), and -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 70 of these patients	59%	61%	62%	61%	56%	59%	76%	59%	64%	UDS
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	54%	NA	NA	NA	99%	NA	97%	NA	59%	HITECH Meaningful Use / MPCA
4. Cervical Cancer Screening Percentage of women 24-64 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 two years prior to the measurement year	Number of all female patient 24-64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sampling of these women	61%	52%	51%	48%	49%	49%	66%	47%	66%	UDS

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
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%	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 70 of these patients	70%	73%	68%	70%	69%	71%	69%	72%	75%	UDS
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 sample of those patients	19%	31%	47%	44%	53%	53%	46%	55%	24%	UDS

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
9. 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	Number of enrollees 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	Number of enrollees with diabetes, hypertension, CHF or COPD	NA	NA	73%	NA	71%	NA	78%	NA	80%	Claims data
10. Primary Care Follow-Up After Hospitalization 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 of hospital discharge	Number 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.	Number of enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center during the measurement year.	NA	NA	79%	NA	66%	NA	65%	NA	50%	Claims data

APPENDIX II

Incentive Payment Protocol

Incentive Payments

The state will withhold 7% from payments made to the primary care health centers (PCHC) through December 31, 2018, 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
- January 1, 2017 – June 30, 2018
- July 1, 2017 – December 31, 2018

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.

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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 III

Pay-for-Performance Incentive Payment Results

Reporting Period: July – December 2015

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, July - December 2015, are summarized below.

Primary Care Health Center Pay-for-Performance Results

The potential incentive payment amount totaled $424,797.90 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**	**GH**	**MHD**	**FC**	**BJKP**	**County**	**Total**
1 - All Patients (1 visit)	80%	70%	80%	80%	60%	95%	74%
2 - Patients with Chronic Disease (2 visits)	80%	84%	96%	95%	96%	92%	91%
3 - Patients with Diabetes HgbA1c Tested	85%	95%	100%	100%	89%	77%	91%
4 - Patients with Diabetes HgbA1c < 9%	60%	70%	63%	68%	67%	61%	66%
5 - Hospitalized Patients	50%	96%	83%	75%	87%	100%	91%

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 $361,070.35 of the initial incentive pool leaving a remaining balance of $63,727.55.

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**	**GH**	**MHD**	**FC**	**BJKP**	**County**	**Total**
Referral Rate to Specialists	680/1000	280	322	528	337	536	351

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 that were achieved.

Table 3 - Amount Due to Each Health Center

Health Center	Incentive Pool	First Round Earnings	Second Round Earnings	Total Due to Providers
GH	$ 182,956.24	$ 146,364.99	$ 27,446.83	$ 173,811.82
MHD	$ 75,684.88	$ 75,684.88	$ 11,354.13	$ 87,039.01
FC	$ 30,475.26	$ 30,475.26	$ 4,571.85	$ 35,047.11
BJKP	$ 73,912.57	$ 59,130.06	$ 11,088.25	$ 70,218.31
County	$ 61,768.95	$ 49,415.16	$ 9,266.49	$ 58,681.65
Total	**$ 424,797.90**	**$ 361,070.35**	**$ 63,727.55**	**$ 424,797.90**

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	Grace Hill							Myrtle							Family Care						
		Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15
TIER 1 OUTCOMES																						
1 – New patients (1 visit)	80%	68%	52%	75%	67%	65%	74%	70%	56%	58%	86%	71%	75%	83%	80%	70%	73%	74%	80%	81%	78%	80%
2 - Patients with chronic diseases (2 visits)	80%	73%	81%	80%	83%	80%	86%	84%	82%	87%	95%	87%	92%	94%	96%	75%	18%	14%	89%	96%	85%	95%
3 - Patients with diabetes HgbA1c tested	85%	62%	91%	88%	87%	91%	92%	95%	67%	78%	72%	48%	91%	86%	100%	68%	70%	81%	100%	100%	89%	100%
4 - Patients with diabetes HgbA1c <9%	60%	61%	60%	61%	60%	61%	60%	70%	50%	48%	50%	58%	77%	47%	63%	54%	53%	64%	75%	71%	68%	68%
5 - Hospitalized Patients	50%	100%	83%	71%	87%	83%	85%	96%	100%	59%	37%	73%	88%	64%	83%	100%	100%	38%	64%	50%	67%	75%
TIER 2 OUTCOMES																						
1 - Emergency Department Utilization	28/1000	34	13	12	N/A	N/A	N/A	N/A	28	10	27	N/A	N/A	N/A	N/A	12	11	20	N/A	N/A	N/A	N/A
2 - Referral Rate to Specialists	680/1000	447	427	315	277	272	280	281	454	353	309	345	287	322	272	656	647	567	599	518	528	521

Pay-for-Performance Criteria	Threshold	BJK People's							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	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 15
TIER 1 OUTCOMES																						
1 – New patients (1 visit)	80%	75%	61%	80%	72%	80%	58%	60%	69%	75%	77%	87%	88%	89%	95%	65%	62%	79%	72%	74%	74%	74%
2 - Patients with chronic diseases (2 visits)	80%	50%	68%	81%	92%	82%	90%	96%	89%	95%	82%	92%	97%	97%	92%	74%	73%	77%	86%	86%	90%	91%
3 - Patients with diabetes HgbA1c tested	85%	71%	57%	85%	89%	81%	90%	89%	71%	83%	85%	89%	92%	89%	77%	66%	77%	83%	80%	90%	90%	91%
4 - Patients with diabetes HgbA1c <9%	60%	46%	37%	55%	56%	62%	61%	67%	39%	64%	63%	68%	80%	65%	61%	54%	53%	59%	63%	68%	60%	66%
5 - Hospitalized Patients	50%	100%	77%	28%	67%	62%	60%	87%	100%	100%	52%	83%	65%	80%	100%	100%	78%	54%	81%	78%	78%	91%
TIER 2 OUTCOMES																						
1 - Emergency Department Utilization	28/1000	24	16	17	N/A	N/A	N/A	N/A	9	7	14	N/A	N/A	N/A	N/A	26	12	12	N/A	N/A	N/A	N/A
2 - Referral Rate to Specialists	680/1000	598	440	363	425	346	337	348	547	510	487	484	506	536	559	496	443	365	363	338	351	349

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.

Appendix IV

Projected Budget Neutrality Impact Through 2018

	DY 1 FFY 2010	DY 2 FFY 2011	DY 3 FFY 2012	DY 4 FFY 2013	DY 5 FFY 2014	DY 6 FFY 2015	DY 7 FFY 2016	DY 8 FFY 2017	DY 9 FFY 2018	DY 10 FFY 2019	Total - 8.5 year demonstration
	07/28/2010 - 09/30/2010	10/01/2010 - 09/30/2011	10/01/2011- 9/30/2012	10/01/2012- 09/30/2013	10/01/2013- 9/30/2014	10/01/2014- 09/30/2015	10/01/2015- 09/30/2016	10/01/2016- 09/30/2017	10/01/2017- 9/30/2018	10/01/2018- 12/31/2018	07/28/2010 to 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*	*$771,488,712*	*$192,872,178*	**$6,727,589,056**
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**	**$771,488,712**	**$192,872,178**	**$6,727,589,056**
With Waiver Projections											
Residual DSH	$167,785,998	$679,083,062	*$675,602,811*	*$735,329,474*	*$713,152,789*	*$714,046,801*	*$782,646,681*	*$786,082,444*	*$746,229,087*	*$186,609,343*	*$6,186,568,490*
St. Louis ConnectCare	*$4,850,000*	*$18,150,000*	*$14,879,909*	*$3,148,648*	*$118,489*	*$0*	*$0*	*$0*	*$0*	*$0*	*$41,147,045*
Grace Hill Neighborhood Health Centers	*$1,462,500*	*$5,850,000*	*$5,071,706*	*$5,016,507*	*$6,073,656*	*$5,648,970*	*$5,428,968*	*$5,621,883*	*$5,465,781*	*$1,358,412*	*$46,998,383*
Myrtle Davis Comprehensive Health Centers	*$937,500*	*$3,750,000*	*$3,097,841*	*$2,108,161*	*$1,838,040*	*$2,157,443*	*$2,409,307*	*$2,578,102*	*$2,506,516*	*$622,945*	*$22,005,854*
Contingency Provider Network	*$0*	*$0*	*$379,372*	*$4,254,902*	*$5,469,199*	*$3,937,955*	*$5,188,923*	*$5,378,626*	*$5,208,595*	*$1,293,225*	*$31,110,798*
Voucher	*$0*	*$0*	*$0*	*$4,541,262*	*$6,358,786*	*$6,926,811*	*$8,620,673*	*$8,530,685*	*$8,289,789*	*$2,048,828*	*$45,316,835*
Infrastructure	$0	$0	$975,000	*$1,925,000*	*$0*	$0	$0	$0	$0	$0	*$2,900,000*
SLRHC Administrative Costs	$75,000	$300,000	$300,000	*$300,000*	*$75,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$1,050,000*
SLRHC Administrative Costs Coverage Model			$584,155	*$4,328,950*	*$3,692,463*	$3,098,002	*$3,820,212*	*$3,901,641*	*$3,788,944*	*$939,425*	*$24,153,794*
CRC Program Administrative Costs	$91,684	$700,000	$700,000	*$700,000*	*$175,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$2,366,684*
Actual expenditures for DY3 DOS				$2,670,607	*$33,308*	*$0*	*-$83*	*$0*	*$0*	*$0*	*$2,703,832*
Actual expenditures for DY4 DOS				$0	*$2,540,653*	*$6,559*	*-$3,797*	*$0*	*$0*	*$0*	*$2,543,415*
Actual expenditures for DY5 DOS						*$2,402,336*	*$101,651*	*$0*	*$0*	*$0*	*$2,503,987*
Projected expenditures for DY6 DOS							*$1,564,534*	*$0*	*$0*	*$0*	*$1,564,534*
Actual expenditures for DY6 DOS							*$2,316,311*	*$0*	*$0*	*$0*	*$2,316,311*
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**	**$771,488,712**	**$192,872,178**	**$6,415,249,963**
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	$312,339,093
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	$29,446,700	$26,010,937	$25,259,625	$6,262,835	$228,681,473
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$7,416,684	$28,750,000	$28,691,815	$28,866,847	$26,304,620	$25,650,027	$25,468,083	$26,010,937	$25,259,625	$6,262,835	$217,049,393

*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 2014 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

Assumptions for 2018 Extension:

1. **The benefit package remains the same as last year.**
2. **The blended match rate for FFY 2018 is the same as FFY 2017 of 63.23% (rounded)**

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

Appendix V

Public Notice Concerning
Missouri's Gateway to Better Health Section 1115 Demonstration Project
Number: 11-W-00250/7

The State of Missouri, Department of Social Services (DSS), hereby notifies the public it is considering requesting a one-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2017. A copy of the demonstration extension application under consideration may be found at http://dss.mo.gov/mhd/. We are providing this notice pursuant to Centers for Medicare & Medicaid Services (CMS) requirements in 42 C.F.R. 431.408.

The Gateway to Better Health Demonstration is designed to provide coverage to low-income adults residing in St. Louis City and St. Louis County who do not qualify for Medicaid. The State is considering requesting the authority to continue funding expenditures for primary and specialty care services provided to uninsured individuals, ages 19 through 64, with family incomes between 0 and 100 percent of the Federal poverty level (FPL). Should the State opt to expand Medicaid during the extension period, the Demonstration will terminate.

Public Comments and Hearings

The public is invited to review and comment on the State's proposed waiver extension request. The full public notice document for the Gateway to Better Health Waiver extension request can be found at http://dss.mo.gov/mhd/ under Alerts and Notifications. Appointments may be made to view a hard copy of the full public notice document, as well as a draft of the extension application, by calling 314-446-6454, ext. 1011. Appointments may be made during regular business hours, 8:00 a.m. - 4:30 p.m., Monday through Friday. Appointments to view the documents will take place at 1113 Mississippi Avenue, St. Louis, MO 63104.

Written Comments will be accepted thru October 26, 2016. Comments may be sent to:

Department of Social Services, MO HealthNet Division
Attention: Gateway Comments
P.O. Box 6500
Jefferson City, MO 65102-6500
Ask.MHD@dss.mo.gov

Public hearings are scheduled for:

Monday, October 3, 2016, 9-10AM*
St. Louis County Department of Public Health
6121 N. Hanley Road
Berkley, MO 63134

Wednesday, October 5, 2016, 3:30-4:30PM*
Forest Park Visitor and Education Center,
Voyagers Room
595 Grand Drive St. Louis, MO 63112

** Individuals wanting to participate in the public hearing via conference call may dial 888-808-6929, access code: 9158702.*

Appendix VI

Public Notice of
Missouri's Application to Extend the
Gateway to Better Health Demonstration Project
Section 1115 Demonstration (Number: 11-W-00250/7)

September 23, 2016

The State of Missouri, Department of Social Services (DSS), hereby notifies the public it is considering requesting a one-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2017. A copy of the draft Demonstration extension application may be found at http://dss.mo.gov/mhd/. We are providing this notice pursuant to Centers for Medicare and Medicaid Services (CMS) requirements in 42 C.F.R. § 431.408.

DSS is considering a proposal that Gateway's "Safety Net Pilot Program" be extended for a period up to one year. The original goal of the Demonstration was to preserve the St. Louis City and St. Louis County safety net of health care services for the uninsured until a transition to health care coverage became available. At this time, Missouri has not yet opted to implement Medicaid expansion under the Affordable Care Act. Therefore, the extension under consideration would request to continue to provide access to services for the uninsured in St. Louis City and County. The State is considering requesting renewal of covered services to individuals with income below 100% of the federal poverty level. Should the State opt to expand Medicaid during the extension period, the Demonstration will terminate.

I. Program Description and Goals

On July 28, 2010, CMS approved the State of Missouri's "Gateway to Better Health" Demonstration, which 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;
II. Transition the "St. Louis model" to a coverage model as opposed to a direct payment model by July 1, 2012;
III. Connect the uninsured and Medicaid populations to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement;
IV. Maintain and enhance quality service delivery strategies to reduce health disparities; and
V. For the first two years of the Demonstration, ensure that there is a 2 percent increase in the number of uninsured persons receiving services at St. Louis ConnectCare, Affinia Healthcare (formerly known as Grace Hill) and Myrtle Hilliard Davis Comprehensive Health Centers.

For the first two years of the Demonstration, certain providers were paid directly for uncompensated care. These providers included St. Louis ConnectCare, Affinia Healthcare (formerly known as Grace Hill) and Myrtle Hilliard Davis Comprehensive Health Centers. As of July 1, 2012, the program transitioned to a coverage model.

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 care and specialty care through a coverage model.

The Pilot Program is designed to provide primary, urgent and specialty care coverage to uninsured[3] adults in St. Louis City and St. Louis County, aged 19-64, who are below 100 percent of the FPL through a coverage model known as Gateway to Better Health. The Demonstration also includes a performance and incentive structure for the primary care providers and tracks health outcomes.

Under the Demonstration, the State has authority to claim as administrative costs limited amounts incurred for the functions related to the design and implementation of the Demonstration pursuant to a Memorandum of Understanding with the St. Louis Regional Health Commission (SLRHC), which is a non-profit, non-governmental organization whose mission is to 1) increase access to health care for people who are medically uninsured and underinsured; 2) reduce health disparities among populations in St. Louis City and County; and 3) improve health outcomes among populations in St. Louis City and County, especially among those most at risk.

This Demonstration Project and the funding mechanisms that preceded it have been critical to maintaining and improving access to health care for uninsured individuals in St. Louis City and County since the closure of the city's last remaining public hospital in 1997.

CMS offers additional information about Section 1115 waivers generally and the Gateway waiver specifically at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

During the extension period, the State proposes to continue the Demonstration, until such time as Missouri's Medicaid eligibility is expanded to include the waiver population, or up to one year, whichever is first.

During this extension of the Demonstration, the State, SLRHC and providers will continue to demonstrate how coverage and access to preventative care cost-effectively improves the health of a low-income population.

The objectives for the extension period of the Demonstration continue to be:

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 in Missouri under the Affordable Care Act;
II. Connect the uninsured population 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.

[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.

II. Beneficiaries and Eligibility Criteria

Gateway to Better Health will continue to provide access to primary care, specialty care and urgent care and will continue to be available to individuals who meet the following requirements:

- A citizen of the United States; legal immigrant who has met the requirements for the five-year waiting period for Medicaid benefits; refugee or asylee under same immigrant eligibility requirements that apply to the Medicaid program
- A resident of St. Louis City or St. Louis County
- Ages 19 through 64
- Uninsured
- At or below the federal poverty level of 100%
- Not eligible for coverage under the federal Medicare program or Missouri Medicaid
- Patients with a primary care home at one of the in network primary care sites.

III. Delivery System

Gateway to Better Health services are provided through a limited provider network. Beneficiaries will continue to choose a primary care home in which to enroll. Primary care homes in the network include:

- BJK People's Health Centers
- Family Care Health Centers
- Affinia Healthcare (formerly known as Grace Hill Health Centers)
- Myrtle Hilliard Davis Comprehensive Health Centers
- St. Louis County Department of Public Health

Primary care provider organizations will continue to be paid under an alternative payment methodology.

For specialty care, beneficiaries may be referred by their primary care physician for specialty care services at a participating specialty care provider, including for physician inpatient services or outpatient hospital care. Specialty care providers will continue to be paid for on a fee-for-service basis for care provided to all Gateway beneficiaries.

IV. Benefits

Beneficiaries enrolled in Gateway to Better Health will continue to receive the following benefits:

> Preventative; wellcare; dental (diagnostic, preventive); internal and family practice medicine (up to 5 five urgent care visits); gynecology; podiatry, generic prescriptions dispensed at primary care clinics as well as brand name insulin and inhalers; cardiology; DME (on a limited basis); endocrinology; ENT; gastroenterology; neurology; oncology, radiation therapy, rheumatology, laboratory/pathology services; ophthalmology; orthopedics; outpatient surgery; physical, occupational or speech therapy (on a limited basis); pulmonology; radiology (x-ray, MRI, PET/CT scans); renal; urology; non-emergency medical transportation.

The State seeks to continue to provide all benefits currently approved for the Gateway to Better Health Demonstration. The final actuarial rates for the extension period will be established in 2016.

V. Cost Sharing

There is no premium for Gateway to Better Health. Beneficiary co-pays are the same as those for patients of Missouri Medicaid, MO HealthNet.

VI. Aggregate and Historical Budgetary and Expenditure Data

Under the current Demonstration, the State is authorized to spend up to $30 million (total computable) annually in lieu of spending that amount of statutorily authorized funding on payments to disproportionate share hospitals (DSHs). The extension application seeks authority for a total computable budget of $30 million (total computable) annually.

VII. Anticipated Changes in Enrollment

It is anticipated that approximately 21,400 individuals would be enrolled in Gateway to Better Health during the extension period. These projections are subject to change when additional actuarial analysis is conducted in the third quarter of 2017.

VIII. Waiver and Expenditure Authorities

It is anticipated the Waiver and Expenditure Authorities would include:

- **Demonstration Population 1:** Effective January 1, 2014, expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between the ages of 19-64 years of age with income up to 100 percent of the FPL to pay for primary care provided by a designated primary care provider or specialty care provider when referred by a designated primary care provider.
- **Expenditure for Managing the Coverage Model:** Effective January 1, 2014, expenditures pursuant to a memorandum of understanding and not to exceed $4,500,000 for costs incurred by the SLRHC to activities related to the continued administration of the coverage model during the extension period.

The state also seeks continued waivers of the following Medicaid requirements:

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

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

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary, to enable the State to establish an enrollment target and maintain waiting lists for the Demonstration population.

Amount, Duration and Scope **Section 1902(a)(10)(B)**

To the extent necessary, to permit the State to offer benefits that differ among the Demonstration population and that differ from the benefits offered under the Medicaid state plan.

Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary, to enable the State to mandatorily enroll the Demonstration population into a delivery system that restricts free choice of provider.

Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary, to enable the State to not provide medical assistance to the Demonstration population prior to the date of application for the Demonstration benefits.

Payment for Services by Federally Qualified Health Centers (FQHCs) **Section 1902(a)(15)**

To the extent necessary, to enable the State to make payments to participating FQHCs for services provided to Demonstration Population using reimbursement methodologies other than those required by section 1902(bb) of the Act to the limited nature of the benefits.

IX. Evaluation of the Gateway to Better Health Demonstration

The State intends to measure progress against the Demonstration objectives throughout the Demonstration and during the extension period. Interim evaluation activities to date indicate that all Demonstration objectives have been met or significant progress can be demonstrated. Additional activities will evaluate whether or not the coverage model proves out the following hypothesis:

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.

X. Public Notice and Input Process

The public is invited to review and comment on the State's proposed waiver extension request.

A draft of the Gateway to Better Health Waiver extension request can be found at http://dss.mo.gov/mhd/. Appointments may be made to view a hard copy of the draft of the extension application by calling 314-446-6454, ext. 1011. Appointments may be made during regular business hours, 8:00 a.m. - 4:30 p.m., Monday through Friday. Appointments to view the documents will take place at 1113 Mississippi Avenue, St. Louis, MO 63104.

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** Individuals wanting to participate in the public hearing via conference call may dial 888-808-6929, access code: 9158702.*

The State and the St. Louis Regional Health Commission will accept verbal and written comments at the public hearings. The outcome of this process and the input provided will be summarized for CMS upon submission of the notification of request for Demonstration extension.

On June 21, 2015, a public hearing was held to inform the public on the progress of the Gateway demonstration, in compliance with 42 C.F.R. § 431.420(c). This meeting was held as part of the regularly scheduled Community Advisory Board of the St. Louis Regional Health Commission. Approximately, 22 people attended the meeting. 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 success to date.

Appendix VII

Post-Award Public Input Forum Notice
Public Hearing Concerning Missouri's Gateway to Better Health Section 1115 Demonstration Project Number: 11-W-00250/7

On December 11, 2015, The State of Missouri, Department of Social Services (DSS), received a one-year extension of its Gateway to Better Health Demonstration from the Centers for Medicare and Medicaid Services (CMS). The Gateway to Better Health Demonstration provides coverage for certain outpatient care to low-income, uninsured adults residing in St. Louis City and St. Louis County who do not qualify for Medicaid.

Under the terms of the extension, Gateway to Better Health provides primary and specialty care services to uninsured individuals, ages 19 through 64, with family incomes below 100 percent of the Federal poverty level (FPL). The program was originally approved in July 2010 and currently is scheduled to expire on December 31, 2016.

Hearing

The public is invited to comment on the progress of the demonstration at a public hearing scheduled for

Tuesday, June 21, 2016
8:30 – 10:00 AM
Employment Connection
2838 Market Street
St. Louis, MO 63103

This meeting is part of the regularly scheduled Community Advisory Board meeting of the St. Louis Regional Health Commission (SLRHC).

NOTE: The most current extension period is set to begin January 1, 2017 and expire on December 31, 2017. Given the date of submission for the 2018 extension application, the post award public hearing for 2017 has not yet been scheduled. The hearing will be held within six months of implementation or before June 30, 2017. The date of the post award public notice hearing will be provided in future reports to CMS.