"Gateway to Better Health"
Final Pilot Plan
June 16, 2011
Number: 11-W-00250/7

Introduction

On July 28, 2010, Missouri's request for a section 1115 demonstration project, entitled "Gateway to Better Health," was approved. This demonstration project will provide financial support to St. Louis ConnectCare, Grace Hill Health Centers (formerly named Grace Hill Neighborhood Health Centers), and Myrtle Hilliard Davis Comprehensive Health Centers for two years until June 30, 2012. Beginning July 1, 2012, a pilot program will be implemented to enroll low-income, uninsured individuals who are not currently eligible for Medicaid into a health care coverage model. Additionally, for all years of the Demonstration, administrative support for the St. Louis Regional Health Commission and the St. Louis Integrated Health Network's Community Referral Coordinator (CRC) program will be provided.

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

This document specifically meets the requirements of milestone #3 (pilot program plan) listed on pages 19, 20 and 21 of the Special Terms and Conditions.

Background

"Gateway to Better Health" Demonstration Project

Approved on July 28, 2010, 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;
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, Grace Hill Health Centers, and Myrtle Hilliard Davis Comprehensive Health Centers.

As mentioned above, by July 1, 2012, the State must implement a pilot program, subject to review and approval by CMS, whereby it will provide a defined health coverage benefit to uninsured individuals residing in St. Louis City and St. Louis County with family income at or below 133 percent of the Federal poverty level (FPL). Only persons who do not meet the eligibility requirements of the Medicaid State plan are eligible for the Demonstration. The goal of the pilot program is to bridge to the implementation of health care reform by preparing the safety net providers and uninsured individuals served by the safety net providers in St. Louis City and St. Louis County for the coverage options available under health reform by January 1, 2014.

Organizational Structure

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

St. Louis Regional Health Commission

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

Roles for the RHC under the Demonstration include:

- Serving as the Fiscal Agent for diverted DSH (July 2010 – June 30, 2012)
- Creating a plan for implementation of a pilot coverage program (draft plan due January 2011, final plan due July 2011)
- Creating an operational plan to implement the pilot program
- Collecting data and making funding recommendations for $24 million allocation to Affiliation Partners in 2011
- Providing ongoing support of the St. Louis Integrated Health Network's Community Referral Coordinator (CRC) program to ensure transparency and community involvement
- Developing a pilot program planning team and staffing team to meet deliverable timeline
- Other roles TBD pending creation and approval of plans to implement the demonstration project's Special Terms and Conditions

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

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

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

Situation Analysis

History of the "St. Louis Model"

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.

The RHC was established under this prior 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 RHC is charged with improving health care access and delivery to the uninsured and underinsured in the St. Louis region. The Commission works within a large network that includes St. Louis County and its public health department and area Federally Qualified Health Centers (FQHCs) and hospitals. The St. Louis Integrated Health Network's Community Referral Program and three "Affiliation Partners" are supported with the funds of this Demonstration Project. These are:

St. Louis ConnectCare, formed in 1997 to provide needed ambulatory services to primarily uninsured and low-income populations who received healthcare through the St. Louis Regional Medical Center integrated health system. In 2005, St. Louis ConnectCare transferred (or "affiliated") its primary care clinics to Grace Hill Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers and focused exclusively on building an accessible specialty and diagnostic care network to support patients who utilize the community-based health centers as their medical home. St. Louis ConnectCare has been transformed to provide specialty health care and urgent care services to the uninsured since St. Louis Regional Medical Center closed.

Primary care physicians from the FQHCs, the St. Louis County primary care clinics, and local community-based volunteer health care clinics refer patients for one or more of thirteen medical and surgical specialties, five radiological modalities, and/or endoscopic procedures in the region's only stand-alone ambulatory surgical center available to all, regardless of ability to pay. If an uninsured patient needs care beyond those that St. Louis ConnectCare directly provides, the Utilization Management Department arranges for advanced diagnostics (MRI, PET, MRA, etc.) procedures and limited hospital services under a voucher system to pay for diagnostic procedures and physician services in a hospital setting.

Grace Hill Health Centers, an FQHC that operates six community health centers strategically located to be accessible to low-income and uninsured residents in St. Louis' medically underserved neighborhoods. The centers are staffed and equipped to provide comprehensive primary and preventive health care. In addition, community health services provided include prenatal and pediatric case management by skilled community health nurses and nurse assistants and an extensive chronic disease management program that uses health coaches to help patients achieve an improved health status. Through health outreach, neighbors are trained to help neighbors access health care services. Two of the Grace Hill Health Centers, formerly ConnectCare primary care clinics, receive funding through the Demonstration Project. The former ConnectCare primary care clinics transferred to Grace Hill are referred to as "legacy

clinics." The legacy clinics operated by Grace Hill are the Murphy O-Fallon Health Center and the Soulard-Benton Health Center.

Myrtle Hilliard Davis Comprehensive Health Centers, an FQHC that operates three community health centers that are located in St. Louis' medically underserved areas. Services are comparable to those offered at other FQHCs. Two of the community health centers, formerly ConnectCare primary care clinics, receive funding through the Demonstration Project. The former ConnectCare primary care clinics transferred to Myrtle Hilliard Davis are referred to as "legacy clinics." The legacy clinics operated by Myrtle Hilliard Davis are the Homer G. Phillips Health Center and the Florence Hill Health Center.

St. Louis Integrated Health Network (IHN), Community Referral Coordinator Program, a 501 c3 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 uninsured and underinsured through increased integration and coordination of a safety net of health care providers. Members of the IHN include Grace Hill Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, Betty Jean Kerr People's Health Centers, Family Care Health Centers, Saint Louis ConnectCare, St. Louis County and St. Louis City Departments of Health, Washington University School of Medicine and Saint Louis University School of Medicine. The St. Louis Regional Health Commission and Missouri Primary Care Association serve as technical advisors to the IHN. The Community Referral Coordinators employed by the IHN work with uninsured individuals who present at emergency rooms to educate patients on available resources for primary, non-emergent care, to schedule follow up appointments with primary care providers, and arrange transportation to appointments. These services are coordinated with individuals while they are in the emergency room.

As stated in the Special Terms and Conditions of the Demonstration Project, the State of Missouri with the support of the St. Louis Regional Health Commission, is in the process of transitioning the "St. Louis model," which provides funding to the aforementioned "Affiliation Partners," to a coverage model as opposed to a direct payment model by July 1, 2012.

Pilot Planning

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

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

The team is composed of the following members:

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

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

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

Melody Eskridge
President and Chief Executive Officer, St. Louis ConnectCare

Alan Freeman
President and Chief Executive Officer, Grace Hill Health Centers

Dolores Gunn, MD
Director, St. Louis County Department of Health

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

Ian McCaslin, MD, MPH
Director, MO HealthNet Division, Department of Social Services, State of Missouri

James Sanger
President and Chief Executive Officer, SSM Health Care St. Louis

Joanne Volovar
President, Molina Healthcare of Missouri

Joe Yancey
Executive Director, Community Alternatives

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

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

In addition to these team members, the RHC staff has sourced actuarial consultants to facilitate the data analysis necessary to build the Pilot Plan. Following a thorough selection process, the RHC hired Wakely Consulting Group for this work. The Wakely team has and currently works with the Commonwealth Care plans in Massachusetts. Their experience in providing an insurance product to the uninsured, specifically those below the federal poverty level, is particularly relevant to this project. In addition, their work with Massachusetts provides access to data that can be used to predict the utilization of a population receiving covered benefits.

From August 2010 through June 2011, the Pilot Program Planning Team met seventeen times to review and make key decisions necessary to complete the first four deliverables of the Demonstration Project, including the Strategic Plan, Draft Evaluation Design, Draft Pilot Plan, and this document the Pilot Plan. This document is outlined as a key deliverable and milestone of the Demonstration Project in Section XIII of the Special Terms and Conditions.

The Community's Perspective

As part of the planning process, the St. Louis Regional Health Commission interviewed patients and medical professionals to ensure their input was considered in the design of the Draft Pilot Plan. RHC staff members interviewed 30 patients and 6 physicians.

Patients were asked to comment about how they currently use the healthcare services provided at the health centers as well as other providers in town; how a coverage model may change how they use services; what benefits they would like to have access to through a coverage model; and how they would like to receive information about this coverage model.

Physicians were asked to comment on which populations would be best served by a coverage model; which barriers to access should be considered in the design of the pilot; what benefits should be included; anticipated changes in utilization with coverage; and potential challenges in enrolling patients and encouraging them to utilize their benefits.

Youth aging out of Medicaid represent one of the target populations for the Demonstration. To ensure their input was considered in the design of the Pilot Program. RHC staff conducted a focus group with members of the SPOT, a local drop-in and health services center for youth. Approximately twenty-one youth between the ages of 16 and 22 participated in the focus group session.

The RHC also made a survey available for the general public to complete. The RHC received more than 100 responses to the survey.

A complete report from the outreach activities is attached (Appendix I). In summary,

Patients reported the following:

- Dental is a critical and difficult service for them to access and pay for. Almost unanimously, they reported that dental should be included as a benefit.
- Because they are uninsured, they are fearful of going to a hospital for care, knowing they cannot afford to pay for the care.
- With coverage they would be inclined to visit more often, especially if their out-of-pocket cost was less than it is today. (76 percent of survey respondents said they would go to the doctor more often if they had insurance.)
- Youth reported customer service is critical for them to determine where and if they will receive health care services. They want the provider organization to be "comfortable and welcoming." They also do not want to overcome a lot of requirements in order to receive care.

Physicians reported the following:

- A defined coverage plan could most benefit those who suffer from a chronic illness(es). Some physicians mentioned the most prevalent conditions as: diabetes, high blood pressure, COPD and asthma.
- Preventative care (e.g. mammography, colonoscopy, nutrition counseling) should be covered at a very low cost to encourage people to receive this care.
- Transportation is a barrier for many patients to get to their appointments as well as to regularly fill their prescriptions.

- Varying degrees of concern exist about access to pharmaceuticals for patients. Some report the low-cost retail programs, the low-cost pharmaceuticals provided at the health centers, and the prescription assistance programs, meet the needs of most of their patients. Others report that even with these programs, some patients report they are unable to afford their medications.
- Dental is not top-of-mind as a critical benefit among primary care physicians, but when asked, they say it is very important to their patients. Many report that patients need recurring doses of antibiotics to take care of dental infections because patients report they are unable to see/afford a dentist.

Populations Served

Per the Special Terms and Conditions, the following individuals will be eligible for the Pilot Program:

- 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 – 64
- Uninsured
- At or below the federal poverty level of 133 percent
- Not eligible for coverage under the federal Medicare program or Missouri Medicaid
- Patients with a primary care home at one of the four legacy sites (former ConnectCare clinics) that are now operated by Grace Hill or Myrtle Hilliard Davis.

In addition to these eligibility terms, the Pilot Program will specifically target: a) young adults who are aging out of Medicaid and are at risk of losing healthcare coverage and b) patients with chronic illness who may significantly benefit from coverage.

Defining a "Legacy" Patient
To ensure patients whose healthcare is currently funded through the Demonstration continue to receive this support during the Pilot Program, the health centers will attempt to first enroll existing patients (those patients who have received services at one of the legacy sites within the last twelve months). Other uninsured patients who choose one of the legacy sites as their primary care home also will be eligible for service, pending the availability of slots for patients as determined by the enrollment cap and wait list policy.

Outreach to new patients will begin after an initial outreach and enrollment period for existing patients. It is estimated that about 16,700 existing patients of the primary care legacy sites would be eligible for the Pilot Program. As detailed on Page 23, current projections indicate the Pilot Program will be able to cover, at a minimum, 17,034 lives with the full set of benefits detailed on Page 15. It is anticipated that outreach efforts to other uninsured individuals will help ensure enrollment targets are met.

In addition to the 16,700 patients receiving primary, specialty and urgent care through the Demonstration, another 19,800 uninsured patients from St. Louis City and County between the ages of 19 to 64 are receiving specialty and urgent care. Of these 19,800 patients, 9,498 are up to 133% of federal poverty level and 10,302 are between 134% and 200% of federal poverty level. These patients are referred to ConnectCare, one of St. Louis Regional Hospital's "legacy" sites, from primary care providers. More than 95% of these referrals come from members of the St. Louis Integrated Health Network; however, about 4% of the referrals for specialty care come from other primary care providers in the region. Members of the St. Louis Integrated Health Network include:

- Betty Jean Kerr People's Health Centers
- Family Care Health Centers
- Grace Hill Health Centers
- Myrtle Hilliard Davis Comprehensive Health Centers
- Saint Louis County Department of Health

The St. Louis Integrated Health Network (IHN) is a 501 c3 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 uninsured and underinsured through increased integration and coordination of a safety net of health care providers. Members of the IHN include Grace Hill Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, Betty Jean Kerr People's Health Centers, Family Care Health Centers, Saint Louis ConnectCare, St. Louis County and St. Louis City Departments of Health, Washington University School of Medicine and Saint Louis University School of Medicine. The St. Louis Regional Health Commission and Missouri Primary Care Association serve as technical advisors to the IHN.

Demonstration funds also cover uninsured patients who self-refer to the Smiley Urgent Care Center at ConnectCare.

The State recommends the Pilot Program provide specialty and urgent care benefits to uninsured adults, ages 19 to 64, who are not otherwise eligible for Medicaid or Medicare who reside in St. Louis City or St. Louis County, up to 200% FPL. It is estimated that an additional 19,800 individuals will receive the specialty and urgent care benefit. These individuals have few options for specialty and urgent care and will be provided access to coverage in 2014 through the coverage options outlined in the Affordable Care Act. Covering these individuals would provide a transition, ensuring access to care for them until 2014.

In summary, at least 17,034 individuals will receive primary, specialty and urgent care benefits. An additional, 19,800 individuals will receive specialty and urgent care benefits. These two groups of patients account for 70 percent of ConnectCare's patient base in fiscal year 2010, and approximately 72 percent of charges at ConnectCare for Fiscal Year 2010. Most of the remaining patients are insured by Medicare, Medicaid or through private insurance.

SLCC Experience in FY10

PatientGroup	Utilizers	Distribution of Utilizers	Distribution of Charges*
Medicaid	5,932	17%	14%
Medicare	1,860	5%	8%
Commercial	2,110	6%	4%
Union	93	0%	0%
Pilot-eligible**	24,109	70%	73%
Other Uninsured	555	2%	0%
Total	34,659	100%	100%

* Charges are based on the SLCC charge master.

** Includes people who received only voucher services.

Eligibility for other Demonstration Programs

Women covered by the State's Women's Health Services program will be eligible for the Pilot Program. However, the services received under the Women's Health Services program will not be covered under the Pilot Program for these patients. Women's health services benefits include: Department of Health and Human Services approved methods of contraception; family planning counseling/ education on various methods of birth control; diagnosis, testing and treatment of a sexually transmitted disease found during a family planning visit including pap tests and pelvic exams; and drugs, supplies, or devices related to women's health services described above that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements).

Provider Network

Provider Organizations

The Special Terms and Conditions outline that "at a minimum," the provider network includes the following entities:

- St. Louis ConnectCare
- Two legacy clinics operated by Myrtle Hilliard Davis Comprehensive Health Centers:
    - Homer G. Phillips Health Center
    - Florence Hill Health Center
- Two legacy clinics operated by Grace Hill Health Centers:
    - Murphy O'Fallon Health Center
    - Soulard-Benton Health Center

It is the State's intent to provide as many eligible individuals as possible a basic set of medical services. For this Pilot Plan, the budget was developed using the services provided by the minimum provider network.

At this time, the State recommends adding to the provider network, on a contingency basis, members of the St. Louis Integrated Health Network who provide health care services in St. Louis City and St. Louis County. These organizations would only be added to the provider network if one of the following scenarios occurred:

- The Demonstration budget allows for a greater number of individuals to be covered than what the minimum provider network can enroll and serve
- Benefits are not available at the minimum provider network, or service level targets are not met per the terms of Service Level Agreements to be developed as part of the operations planning

The entities that would qualify as potential contingency providers include the following members of the St. Louis Integrated Health Network:

- Betty Jean Kerr People's Health Centers
- Family Care Health Centers
- Grace Hill Health Centers (non-legacy clinics)
- Myrtle Hilliard Davis Comprehensive Health Centers (non-legacy clinics)
- Saint Louis County Department of Health
- Saint Louis University School of Medicine
- Washington University School of Medicine

The St. Louis Integrated Health Network (IHN) is a 501 c3 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 uninsured and underinsured through increased integration and coordination of a safety net of health care providers. Members of the IHN include Grace Hill Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, Betty Jean Kerr People's Health Centers, Family Care Health Centers, Saint Louis ConnectCare, St. Louis County and St. Louis City Departments of Health, Washington University School of Medicine and Saint Louis University School

of Medicine. The St. Louis Regional Health Commission and Missouri Primary Care Association serve as technical advisors to the IHN.

Provider/Medical Professionals

The medical professionals at the affiliation partners currently treating the eligible population are detailed in the following list. It is not anticipated that the covered professionals will be different from what is detailed here.

FQHC Providers:
Doctors (MD, DO)
Dentists (DDS, DMD)
Nurse Practitioners (NP, FNP-BC, WHNP)
Podiatrists (DPM)
Optometrists (OD)
Certified Nurse Midwives (CNM, FNP)
Social Workers (MSW, LCSW)
Nurse Administrators (MSN, FNP-BC)
Dietitian (MS RD)
Dental Hygienists (RDH)
Nurses (RN)

ConnectCare Providers:
Specialty Care Physicians
-Gastroenterologists
-Cardiologists
-Nephrologists
-General Surgeons
-Neurologists
-Endocrinologists
-Urologists
-Orthopedists
-Dermatologists
-Rheumatologists
-Otolaryngologists
-Pulmonologists
Urgent Care Providers
Radiologists
Ambulatory Surgical Center Providers

Utilization Management

It is anticipated that demonstration-eligible individuals will need a referral from their primary care physician at one of the community health centers to access specialty care services. Also, a utilization management department will review and approve services not offered at ConnectCare. These policies will help manage the fixed budget of the Demonstration Project. These same policies exist today.

Covered Benefits

The Pilot Program will cover the benefits outlined in the Special Terms and Conditions. These benefits include: preventative, wellcare, dental, pharmacy, durable medical equipment, oncology, rheumatology, cardiology, endocrinology, ENT, gastroenterology, internal medicine, neurology, ophthalmology, orthopedics, pulmonology, renal, urology, and outpatient surgery.

The dental, pharmacy and durable medical equipment benefits need to be further defined to ensure the program is able to operate within budget parameters. The State proposes offering the following dental services: diagnostic, periodontal, preventive, prosthodontics and the removal of erupted teeth; offering essential DME items such as oxygen; and offering pharmacy coverage for generic drugs.

The state determined it was necessary to limit the pharmacy benefit to generic drugs to enable patients to qualify for Prescription Assistance Programs offered by pharmacy manufacturers. Today, many of the health center patients rely on these programs to receive brand name drugs for free or at low cost. It is anticipated that the patients who qualify for the Pilot Program will continue to qualify for free or low-cost brand name medications through the Prescription Assistance Programs. If the Pilot Program covered brand name drugs, patients would not qualify for many of the Prescription Assistance Programs they use today.

The Demonstration funds currently do not finance mental health, behavioral health or substance abuse services. As a result, these will not be part of the benefits package during the Pilot in order to manage fixed budget requirements. Today, if health center patients need these services, the State of Missouri provides a network of services through the Department of Mental Health and its Administrative Agents in the Eastern Region.

In addition to the benefits described in the Special Terms and Conditions, the state recommends the following benefits should be included in the Pilot Program: laboratory/pathology services, radiology, podiatry, transportation, and physical, occupational and speech therapy benefits limited to those services required after covered surgical procedures (e.g., after knee replacement surgery).

It is anticipated that the benefits package will be offered in two parts as described below:

> ***Tier 1 Benefits: Preventative; wellcare; dental (diagnostic, periodontal, preventive, prosthodontics and the removal of erupted teeth); internal and family practice medicine; gynecology; generic prescriptions dispensed at primary care clinics***
>
> ***Tier 2 Benefits: 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); podiatry; pulmonology; radiology (x-ray, MRI, PET/CT scans); renal; urology; urgent care; transportation; and generic prescriptions dispensed at an urgent care or specialty care clinic***

Eligible patients who choose a medical home at one of the primary care clinics in the provider network will receive Tier 1 and Tier 2 benefits. Eligible patients referred by other primary care providers for specialty care, or eligible patients who self-refer to the Smiley Urgent Care Center at ConnectCare will

receive Tier 2 benefits. (The eligibility and enrollment of those patients who only qualify for Tier 2 benefits will be detailed in the Operations Plan.)

Management of Voucher Services

Patients with Tier 2 benefits also will be eligible for limited benefits administered through a "voucher" program as funding allows. (Actuarial modeling has included projections for anticipated voucher utilization during the Pilot.) The benefits covered under the voucher program include physician fees for inpatient care, physician and hospital services for outpatient care, and physician fees for emergency room services. These vouchers are administered when a benefit is not available through the covered provider network. Today, examples include oncology and outpatient surgeries not available at ConnectCare.

Those eligible for the voucher program will have established eligibility for Tier 2 benefits, which means they will be uninsured residents of St. Louis City or County, between the ages of 19 and 64, and below 200% of FPL. To receive the benefit, the patient will have been referred from an eligible community health center authorizing the service within the past 12 months from the date of the request. The service must be deemed medically necessary by the Pilot Program's utilization management process, which will be detailed in the operations planning.

Cost Sharing Strategies

The Special Terms and Conditions outline that co-pays for the Pilot Project should be the same as those for patients of Missouri Medicaid, MO Health Net. The following details the current co-pays for enrollees of the Missouri Medicaid Fee for Service plan:

$10.00 Inpatient Hospital per Hospitalization
$ 3.00 Outpatient Services
$ 1.00 Physician Services
$ .50 Clinic Services
$ 1.00 X-ray and Laboratory Services
$ 1.00 Nurse Practitioner Services
$ .50 CRNA Services
$ 2.00 Rural Health Clinic Services
$ 1.00 Case Management Services
$ 2.00 Federally Qualified Health Center Services
$ 2.00 Psychology Services

For Dental, Optical and Podiatry services, the following co-payments apply based on the provider's billed amount:

$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

Exemptions to Co-pay Requirements include:

- Emergency admissions or transfer inpatient admissions;
- Emergency services provided in an outpatient clinic or emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
    - Placing the patient's health in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part;
- Certain therapies - chronic renal dialysis, physical, radiation, and chemotherapy;
- Mental Health services provided by community mental health facilities operated by the Department of Mental Health or designated by the Department of Mental Health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system;
- Family planning services;
- Hospice services;
- NEMT public transit and gas reimbursement modes of transportation.

Under current pharmacy dispensing fee policy all Missouri Medicaid eligible participants are subject to the fee requirement when provided covered pharmacy services, with the exception of the following, which are excluded:

- Participants under age 19;
- Institutionalized participants who are residing in a skilled nursing facility, a psychiatric hospital, a residential care facility or an adult boarding home;
- Foster care children up to 21 years of age;
- All Medicare/Medicaid crossover claims as primary coverage;
- Those drugs specifically identified as relating to family planning services;
- Emergency services; and
- Services provided to pregnant women, which are directly related to the pregnancy or complication of the pregnancy

Pharmacy Dispensing Fees

The Missouri Medicaid pharmacy fee requirement is considered a portion of the professional dispensing fee and is *not* deducted from reimbursement to providers.

Ingredient Cost for Each Prescription	**Member Fee Amount**
0 - $10.00	$0.50
$10.01 - $25.00	$1.00
$25.01 – higher	$2.00

The co-pays listed above represent the entire proposed cost for patients of the Pilot Program. These thresholds will ensure the total annual aggregate amount of Demonstration cost sharing, Medicaid cost sharing, and CHIP premiums and cost sharing do not exceed 5 percent of family income for the year involved. Family income is determined under the methodology applicable to the group under the state's Medicaid plan.

Providers of service *must* charge and collect the copay or coinsurance amount. *Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the participant's inability to pay the fee when charged*. A participant's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant's liability to pay the amount due.

As a basis for determining whether a participant is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant's statement of inability to pay at the time the charge is imposed.

Provider Payment Strategies

To determine the appropriate payment methodologies that will meet the objectives of the Demonstration Project and the Pilot Plan as outlined in both the Special Terms and Conditions as well as the Evaluation design, the Pilot Program Planning Team evaluated a spectrum of methodologies from capitation to fee-for-service based on the following criteria:

I. Align payment model to goals of the demonstration project
    a. Services to be obtained in appropriate setting (Community Health Center vs ConnectCare vs Hospital ED)
    b. Maintain and enhance quality service delivery to target population
    c. Transition current block-grant reimbursement to coverage model
II. Ensure access is maintained or enhanced for uninsured patients
III. Provide ability to remain within programmatic budget parameters
IV. Relatively easy to implement and administer
V. Cost-effective to implement and maintain
VI. Create "glidepath" to stakeholders to the implementation of PPACA in 2014

Primary Care Provider Organizations

The Pilot Program Planning Team has determined that for primary care provider organizations, in this case the community health centers, a capitated model with potential for pay-for-performance incentive payments best meets the objectives of the Demonstration Project and the Pilot Program. The per-member-per month rate will be paid to the health center where the member enrolls. The rate will be set based on historic utilization and risk adjusted based on age, sex and chronic conditions of current eligible patients. The rate will cover services provided at the community health centers or currently contracted out, such as laboratory services.

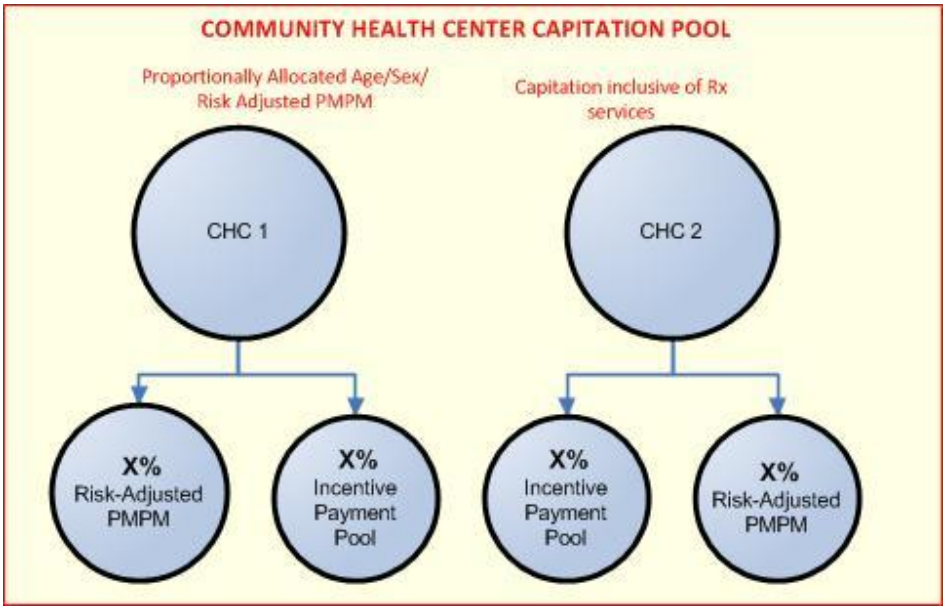
The health centers will be paid a percentage of their total per-member-per month rate and another percentage will be withheld and paid out in whole or part every six months of the pilot when certain clinical measures are attained. These percentages will be finalized as part of the operations planning. It is anticipated they will be provided in the Draft Operations Plan, due October 1, 2011.

In addition, the health centers will be required to submit utilization data on a monthly basis. This information will make them eligible for additional funds from a contingency fund if the utilization data demonstrates the need exists. The amount of the contingency fund will be finalized as part of the operations planning. The contingency fund will be limited due to the limited budget of the Demonstration. The contingency fund is designed to fund at a conservative level unanticipated changes in patient behavior and referral patterns of primary care physicians for specialty care, prescriptions and diagnostic services. The contingency budget enables the Pilot Program to make limited adjustments for the actual behaviors of patients and physicians during the program. It also provides flexibility in responding to potential cash flow issues, which may arise during a transition from a block grant model to a coverage model.

Paying the primary care provider organizations on a capitated basis will minimize the administrative cost of the program, making more funds available for direct patient care, while incenting the health centers

to provide quality care and to transition to a model where they are reimbursed for services rendered rather than by direct block grant funding.

Illustration 1: Primary Care Payment Methodology



Community Health Center Pay-for-Performance Incentive Eligibility

It is anticipated that pay-for-performance incentive payments will be paid out at six-month intervals of the Pilot Program. Following are the proposed criteria for the community health center's first incentive payments (anticipated to be paid within 30 days of receipt of data for the period of July 1, 2012 – December 31, 2012):

Pay-for-Performance Incentive Criteria	Threshold	Weighting
All Patients Enrolled As of 7/1/2012 - Minimum of at least 1 office visit (including a health risk assessment and health and wellness counseling) within the first 6 months following enrollment	80%	20%
Patients with Diabetes, Hypertension, CHF or COPD – 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	80%	20%
Patients with Diabetes - HgbA1c and LDL testing performed within the first 4 months following the latter of either: a) initial enrollment, or b) initial diagnosis	85%	20%
Patients with Diabetes – percentage of diabetics who have a HgbA1c <8% within 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	60%	20%
Hospitalized Patients - percentage of hospitalized enrollees who have a follow-up primary care encounter w/i 14 days of hospital discharge	90%	20%
TOTAL POSSIBLE SCORE		**100%**

Specialty Care Provider Organizations

Today, St. Louis ConnectCare provides a significant proportion of the specialty care and diagnostic services to the St. Louis region's uninsured. ConnectCare outsources certain specialty physician and ancillary services to contracted providers (ex: MRI, outpatient surgery, certain clinical labs, medical oncology services, etc) and provides patients "vouchers" to access care provided by these other providers. In addition, ConnectCare operates an urgent care center that all patients of the St. Louis region's safety net or those without a medical home may use.

In evaluating potential payment methodologies, the State has determined that for those patients with Tier 1 and Tier 2 benefits, specialty and urgent care will be based on a capitation model which will include a base cap rate combined with a pay-for-performance incentive payment opportunity. The pay-for-performance incentive payment will be based on achieving specified goals for the following:

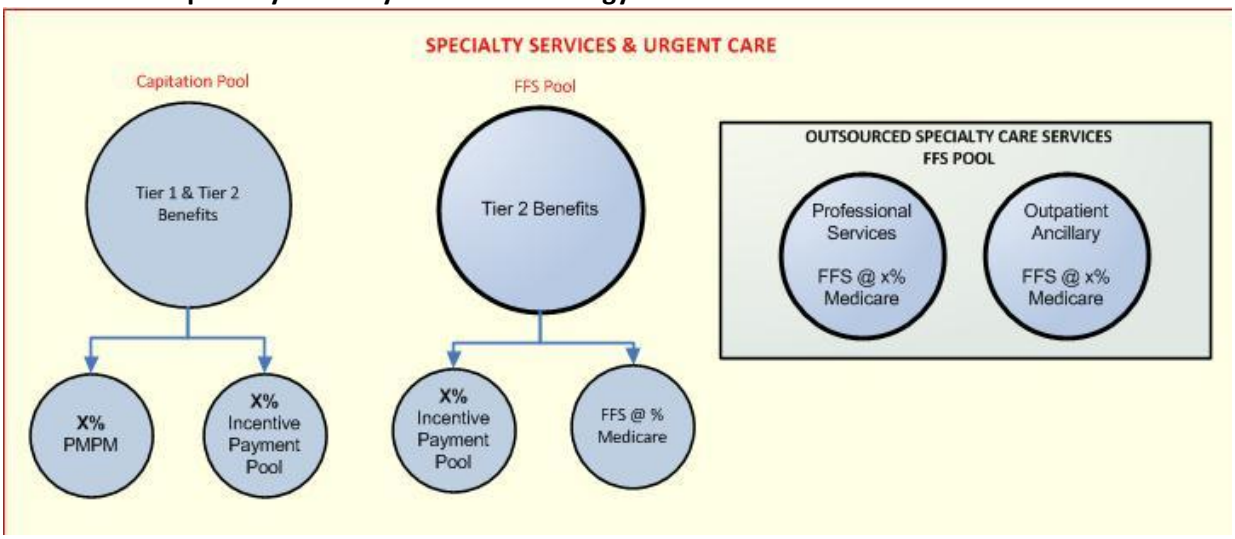
- Timely patient access as measured by appointment wait times
- Referring physician satisfaction
- Timely, accurate filing of patient encounters and claims data

For those patients with Tier 2 benefits only, specialty and urgent care reimbursement will be based on a fee-for-service methodology at a percentage of Medicare with a base payment combined with a pay-for-performance incentive payment opportunity. The pay-for-performance incentive payment will be based on achieving specified goals for the following:

- Timely patient access as measured by appointment wait times
- Referring physician satisfaction

In addition, for those outsourced specialty care services (vouchers) described above, services will be paid on a fee-for-service basis at a percentage of Medicare.

Illustration 2: Specialty Care Payment Methodology



Additional Provider Incentives

Any remaining funds in either the community health center pay-for-performance incentive pools or the specialty care pools will flow to a Global Incentive pool. All the providers will be eligible for these funds based on the following criteria:

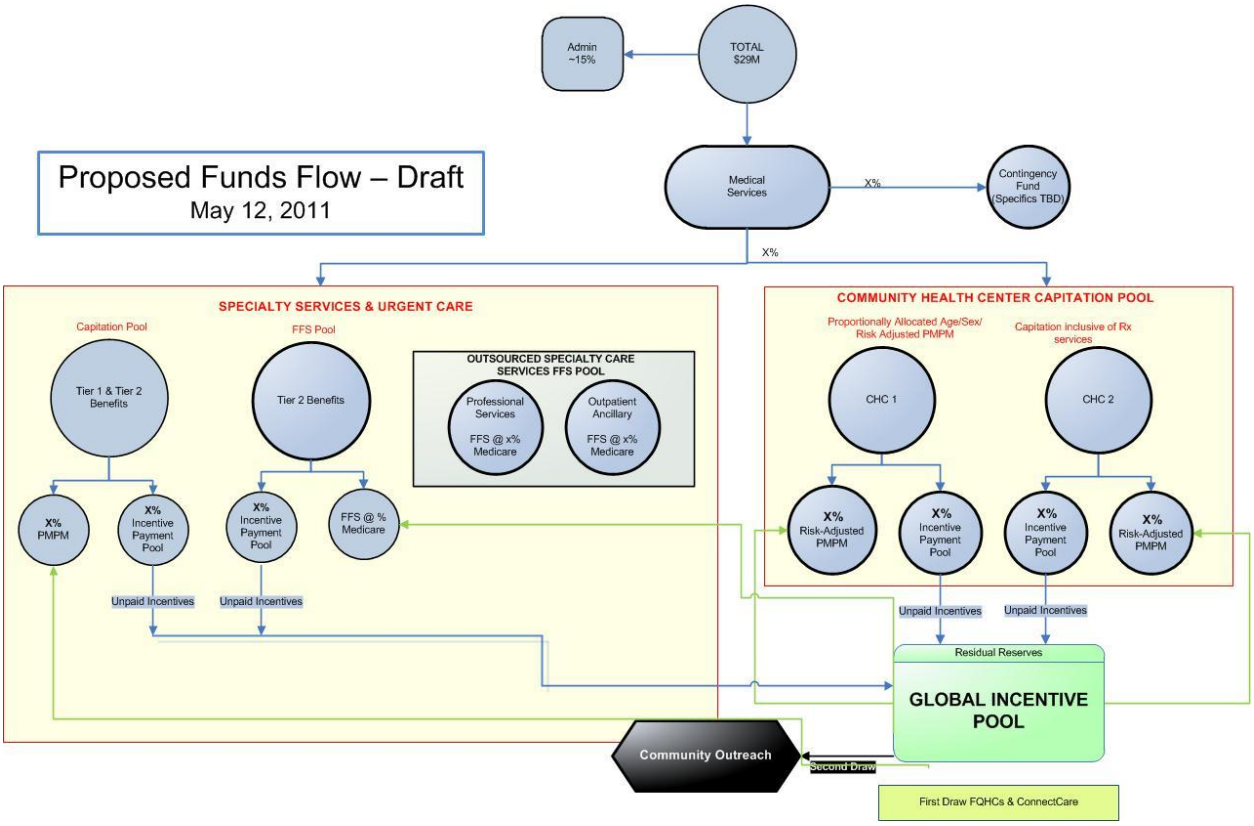
Community health center criteria –

- Emergency department utilization among enrollees (based on % of historical expected rate) – weighted at 30 percent
- Rate of referrals to specialists (based on % of historical expected rate) – weighted at 70 percent

Specialist criteria –

- Wait times for appointments – measurements and benchmarks TBD during operations planning
- Referring physician satisfaction – collected via provider survey tool
    - Timely receipt of consultation documentation
    - Ability of primary care providers to speak with a specialist when requested

Illustration 3: Payment Methodology Funds Flow
(Also included as Appendix II)



Medical Services Budget & Enrollment Cap

In order to develop a draft medical services budget, Wakely Consulting Group analyzed utilization data from July 1, 2009, to June 30, 2010, provided by the Affiliation Partners. The draft medical services budget is based on data only from the legacy primary care clinics of Grace Hill and Myrtle Hilliard Davis, as well as data from ConnectCare, including its voucher program.

ConnectCare currently serves as the specialty care and urgent care provider for many uninsured across the St. Louis safety net including patients from the legacy primary care sites that were previously operated by ConnectCare. In order to design a pilot program that ensures the integrity of the safety net and maintains current levels of access, all ConnectCare utilization was used in the modeling, regardless of patient origin.

In addition, the utilization data analyzed was only from patients who would be eligible for the program based on age, residency and poverty level.

The analysis of the data from the Affiliation Partners provided an overview of current utilization trends. In order to develop as accurate a budget as possible, this data was compared to utilization data from the Massachusetts Commonwealth Care program, specifically the plan that targets adults who do not qualify for Medicaid or Medicare and are below the federal poverty level of 100 percent. The Massachusetts experience was helpful in predicting the possible utilization of a population receiving covered benefits.

For planning purposes, the St. Louis utilization data, adjusted against the Massachusetts experience as appropriate, was priced at Medicare rates. The Massachusetts data was used to ascertain an appropriate average length of enrollment for an 18-month program, which was 11.3 months. With all this information, the analysis suggests a per-member-per-month rate of approximately $135 - $155, including administrative costs. The actuarial modeling will continue to refine these numbers, and because the program is not scheduled to go live until July 1, 2012, the analysis will be conducted again in the first quarter of 2012 to finalize the per-member-per-month rate and the final number of individuals anticipated to be covered. This will ensure the most recent information, representing the most likely experience of the pilot program, is used to develop the final budget and rates.

Enrollment Cap

Based on the above information, the State recommends covering a minimum of 17,034 lives who will receive both Tier 1 and Tier 2 benefits. At this time, based on current modeling, the State recommends an enrollment cap of about, 18,795 lives for Tier 1 and Tier 2 benefits. The State also recommends an enrollment cap of 19,800 for those individuals eligible for Tier 2 benefits only. If the analysis conducted in the first quarter of 2012 confirms that the Demonstration budget could cover a greater number of individuals, the enrollment caps will be adjusted appropriately. Furthermore, if when the Pilot Program commences, actual utilization is below projections making more budget available for more patients, the enrollment cap will be adjusted appropriately.

Administrative Services Budget

For planning purposes, the state has assumed fifteen percent of the total available funds will need to be expended on the administration of the Pilot Program. In developing the operations plan, the State with the Regional Health Commission will look for ways to gain efficiencies in the administration of the program to maintain as much budget as possible for direct patient care.

To develop a working budget, Wakely Consulting Group examined the administrative costs of the Commonwealth Care plans and the Commonwealth Choice plans in Massachusetts as well as consulted third-party data sources of administrative expenses for insurance carriers and third-party administrators. (The Commonwealth Care plans are subsidized plans for those under 300 percent of the federal poverty level; the Commonwealth Choice plan is a private plan for those without insurance who do not qualify for one of the subsidized plans. The Commonwealth Choice plan was evaluated because its enrollment of about 20,000 is comparable to what is anticipated for the Pilot Program.) Information from all three of these sources was used to develop the budget outlined below.

The ongoing expenses are presented as a range dependent on the number of enrollees. These amounts are subject to change as the state finalizes the operations plan and as the market responds to requests for proposals to provide these services. The start-up costs also are outlined below and are subject to change based on decisions made in developing the operations plan.

	Budget Forecast - Dollars			Budget Forecast - PMPM		
	Low	Moderate	High	Low	Moderate	High
Annual Members	26,500	28,600	37,200	26,500	28,600	37,200
Annual Member Months	244,000	263,000	342,000	244,000	263,000	342,000
Program Administration:						
Program Coordinator	$139,500	$139,500	$139,500	$0.57	$0.53	$0.41
Project Manager	$186,000	$186,000	$186,000	$0.76	$0.71	$0.54
Consulting & Professional Support	$100,000	$100,000	$100,000	$0.41	$0.38	$0.29
Finance & Reporting:						
Finance Manager	$155,000	$155,000	$155,000	$0.64	$0.59	$0.45
Reporting Tools/Data Warehouse/Banking	$50,000	$50,000	$50,000.00	$0.20	$0.19	$0.15
Public Information / Outreach	$54,709	$58,969	$76,682	$0.22	$0.22	$0.22
Eligibility determination & enrollment	$668,560	$720,620	$937,080	$2.74	$2.74	$2.74
Claims adjudication/processing/payment	$584,698	$630,228	$819,536	$2.40	$2.40	$2.40
Customer Call Center	$745,404	$803,448	$1,044,788	$3.05	$3.05	$3.05
Start-Up cost:						
Eligibility determination & enrollment	$200,000	$200,000	$200,000	$0.82	$0.76	$0.58
Claims adjudication/processing/payment	$225,000	$225,000	$225,000	$0.92	$0.86	$0.66
Customer Call Center	$300,000	$300,000	$300,000	$1.23	$1.14	$0.88
Total Expense - Annualized Basis	$3,408,871	$3,568,765	$4,233,586	$13.97	$13.57	$12.38
Total Expense - 18 Month Basis	$5,113,307	$5,353,147	$6,350,378	$13.97	$13.57	$12.38
Budget Target - 18 Months	$5,851,763	$5,851,763	$5,851,763	$15.99	$14.83	$11.41
Over/(Under) Budget	-$738,456	-$498,616	$498,616	-$2.02	-$1.26	$0.97

Policies and Procedures

Policies for enrollment and disenrollment for the Pilot Program will be the same as those for other State Medicaid programs.

Enrollment

Application

In addition to county offices of the State's Family Support Division, applications for the Pilot Program must be available and accepted at the Federally Qualified Health Centers included in the provider network. If the community health center does not have an Enrollment Specialist on site, the facility's staff is allowed to accept applications and forward them to the county FSD office. The date of the application is the date it is received by the facility. (Currently, uninsured patients at the community health centers are referred to outreach workers staffed at each health center. These employees facilitate Medicaid applications and coordinate the application and enrollment process with FSD employees assigned to their organizations. ConnectCare provides a social worker who assists patients in applying for Medicaid and other services.)

If a request is received and the person is unable to file an application in person or by mail, arrangements will be made for a home visit. The home visit will be completed within one week, if possible. The application date is the day the request is made.

When a request for assistance is made through a third party (i.e. relative, hospital, agency):

- If the applicant is aware of the request, an application will be sent by mail.
- If the applicant is not aware of the request, the referring person will be asked to provide the address and telephone number of the prospective applicant. If the information is provided, an application will be sent by mail.

Eligibility commences the latter of July 1, 2012, or on the date of application.

Verification Requirements

Enrollment Specialists, who are employees of the Family Support Division, will obtain and record information in the case record that clearly shows that all eligibility requirements for a program are met or that one or more of such requirements are not met and, consequently, ineligibility exists.

Anyone who applies for assistance has the responsibility to furnish access to the information necessary for determining eligibility, both initially and on a continuing basis. The claimant can furnish information that can be easily verified by observation, by public records, or collateral sources.

Obtaining and verifying information to establish eligibility is a joint cooperative effort between the claimant and the Enrollment Specialist. It is the claimant's responsibility to provide the Enrollment Specialist with enough information regarding the claimant's income and circumstances so that an eligibility determination can be made. It is the Enrollment Specialist's responsibility to inform the

claimant what specific information is needed. A claimant must be given at least 10 days to supply necessary information.

If the claimant refuses or fails to provide the necessary information to establish eligibility within 10 days, an application may be rejected or adverse action notice sent to close an active case. To apply the 10 day deadline, the information must be available to the claimant.

In addition to Medicaid eligibility, items to be verified include:

- Residence/household composition
- Age
- Social Security number
- Citizenship status
- Income

The procedures for verifying these will be the same as those used by the State Medicaid system. As in other Missouri Medicaid programs, the participant's statement on insurance status will be accepted unless questionable. Health insurance is defined as insurance that minimally provides coverage for physician's services and hospitalization. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Disenrollment

Because the pilot program is only 18 months long, the State does not anticipate that it will re-determine the eligibility of participants for the Pilot Program. However, it is anticipated that during the Pilot Program, members' eligibility for Medicaid expansion -- expected to be available January 1, 2014 -- will be determined. The process and timing of determining Medicaid eligibility for 2014 will be detailed in the State's Transition Plan due to CMS July 1, 2012.

Participants will be instructed to notify Pilot Program administrators if they:

- Become eligible for other insurance
- Move outside St. Louis City or St. Louis County

If it is believed a member is no longer eligible, the State will review the individual's possible eligibility under all Medicaid healthcare programs. If a change in circumstances results in a determination of ineligibility for the Pilot Program, eligibility for all Medicaid categories must be established prior to taking action to close the case. All available information must be carefully reviewed. If potential eligibility exists under another category, the case will remain open and coverage will remain until eligibility for other coverage can be determined with the intent of not disrupting coverage.

If no other eligibility exists, action will be initiated to close the case by sending an advance notice of adverse action. If a hearing is not requested, the case will be closed when the notice of adverse action expires. At such time, the claimant will be notified in writing confirming the closing.

When a member of the Pilot Program becomes eligible for Medicaid due to pregnancy, disability or other reason, the State will disenroll members in the Pilot Program, moving them to the Medicaid program for which they are eligible. Coverage in the Pilot Program will not be terminated until the Medicaid coverage is approved. Participants will be notified of the changes in their coverage and will be supplied a statement that eligibility no longer exists for the Pilot Program.

The State also will determine a method for patients to disenroll from the community health center they choose as their primary care home and to re-enroll at another community health center in the provider network. This method will be detailed in the operations plan.

Wait List

The state's limit on the number of individuals who participate in a waiver may result in a waiting list for waiver services (e.g., entrance to the waiver of otherwise eligible applicants must be deferred until capacity becomes available as a result of turnover.) Entrance to the waiver may not be deferred when there is unused waiver capacity (except when a state has established a point-in-time limit, reserved capacity or made entrance subject to a phase-in schedule). If it is necessary to defer the entrance of individuals to the waiver, the state must have policies that govern the selection of individuals for entrance to the waiver when capacity becomes available. These policies should be based on objective criteria and applied consistently in all geographic areas served by the waiver. For the purposes for the Gateway to Better Health Pilot Program, individuals will be selected on a first come first serve basis in the event of a waiting list.

Outreach, Engagement and Enrollment

It is anticipated that most of those eligible for enrollment in the Pilot Program's Tier 1 and Tier 2 benefits will have an established primary care home at one of the legacy sites. As a result, much of the outreach, engagement and enrollment will take place at those sites beginning March 1, 2012. In addition, outreach staff of the community health centers in coordination with outreach staff of the Missouri Department of Social Services, Family Support Division (FSD), will work in the community to identify those eligible and to begin enrolling them March 1, 2012.

Other targeted means of communication, including distributing information by U.S. mail, will be used. (To date, patients interviewed through outreach efforts report U.S. mail as the best way to reach them.) Because of the limited availability of the pilot program, it is not anticipated that mass advertising will be used. Instead, the health centers and FSD will use targeted forms of outreach and engagement to notify patients of their eligibility for the program.

Because the health centers will be paid a per-member-per-month rate for each patient they enroll, they will be incented to enroll as many patients as possible in the program.

Furthermore, because the program is designed to target those individuals who are aging out of Medicaid, FSD and the health centers will coordinate efforts to reach these individuals and enroll them in the program.

Enrollment Coordination

It is anticipated that enrollment will be conducted through the Medicaid system. As stated in the Special Terms and Conditions, the State will ensure that persons are first screened for eligibility under the Medicaid State plan before enrolling them in the Pilot Program. The State will follow the same enrollment processes as for Medicaid State plan individuals (subject to an enrollment cap based on available funding as described in section VI, paragraph 4.)

As part of the operations planning, FSD is identifying how to accommodate the significant number of applications it will receive prior to July 1, 2012. The intent is that applicants who submit completed applications by May 18, 2012, and who do not require a medical review, are notified of the acceptance or denial of their application by July 1, 2012. The health centers will work with their patients who may require a medical review to submit those applications by March 15, 2012, giving FSD 90 days to complete the medical review with the intent of notifying applicants of their acceptance or denial of their applications by July 1, 2012.

As the enrollment plan is finalized, one issue that will be addressed is the management of those individuals enrolled in the Pilot Program who become eligible for Medicaid due to pregnancy, disability or other reason during their enrollment in the Pilot Program. Currently, individuals who qualify for Medicaid become eligible during the month of application or up to three months prior to application. The State will need to determine how to handle funds management for those patients who qualify for Medicaid retroactively.

Furthermore, the enrollment plan will address how the enrollment of patients who qualify only for Tier 2 benefits is facilitated. We anticipate that those patients who qualify only for Tier 2 benefits will be enrolled into the Tier 2 plan for the duration of the Pilot Program.

The St. Louis Regional Health Commission approved the formation of an outreach and marketing team on March 16, 2011. This team is charged with developing an outreach and marketing plan for the Demonstration project that includes population-specific outreach strategies for enrolling members in the Demonstration pilot plan.

Key Deliverables:

- Definition of target population(s)
- Outreach and marketing plan
- Applicants enrollment process
- Process for providing and capturing ongoing patient feedback

Proposed Membership:

Stakeholder Group
Pilot Program Planning Team (Chair)
Provider Services Advisory Board
Community Advisory Board
Grace Hill (Legacy Site)
Myrtle Hilliard Davis (Legacy Site)
ConnectCare (Legacy Site)
Non-legacy health center
State
Aging-Out Youth Specific
Chronic Disease Specific
Integrated Health Network
Hospitals

Next Steps

As the Pilot Program Planning Team, the St. Louis Regional Health Commission and the State of Missouri develop the Draft Operations Plan due to CMS on October 1, 2011, they will focus on the following activities:

- Operational decisions and budget for:
  - Customer service
  - Claims processing
  - Eligibility and enrollment
  - Utilization management
  - Financial management
  - Member materials/information
  - Information systems
- Process for determining eligibility and enrolling patients from contingency provider organizations
- Enrollment of Tier 2 patients
- Percentage of funds in incentive pools and the contingency fund
- Benchmarks for incentive payments for:
  - ED utilization
  - Rate of referrals of PCPs to specialists
  - Wait times for specialist referrals
  - Referring physician satisfaction
- Service level agreement terms for network provider organizations

Appendix I

St. Louis Regional Health Commission
"Gateway to Better Health" Demonstration Project
Pilot Program Planning Team

Outreach and Engagement Report

Background

As part of the planning process for the Pilot Program, the St. Louis Regional Health Commission has interviewed patients and medical professionals to ensure their input was considered in the design of the Pilot.

RHC staff members interviewed 30 patients of the FQHCs and 6 physicians who practice at the FQHCs. To better understand the aging out population, RHC staff conducted a focus group with members of the SPOT, a local drop-in and health services center for youth. Approximately twenty-one youth between the ages of 16 and 22 participated in the focus group session.

In all interviews and focus groups, patients were asked to comment about how they currently use the healthcare services provided at the health centers as well as other providers in town; how a coverage model may change how they use services; what benefits they would like to have access to through a coverage model; and how they would like to receive information about this coverage model.

Physicians were asked to comment on which populations would be best served by a coverage model; which barriers to access should be considered in the design of the pilot; what benefits should be included; anticipated changes in utilization with coverage; and potential challenges in enrolling patients and encouraging them to utilize their benefits.

The RHC also made a survey available for the general public to complete. The RHC received more than 100 responses to the survey.

Key Findings

Patients reported the following:

- Dental is a critical and difficult service for them to access and pay for. Almost unanimously, they reported that dental should be included as a benefit.
- Because they are uninsured, they are fearful of going to a hospital for care, knowing they cannot afford to pay for the care.
- With coverage they would be inclined to visit more often, especially if their out-of-pocket cost was less than it is today. (76 percent of survey respondents said they would go to the doctor more often if they had insurance.)
- Youth reported customer service is critical for them to determine where and if they will receive health care services. They want the provider organization to be "comfortable and welcoming." They also don't want a lot of requirements in order to receive care.

Physicians reported the following:

- A defined coverage plan could most benefit those who suffer from a chronic illness(es). Some physicians mentioned the most prevalent conditions as: diabetes, high blood pressure, COPD and asthma.
- Preventative care (e.g. mammography, colonoscopy, nutrition counseling) should be covered at a very low cost to encourage people to receive this care.
- Transportation is a barrier for many patients to get to their appointments as well as to regularly fill their prescriptions.
- Varying degrees of concern exist about access to pharmaceuticals for patients. Some report the low-cost retail programs, the low-cost pharmaceuticals provided at the health centers, and the prescription assistance programs, meet the needs of most of their patients. Others report that even with these programs, some patients report they are unable to afford their medications.
- Dental is not top-of-mind as a critical benefit among primary care physicians, but when asked, they say it is very important to their patients. Many report that patients need recurring doses of antibiotics to take care of dental infections because patients report they are unable to see/afford a dentist.
- Some services are particularly difficult for the uninsured to access. Those mentioned include mental health services, physical therapy, pain management and sleep studies.

Quotes from Interview Subjects

Patients

I'm afraid to go to the hospital. I have a $5,000 bill from [Hospital A] right now that I'm trying to work out.

I have to be really sick or almost dead to go to the hospital.

If I had insurance, I would come more and I'd know more about my health.

[Health Center A] is still a clinic, not a hospital. They're still sending me other places.

The plan should cover everything. Health care should be free.

I would come more if they didn't charge so much.

I would come more to be more aware of my health and to see the dentist.

If I had insurance, I wouldn't be so scared to come to the doctor. What if they find something? Then what do I do?

I come here about two times per month when I'm sick or need a check up or need medication. I also have a doctor at [Hospital A]. Every now and again I go there.

Physicians

It will be a relief for me that my patients have insurance. This means I can get them the tests they need.
Put dental at the top of the list. Co-pays are currently $20 a visit. I see horrible abscesses. Patients don't get it fixed. It's a tragedy for them. Almost every patient I see needs dental care.

Every day I have one or two patients ask for antibiotics for a tooth abscess instead of going to the dentist.

The reason our patients don't come now is because they can't pay the co-pays, and they can't afford the medications.

Psychiatric care is the most important. We see lots of patients with psychiatric issues. No clinic gives us access to psychiatrists, and it takes 3 to 5 months to get patients into a community mental health center. With MPC closing, these patients have nowhere to go.

This patient population has a lot of suspicions about the medical system. They have stories about bad things that happened to them or people they know. They have concerns about not being able to pay. They will need education about this program.

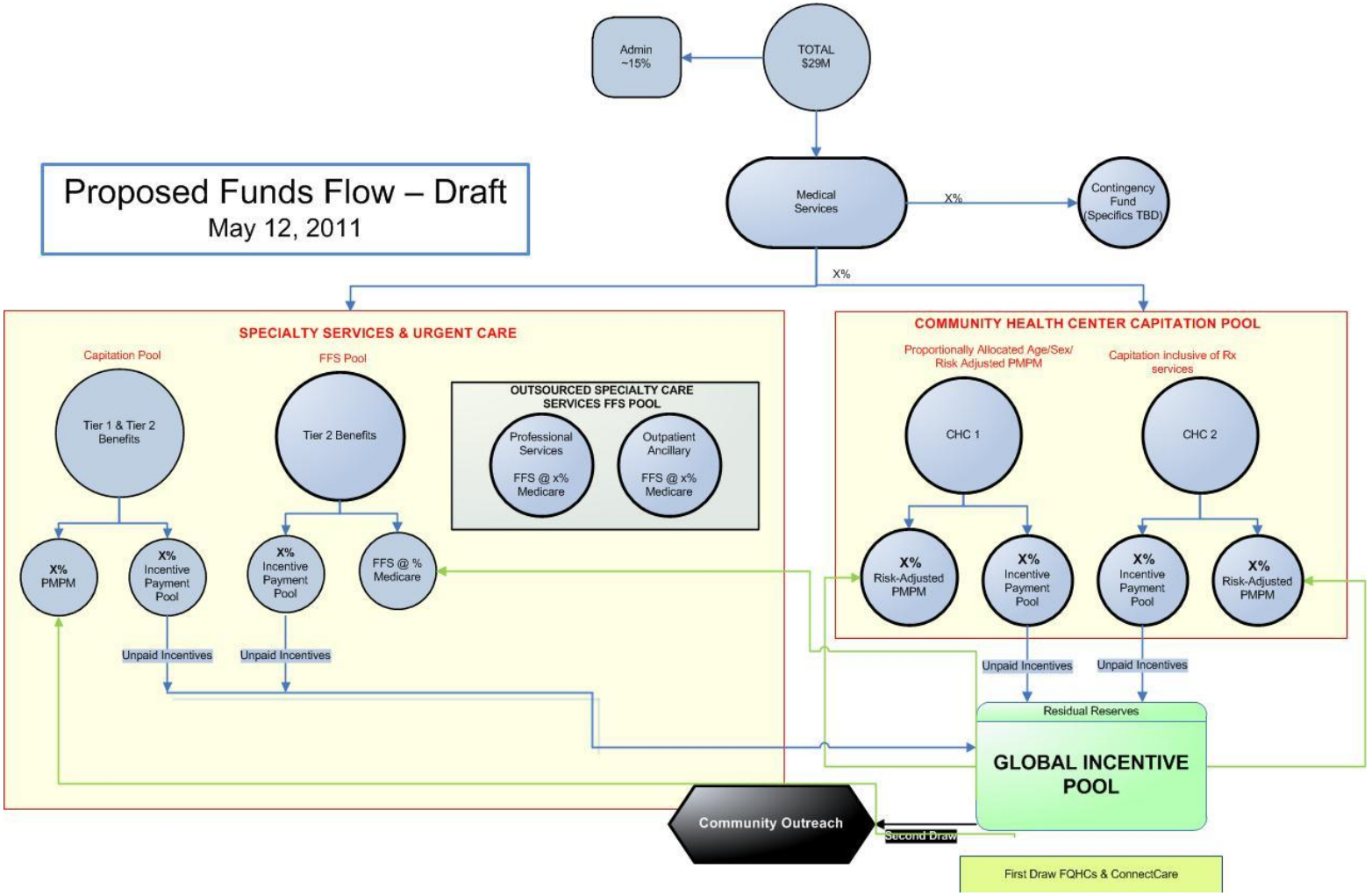
These patients still have a lot of distrust. They will ask if it (the program) is real and will want to know what it will cover. They will want to know where they can go for treatment. If they can't go anywhere else than they go today, they may not think it is valuable.

A lot of these patients doctor shop. They just go to what's close. A PCP home is a foreign concept to them.

Many of these patients will be too proud to say they need the help this program can provide.

People will do anything for money. I would think about how we can incent patients to live healthier lifestyles.

Appendix II
Payment Methodology Funds Flow



Appendix III
St. Louis Integrated Health Network Map

Appendix IV
Business Sustainability Plans

Each of the three "Affiliation Partners" currently funded by the "Gateway to Better Health" Demonstration project has submitted draft sustainability plans for their operations for two time periods:

- During the Pilot Program, July 1, 2012 – June 30, 2013 (primary care organizations); July 1, 2012 – December 31, 2013 (specialty care organization)
- Post-Demonstration, January 1, 2014 – December 31, 2014

They also have provided baseline encounter, user and financial information for calendar year 2010. In addition, the St. Louis Regional Health Commission and St. Louis Integrated Health Network Community Referral Coordinator Program have provided projected revenues and expenses for calendar year 2014.

Primary Care Organization Sustainability

The financial projections from Grace Hill Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers indicate that the primary care health care providers will be financially sustainable during the period of the Pilot Program and in 2014, post-"Gateway" Demonstration, with operations in scope and scale similar to those in operation today.

Projections for the time period during the Pilot Program are based on approximately 18,795 lives covered during the first year of the Pilot Program. Based on the current projections, which are subject to change based on final actuarial modeling to be completed in Spring 2012, using 2011 utilization data from the health centers, enrollment targets for the first year of the Pilot Program follow:

- Grace Hill Health Centers: 11,825 lives
- Myrtle Hilliard Davis Comprehensive Health Centers: 6,970 lives

In the following pages, each organization provides CY 2010 revenues, expenses and volumes by payer; projected revenues, expenses and volumes for the first year of the Pilot; and projected revenues, expenses and volumes in 2014. Projected Pilot Program revenues are based on reimbursement rates commensurate with Medicare rates.

The sustainability of the organizations in 2014 is possible due to the expansion of coverage options available to the currently uninsured under the Affordable Care Act signed into law in 2010. Without this expansion of coverage, the health providers funded through the "Gateway" Demonstration would have had to substantially reduce the scope and scale of primary and specialty care operations in St. Louis' urban core.

The financial sustainability of each organization's current operational configuration is dependent upon successfully meeting the volume targets provided in the sustainability models for each payer category, and provides CMS, the State of Missouri, and the St. Louis Regional Health Commission with quantifiable benchmark targets to measure progress toward sustainability.

Specialty Care Organization Sustainability

Projections from St. Louis ConnectCare indicate that the Pilot Program will provide a period of transition for the organization to re-engineer its business to operate sustainably in 2014. As with the primary care organizations, this sustainability is possible due to the expansion of coverage options available to the currently uninsured under the Affordable Care Act signed into law in 2010. Without this expansion of coverage, St. Louis ConnectCare would have to substantially reduce the scope and scale of its operations.

Projections for the time period of the Pilot Program are based on St. Louis ConnectCare providing services to individuals eligible for the Pilot, including:

- Patients of the legacy clinics of St. Louis Regional Hospital eligible for Tier 1 and Tier 2 benefits up to 133% of federal poverty level
- Patients eligible for Tier 2 benefits up to 200% of federal poverty level

In the following pages, St. Louis ConnectCare provides CY 2010 revenues, expenses and volumes by payer; projected revenues, expenses and volumes for 18 months of the Pilot; and projected revenues, expenses and volumes in 2014. Projected Pilot Program revenues are based on reimbursement rates of 167 percent of Medicare for four quarters, 150 percent of Medicare for one quarter and 100 percent of Medicare for one quarter.

The financial sustainability of St. Louis ConnnectCare is dependent upon successfully meeting the volume targets provided in the sustainability models for each payer category, and provides CMS, the State of Missouri, and the St. Louis Regional Health Commission with quantifiable benchmark targets to measure progress toward sustainability.

St. Louis Integrated Health Network (IHN) Community Referral Coordinator (CRC) Program

Beginning on Page 32, the IHN details the benchmarks for the Community Referral Coordinator Program as it plans for sustainability by 2014. It is anticipated that following a cost-benefit analysis conducted with the oversight of the program's stakeholders, including hospitals and health centers, that additional funders will be identified.

St. Louis Regional Health Commission (SLRHC)

Beginning on Page 35, the St. Louis Regional Health Commission details its role in the community and how it has secured funding in the past and expects to do so in the future. It is anticipated that in 2013, the SLRHC will identify its priorities post-2014 and the associated funding sources.

Grace Hill Health Centers, Inc.

Grace Hill Health Centers operates six centers. The following are legacy clinics of St. Louis Regional Hospital:

- Grace Hill Murphy O'Fallon Health Center
- Grace Hill Soulard-Benton Health Center

Grace Hill also operates the following health centers:

- Grace Hill Water Tower Health Center
- Grace Hill South Health Center
- Grace Hill at St. Patrick Health Service
- Grace Hill at BJC Behavioral Health

The Grace Hill centers listed above that are *not* legacy centers of St. Louis Regional Hospital receive Health Resources and Services Administration (HRSA) grants. Murphy O'Fallon Health Center receives some HRSA funding for community health homeless nurses who reside at the center. This funding existed prior to the "Affiliation" of the legacy health centers with Grace Hill. Staff moved from another Grace Hill site to Murphy O'Fallon after the affiliation. Typically, funding only is available from HRSA for expanding services to a new site. HRSA funding was not available when Grace Hill assumed responsibility for the Murphy O'Fallon and Soulard Benton health centers. Because these are not new sites, it is not anticipated that either site will be eligible for HRSA funding.

The following Statements of Revenue and Expenses include "Contributed Services." This includes the following items:

- Rent at less than market rates at Soulard Benton and Murphy O'Fallon, valued at the difference between amount paid to the City of St. Louis of $10 annually for each site and the reasonable rate paid for like facilities;
- Donated pharmaceuticals and supplies from Pfizer and AstraZeneca and certain other medical suppliers;
- The value of services provided in excess of the contracted volume by homeless vendors; and
- Donated physician and nursing time by the residency program at Washington University and nursing school at St. Louis University

The following Statements of Revenue and Expenses include "Other Federal Revenue." This includes funding for Healthcorps members and for a HUD lead prevention/remediation program that ended in 2010. These services are provided from another site where these staff and services are provided. Funding under the Healthcorps program continues at the same level as in the past, mainly because 40% matching non-federal funds have to be obtained to continue the program. These are obtained through a state women's and minority outreach grant that is in jeopardy due to state funding challenges. Note that neither of these programs is for providing medical/dental/mental health services.

Background and Assumptions: July 1, 2012 – June 30, 2013

The projection of the operating plan for the twelve month period ending June 30, 2013 reflects a surplus from operations of $8,320 based on total revenue of $30,401,185 and total expenses of $30,392,865.

The following assumptions were built into the financial projections:

- HRSA funding was kept at the current level plus expected Increased Demand for Service funding (IDS) and Expanded Services funding (ES) was added;
- For Medicaid revenue, assumed current rates of reimbursement per encounter at each site for the population currently enrolled in Medicaid;
- Assumed overall 2% increase in patients each year;
- Pilot program revenue was based on the most conservative estimate provided by Wakely Consulting Group which included enrollment of 11,825 adult patients at the two legacy Grace Hill sites, and reimbursement at 100% of Medicare rates;
- Half of state funding was removed due to the uncertainty of future funding;
- Budgeted 2011 costs were used with a 1.5% increase for 2012 except in some areas where changes are planned to reduce overall costs such as planned termination of the lease for administrative space;
- Assumed no new funding sources and no new services;

Overall, the health center projects a profit of $8,320 with a higher surplus projected at the Soulard Benton site due to the higher enrollment of patients in the Pilot Program at that site. Other sites project a lower margin due to their higher level of homeless services and services to the undocumented uninsured patient population.

The number of users is projected to be 43,791, which are comprised of 33,691 medical, 8,200 dental and 1,900 other users.

Background and Assumptions: January 1, 2014 – December 31, 2014

The projection of the operating plan for 2014 reflects a surplus from operations of $370,392 for calendar year 2014 based on total revenue of $32,257,751 and total expenses of $32,887,360.

Due to the uncertainty surrounding healthcare reform and how this will impact our patient volume, HRSA grants and Medicaid reimbursement, the following assumptions were built into the financial projections:

- HRSA funding was kept at the current level plus expected Increased Demand for Service funding (IDS) and Expanded Services funding (ES) was added;
- For Medicaid revenue, assumed current rates of reimbursement per encounter at each site for the population currently enrolled in Medicaid with continued cost based reimbursement and 2% inflationary increase per year;
- For new adult population covered by Medicaid, assumed 3.2 visits per year at the current average encounter rate of $156 with a 10% denial rate;
- Assumed overall 2% increase in patients each year;
- Assumed 15%-17% of uninsured adult patients would remain uninsured in 2014 due to enrollment issues related to their homeless or immigration status;
- All state funding was removed due to the uncertainty of future funding;
- An across-the-board 2% cost increase was projected each year;
- Assumed no new funding sources and no new services;
- For patients insured by the insurance exchange in 2014, the current net revenue per encounter for commercial insurance was used.

Overall, the health center projects a profit of $370,392 with a higher surplus projected at the Soulard Benton site. Other sites project a lower margin due to their higher level of homeless services, a projected loss of state funding and services to the undocumented immigrant population, particularly at our South location. The projection was prepared conservatively, anticipating that the undocumented population would not be eligible for expanded Medicaid or enroll in the exchange products, that the homeless population would be more difficult to enroll because they tend to be less compliant and more difficult to locate due to their transient nature. If the ACA would provide Medicaid coverage for undocumented immigrants and provide a means to auto-enroll the homeless, these centers' fiscal outlook would improve.

The number of users is projected to be 45,700, which are comprised of 34,900 medical, 8,475 dental and 2,325 other users.

Grace Hill Health Centers, Inc.
Statement of Revenue and Expense for the year ending December 31, 2010

	Clinical Operations				Other Programs	
	Center #1 Murphy O'Fallon	Center #2 Soulard Benton	Other Centers All Other	Total Clinical	Lead, Healthcorps, WIC, Headstart, funding for South construction	Total
Revenues						
HRSA Grants			$ 5,527,580	$ 5,527,580	$ 1,145,876	$ 6,673,456
Other Federal Revenue					$ 1,400,485	$ 1,400,485
Medicaid/Medicare	$ 6,635,344	$ 2,818,723	$ 3,065,525	$ 12,519,592		$ 12,519,592
Other Patient Revenue	$ 506,090	$ 530,250	$ 260,657	$ 1,296,996		$ 1,296,996
DSH Funding	$ 2,862,750	$ 2,862,750		$ 5,725,500		$ 5,725,500
Community Funding						
Other Funding			$ 1,533,686	$ 1,533,686		$ 1,533,686
Contributed Services	$ 978,342	$ 564,596	$ 362,128	$ 1,905,066		$ 1,905,066
Total Revenues	**$ 10,982,526**	**$ 6,776,319**	**$ 10,749,576**	**$ 28,508,420**	**$ 2,546,361**	**$ 31,054,781**
Expenses						
Salaries, employee benefits and payroll taxes	$ 7,775,605	$ 4,832,416	$ 6,037,902	$ 18,645,923	$ 938,649	$ 19,584,573
Professional and contractual services	$ 1,240,952	$ 679,718	$ 1,214,985	$ 3,135,655	$ 438,580	$ 3,574,235
Supplies	$ 197,346	$ 122,781	$ 161,428	$ 481,555	$ 3,171	$ 484,726
Insurance	$ 37,369	$ 24,367	$ 57,238	$ 118,974	$ 17,647	$ 136,621
Pharmaceuticals	$ 414,188	$ 274,525	$ 595,398	$ 1,284,111		$ 1,284,111
Occupancy	$ 364,940	$ 259,766	$ 773,939	$ 1,398,645	$ 73,612	$ 1,472,257
Depreciation	$ 275,389	$ 172,849	$ 537,662	$ 985,900	$ 26,432	$ 1,012,332
Contributed services	$ 978,342	$ 564,596	$ 362,128	$ 1,905,066		$ 1,905,066
Other	$ 83,038	$ 104,045	$ 1,010,495	$ 1,197,578	$ 28,483	$ 1,226,061
Total Expenses	**$ 11,367,169**	**$ 7,035,063**	**$ 10,751,175**	**$ 29,153,407**	**$ 1,526,574**	**$ 30,679,982**
Surplus / (Deficit)	**$ (384,643)**	**$ (258,744)**	**$ (1,599)**	**$ (644,987)**	**$ 1,019,787**	**$ 374,799**

Grace Hill Health Centers, Inc.
Statistical Information for the 12 Months Ending December 31, 2010

	Clinical Operations				Other Programs	
	Center #1	**Center #2**	**Center #3**	**Total Clinical**	**(optional)**	**Total**
	Murphy O'Fallon	**Soulard Benton**	**All other**		**[Name]**	
Number of Users						
Medical users	10,702	8,386	13,184	32,272		32,272
Dental users	3,332	3,567	1,233	8,132		8,132
Other users	523	348	839	1,710		1,710
Urgent Care users						-
Specialty Care users						-
Total Users	**14,557**	**12,301**	**15,256**	**42,114**		**42,114**
						-
New medical users (patients not seen by GHNHC, MHDCHC, SLCC within last 12 mos.)	2,189	1,969	3,245	7,403		7,403
						-
Encounters						-
Primary Medical Care	28,993	24,158	45,857	99,008		99,008
Dental	7,017	6,802	6,148	19,967		19,967
Mental Health	4,117	1,103	980	6,200		6,200
Substance Abuse			8,657	8,657		8,657
Enabling Services	4,106	112	7,601	11,819		11,819
Total Encounters	**45,954**	**33,132**	**70,342**	**149,428**		**149,428**
						-
Users by payor class						-
Medicaid	6,280	3,971	3,506	13,757		13,757
Medicare	1,006	610	475	2,091		2,091
Other insurance	552	424	404	1,380		1,380
Uninsured	6,719	7,296	10,871	24,886		24,886
	14,557	12,301	15,256	42,114		42,114

Grace Hill Health Centers, Inc.
Projected Statement of Revenue and Expense
July 1, 2012 through June 30, 2013

	Clinical Operations			
	Center #1	**Center #2**	**Other Centers**	**Total Clinical**
	Murphy O'Fallon	**Soulard Benton**	**Other Sites**	
Revenues				
HRSA Grants	1,862,000		$ 4,222,280	$ 6,084,280
Other Federal Revenue			$ 132,000	$ 132,000
Medicaid	$ 5,733,000	$ 3,640,000	$ 3,367,000	$ 12,740,000
Medicare	$ 260,846	$ 165,993	$ 118,566	$ 545,405
Pilot Program	$ 3,154,200	$ 3,645,800		$ 6,800,000
Commercial	$ 147,000	$ 120,000	$ 133,500	$ 400,500
Other Patient Revenue	$ 30,000	$ 35,000	$ 344,000	$ 409,000
Community Funding				
Other Funding			$ 1,355,000	$ 1,355,000
Contributed Services	$ 1,000,000	$ 575,000	$ 360,000	$ 1,935,000
Total Revenues	**$ 12,187,046**	**$ 8,181,793**	**$ 10,032,346**	**$ 30,401,185**
Expenses				
Salaries, employee benefits and payroll taxes	$ 8,326,500	$ 5,307,698	$ 6,157,469	$ 19,791,667
Professional and contractual services	$ 1,264,232	$ 709,065	$ 1,168,390	$ 3,141,687
Supplies	$ 201,048	$ 128,081	$ 171,308	$ 500,437
Insurance	$ 37,369	$ 24,367	$ 57,238	$ 118,974
Pharmaceuticals	$ 393,600	$ 314,500	$ 605,000	$ 1,313,100
Occupancy	$ 435,000	$ 275,000	$ 539,000	$ 1,249,000
Depreciation	$ 356,000	$ 173,000	$ 535,000	$ 1,064,000
Contributed services	$ 1,000,000	$ 575,000	$ 360,000	$ 1,935,000
Other	$ 395,000	$ 320,000	$ 564,000	$ 1,279,000
Total Expenses	**$ 12,408,749**	**$ 7,826,711**	**$ 10,157,405**	**$ 30,392,865**
Surplus / (Deficit)	**$ (221,703)**	**$ 355,082**	**$ (125,059)**	**$ 8,320**

Grace Hill Health Centers, Inc.
Projected Statistical Information for July 1, 2012 – June 30, 2013

	Clinical Operations				Other Programs	
	Center #1	**Center #2**	**Center #3**	**Total Clinical**	**(optional)**	**Total**
	Murphy O'Fallon	**Soulard Benton**	**Other Sites**			
Number of Users						
Medical users	10,201	9,090	14,400	33,691		33,691
Dental users	3,300	3,400	1,500	8,200		8,200
Other users	600	400	900	1,900		1,900
Total Users	**14,101**	**12,890**	**16,800**	**43,791**		**43,791**
Users by payor class						
Medicaid	6,300	4,000	3,700	14,000		14,000
Medicare	1,100	700	500	2,300		2,300
Pilot Program	5,485	6,340		11,825		11,825
Commercial Insured	550	450	500	1,500		1,500
Uninsured	666	1,400	12,100	14,166		14,166
Total Users (equals row 15)	**14,101**	**12,890**	**16,800**	**43,791**		**43,791**
Encounters						
Primary Medical Care	31,365	26,880	49,700	107,945		107,945
Dental	7,213	6,850	6,150	20,213		20,213
Mental Health	4,200	1,500	1,200	6,900		6,900
Substance Abuse			8,650	8,650		17,300
Enabling Services	4,200	300	7,500	12,000		12,000
Other	1,900	1,000	1,100	4,000		4,000
Total Encounters	**48,878**	**36,530**	**74,300**	**159,708**		**159,708**

Grace Hill Health Centers, Inc.
Projected Statement of Revenue and Expenses
Calendar Year Jan 1, 2014 through December 31, 2014

	Clinical Operations				
	Center #1 Murphy O'Fallon	Center #2 Soulard Benton	Other Centers All Other	Total Clinical	Total
Revenues					
HRSA Grants	2,684,200		$ 3,400,080	$ 6,084,280	$ 6,084,280
Other Federal Revenue			$ 132,000	$ 132,000	$ 132,000
Hospital existing	736,368	736,368	736,368	$ 2,209,104	$ 2,209,104
Medicaid existing	$ 5,445,812	$ 3,093,848	$ 2,220,435	$ 10,760,095	$ 10,760,095
Medicaid newly insured adults	$ 2,145,312	$ 2,905,943	$ 3,144,960	$ 8,196,215	$ 8,196,215
Medicare	$ 160,250	$ 215,688	$ 169,469	$ 545,406	$ 545,406
"Exchange"	$ 33,750	$ 47,250	$ 148,500	$ 229,500	$ 229,500
Commercial	$ 77,625	$ 54,000	$ 64,125	$ 195,750	$ 195,750
Other Patient Revenue	$ 301,000	$ 373,220	$ 391,155	$ 1,065,375	$ 1,065,375
Community Funding					
Other Funding			$ 1,055,000	$ 1,055,000	$ 1,055,000
Contributed Services	$ 1,659,316	$ 792,137	$ 333,573	$ 2,785,026	$ 2,785,026
Total Revenues	**$ 13,243,633**	**$ 8,218,454**	**$ 11,795,665**	**$ 33,257,751**	**$ 33,257,751**
Expenses					
Salaries, employee benefits and payroll taxes	$ 8,589,120	$ 4,658,880	$ 7,808,768	$ 21,056,768	$ 21,056,768
Professional and contractual services	$ 1,357,920	$ 871,056	$ 1,101,130	$ 3,330,106	$ 3,330,106
Supplies	$ 132,480	$ 161,200	$ 290,160	$ 583,840	$ 583,840
Insurance	$ 47,472	$ 24,288	$ 47,320	$ 119,080	$ 119,080
Pharmaceuticals	$ 414,000	$ 322,954	$ 632,320	$ 1,369,274	$ 1,369,274
Occupancy	$ 540,960	$ 351,520	$ 1,174,656	$ 2,067,136	$ 2,067,136
Depreciation	$ 267,000	$ 165,000	$ 425,000	$ 857,000	$ 857,000
Contributed services	$ 1,659,316	$ 792,137	$ 333,573	$ 2,785,026	$ 2,785,026
Other	$ 197,600	$ 172,224	$ 349,306	$ 719,130	$ 719,130
Total Expenses	**$ 13,205,868**	**$ 7,519,259**	**$ 12,162,232**	**$ 32,887,360**	**$ 32,887,360**
Surplus / (Deficit)	**$ 37,765**	**$ 699,194**	**$ (366,567)**	**$ 370,392**	**$ 370,392**

See attached budget narrative and assumptions

Grace Hill Health Centers, Inc.
Projected Statistical Information for the 12 Months Ending December 31, 2014

	Clinical Operations				Other Programs	
	Center #1 Murphy O'Fallon	Center #2 Soulard Benton	Center #3 All Other	Total Clinical	(optional) [Name]	Total
Number of Users						
Medical users	10,400	9,300	15,200	34,900		34,900
Dental users	3,250	3,125	2,100	8,475		8,475
Other users	1,050	675	600	2,325		2,325
Urgent Care users						
Specialty Care users						
Total Users	**14,700**	**13,100**	**17,900**	**45,700**		**45,700**
Users by payor class						
Medicaid (assuming up to 133% of poverty for adults)	**11,875**	**10,550**	**10,816**	**33,241**		**33,241**
Medicare	**1,000**	**700**	**550**	**2,250**		**2,250**
Exchange (assume current uninsured > 133% FPL)	**250**	**350**	**1,100**	**1,700**		**1,700**
Commercial Insured	**575**	**400**	**475**	**1,450**		**1,450**
Uninsured	1,000	1,100	4,959	7,059		7,059
Total Users (equals row 15)	14,700	13,100	17,900	45,700		45,700
Encounters						
Primary Medical Care	32,235	27,500	52,800	112,535		112,535
Dental	7,100	6,230	5,300	18,630		18,630
Mental Health	4,300	1,800	1,050	7,150		7,150
Substance Abuse			8,100	8,100		8,100
Enabling Services	10,000	4,000	9,000	23,000		23,000
Other (podiatry and optometry)	2,950	185	500	3,635		3,635
Urgent Care users						
Specialty Care						
Cardiology						
Dermatology						
Endocrinology						
Other						
Total Encounters	56,585	39,715	76,750	173,050		173,050

Myrtle Hilliard Davis Comprehensive Health Centers, Inc.

Myrtle Hilliard Davis Comprehensive Health Centers, Inc. (MHDCHC) operates three health centers. The following are legacy clinics of St. Louis Regional Hospital:

- Florence Hill Health Center
- Homer G. Phillips Health Center

MHDCHC also operates a site named Comp 1, which receives HRSA grants. In October 2005, two legacy clinics (Homer G. Phillips and Florence Hill) "Affiliated" with MHDCHC. MHDCHC participated in a conference call in 2006 with HRSA relating to funding for New Access Points. During the phone conference, the center was informed that funding for New Access Points was only available for new centers. Also, at every available opportunity, the center has continued to request funding for the legacy sites but has not been successful because HRSA only funds new access points.

MHDCHC requested HRSA funding under the America Recovery and Reinvestment Act (ARRA) *Facility Investment Program* opportunity. The funding request was intended to co-locate behavior health and substance abuse services at the main site. Unfortunately, the funding was not awarded. However, the organization plans to participate in the next funding cycle. Behavioral health and substance abuse services are provided through a collaborative partnership with (Metropolitan Mental Hospital, Betty Jean Kerr Hopewell Center, West End Methadone Treatment Clinic, BJC Mental Health Services and other local behavior health organizations).

Enabling services as defined by Uniformed Data System (UDS) include:

Case Management – staff who provide services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. Case managers may provide eligibility assistance, if performed in the context of other case management functions. Staff may include nurses, social workers and other professional staff who are specifically allocated to this task during assigned hours, but not when it is an integral part of their other function. Care/Referral Coordinators are considered Case Managers.

Patient and Community Education Specialists – health educators, family planning specialists, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.

Outreach Workers – individual conducting case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.

Eligibility Assistance Workers – all staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, WIC, SSI, food stamps, TANF and related assistance programs.

Interpretation Staff- staff who's full time or dedicated time is devoted to translation and /or interpretation services.

Personnel Performing other Enabling Service Activities- all other staff performing services as enabling services, not described above. There is a "specific" field that must be used to describe what these staff members are doing.

MHDCHC provides the following 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.

The following Statements of Revenue and Expenses include "Other Federal Revenue." This includes funding received for a specific position within the organizations which are staffed at Comp 1. The revenue received was for Increased Demand for Services (IDS) ARRA funding for specific positions to be added and retained within the organization in order to avoid layoffs and increase access to services. The addition of (3) positions included 1FTE dentist and 2FTE dental assistants at Comp 1. The positions retained were 3 outreach workers previously funded through the Missouri Primary Care Association (MPCA) Women Health and Minority grant for Comp 1.

In addition to IDS ARRA funding, the center received Capital Improvement Program (CIP) ARRA funding for capital improvements and not operational revenue to improve and enhance clinical technology to make available high-quality healthcare services. The funds received were for electronic health records upgrades, facility equipments, parking lot repair, new roof, exam tables, digital radiology equipment, digital ophthalmology equipment and dental equipment. The capital improvement funding from the CIP grant benefited all three sites.

The following financial statements list "Contributed Services." This is donated pharmaceuticals from Pfizer.

The following financial statements also list "Other Funding." These include the following funds:

- Missouri Primary Care Association funding for (Women and Minority, Oral Health Services, Expansion Services, Teen Enrollment Services, Bio-Terrorism and Health Disparity Collaborative)
- Grace Hill Homeless Funding – homeless patients medication and clinical services
- Dismas House -- clinical visits for clients in re-entering program.

- West End Clinic -- physical examinations of clients in chemical treatment program
- Show Me Healthy Women -- breast exams and cervical cancer exams for uninsured women

Background and Assumptions: July 1, 2012 – June 30, 2013

The projection of the operating plan for the first year of the Pilot Program reflects a surplus of $90,461 based on total revenue of $18,879,691 and total expenses of $18,789,230.

The following assumptions were built into the financial projections:

- HRSA funding was kept at the current level plus the expected Increased Demand for Service (IDS) funding was added;
- For Medicaid revenue, assumed current rates of reimbursement per encounter at each site for the population currently enrolled in Medicaid;
- For new adult population covered by Medicaid, assumed 2.8 visits per year at the current average encounter rate with a 10% denial rate.
- Assumed overall 2% increase in patients each year;
- Pilot program revenue was based on the most conservative estimate provided by Wakely Consulting Group which included enrollment of 6,970 adult patients at the two legacy Myrtle Hilliard sites, and reimbursement at 100% of Medicare rates;
- Half of state funding was removed due to the uncertainty of future funding;
- Budgeted 2011 costs were used with a 5% increase for 2012;
- Assumed no new funding sources and no new services.

Background and Assumptions: January 1, 2014 – December 31, 2014

MHDCHC projects financial sustainability through December 31, 2014. The projected revenue budget for fiscal year 2014 is $22,165,512. There were several assumptions taken into consideration such as:

- All state funding was removed due to the uncertainty of future funding
- HRSA funding was kept at the current level plus expected Increased Demand for Service funding (IDS) and Expanded Services funding (ES) was added
- A 2% cost increase was projected each year
- Assumed no new funding sources

- For Medicaid revenue, assumed current rates at each site with 2% inflationary increase per year

Overall, the health center projects a profit of $225,279. The main facility is projected to generate a profit of $253,274 and Homer G. Phillips is estimated to operate with a loss of $15,905 and Florence Hill is projected to operate with a loss of $12,090. The projected losses for the two legacy centers are small and will not affected the overall sustainability of the organizations ability to operate. At the time of the data submission, several crucial facts where unknown including specific detailed information related to the financial aspect of proposed Affordable Care Act. Under the Pilot project, the patients are auto assigned to the legacy sites. Under the Reform Act, the patients will have the opportunity to select other providers; MHDCHC has estimated that at least a small percentage of patients will opt to try other providers, thereby decreasing the number of patients served therefore resulting in a small projected loss. For example, details such as coverage eligibility and allowable services factor into the organizations ability to project with certainty the financial impact. Therefore, the organization projected a small operational loss at the two legacy sites. However, MHDCHC will be able to make a more definitive projection as additional information becomes available regarding the Affordable Care Act. Current strategic planning has been made possible through information the organization has obtained in preparation for participation in other programs such as the Meaningful Use (National HIT Program), the Accountable Care Organization program, the Patient- Centered Medical Home initiative, and the National Committee for Quality Assurance (NCQA) Certification. The organization anticipates long-term sustainability support from additional financial benefits provided by participation in the above mentioned health care quality programs.

In 2014, the number of users is projected to be 36,947, of which 25,546 are medical users, 8,990 dental users and 2,411 are other users. Also, a 2% increase was projected in patients per year from 2009 – 2014. Medicaid users assume the 15% to 17% of uninsured patients seen at Comp 1 will remain uninsured in 2014 due to enrollment issues. The center projects to generate 116,621 encounters in 2014 of which 67,609 from Comp 1, 25,711 from Homer G. Phillips and 23,301 from Florence Hill.

Myrtle Hilliard Davis Comprehensive Health Centers, Inc.

Statement of Revenue and Expense for the year ending December 31, 2010

	Clinical Operations				Other Programs	
	Center #1	Center #2	Other Centers	Total Clinical	(optional)	Total
	MHDCHC-Main Site	Homer G. Phillips	Florence Hill		[Name]	
Revenues						
HRSA Grants	$ 2,423,276			$ 2,423,276		$ 2,423,276
Other Federal Revenue	$ 543,441			$ 543,441		$ 543,441
Medicaid/Medicare	$ 3,352,261	$ 1,173,291	$ 636,930	$ 5,162,482		$ 5,162,482
Other Patient Revenue	$ 3,780,210	$ 1,323,074	$ 1,197,067	$ 6,300,351		$ 6,300,351
DSH Funding		$ 1,836,271	$ 1,807,381	$ 3,643,652		$ 3,643,652
Community Funding				$ -		$ -
Other Funding	$ 1,261,821	$ 441,637	$ 399,577	$ 2,103,035		$ 2,103,035
Contributed Services	$ 853,760	$ 298,816	$ 270,357	$ 1,422,933		$ 1,422,933
Total Revenues	**$ 12,214,769**	**$ 5,073,089**	**$ 4,311,312**	**$ 21,599,170**		**$ 21,599,170**
Expenses						
Salaries, employee benefits and payroll taxes	$ 7,705,055	$ 3,505,575	$ 2,886,204	$ 14,096,834		$ 14,096,834
Professional and contractual services	$ 837,992	$ 293,297	$ 265,364	$ 1,396,653		$ 1,396,653
Supplies	$ 802,804	$ 280,982	$ 254,221	$ 1,338,007		$ 1,338,007
Insurance	$ 78,887	$ 27,611	$ 24,981	$ 131,479		$ 131,479
Pharmaceuticals	$ 873,575	$ 305,751	$ 276,632	$ 1,455,958		$ 1,455,958
Occupancy	$ 248,653	$ 87,028	$ 78,740	$ 414,421		$ 414,421
Depreciation	$ 530,959	$ 185,836	$ 168,137	$ 884,932		$ 884,932
Contributed services	$ 853,760	$ 298,816	$ 270,357	$ 1,422,933		$ 1,422,933
Other	$ 245,188	$ 85,816	$ 77,643	$ 408,647		$ 408,647
Total Expenses	**$ 12,176,873**	**$ 5,070,712**	**$ 4,302,279**	**$ 21,549,864**		**$ 21,549,864**
				$ -		
Surplus / (Deficit)	**$ 37,896**	**$ 2,377**	**$ 9,033**	**$ 49,306**		**$ 49,306**

Myrtle Hilliard Davis Comprehensive Health Centers

Statistical Information for the 12 Months Ending December 31, 2010

	Clinical Operations				Other Programs	
	Center #1 Comp 1	Center #2 Homer G. Phillips	Center #3 Florence Hill	Total Clinical	(optional) [Name]	Total
Number of Users						
Medical users	13,527	5,060	5,441	24,028		24,028
Dental users	5,251	2,089	2,483	9,823		9,823
Other users	1,402	521	300	2,223		2,223
Urgent Care users						
Specialty Care users						
Total Users	**20,180**	**7,670**	**8,224**	**36,074**		**36,074**
New medical users (patients not seen by GHNHC, MHDCHC, SLCC within last 12 mos.)	2,521	1,427	1,084	5,032		5,032
Encounters						
Primary Medical Care	45,665	14,271	14,555	74,491		74,491
Dental	12,321	4,914	4,798	22,033		22,033
Mental Health						
Substance Abuse						
Enabling Services	1,013	929	602	2,544		2,544
Total Encounters	**59,516**	**20,168**	**19,957**	**99,641**		**99,641**
Users by payor class						
Medicaid	4,131	2,120	2,766	9,017		9,017
Medicare	636	577	354	1,567		1,567
Other insurance	1,528	576	675	2,779		2,779
Uninsured	13,885	4,397	4,429	22,711		22,711
	20,180	**7,670**	**8,224**	**36,074**		**36,074**

Myrtle Hilliard Davis Comprehensive Health Centers

Projected Statement of Revenue and Expenses

July 1, 2012 – June 30, 2013

	Clinical Operations				Other Programs	
	Center #1	Center #2	Other Centers	Total Clinical	(optional)	Total
	MHDCHC-Main Site	Homer G. Phillips	Florence Hill		[Name]	
Revenues						
HRSA Grants	$ 2,739,516			$ 2,739,516		$ 2,739,516
Other Federal Revenue	$ 40,000			$ 40,000		$ 40,000
Medicaid	$ 3,690,209	$ 1,308,410	$ 1,366,300	$ 6,364,919		$ 6,364,919
Medicare	$ 1,119,988	$ 664,266	$ 357,091	$ 2,141,345		$ 2,141,345
Pilot Program		$ 2,080,000	$ 1,920,000	$ 4,000,000		$ 4,000,000
Commercial	$ 740,656	$ 278,069	$ 216,502	$ 1,235,227		$ 1,235,227
Other Patient Revenue	$ 211,620	$ 170,429	$ 148,930	$ 530,979		$ 530,979
Community Funding				$ -		$ -
Other Funding	$ 397,094	$ 2,362	$ 7,463	$ 406,920		$ 406,920
Contributed Services	$ 786,709	$ 354,361	$ 279,715	$ 1,420,786		$ 1,420,786
Total Revenues	**$ 9,725,792**	**$ 4,857,897**	**$ 4,296,001**	**$ 18,879,691**	**$ -**	**$ 18,879,691**
Expenses						
Salaries, employee benefits and payroll taxes	$ 5,900,504	$ 3,250,983	$ 2,970,139	$ 12,121,626		$ 12,121,626
Professional and contractual services	$ 540,053	$ 484,775	$ 452,944	$ 1,477,772		$ 1,477,772
Supplies	$ 641,386	$ 225,664	$ 126,243	$ 993,294		$ 993,294
Insurance	$ 46,688	$ 13,759	$ 13,035	$ 73,481		$ 73,481
Pharmaceuticals	$ 670,630	$ 251,699	$ 273,581	$ 1,195,910		$ 1,195,910
Occupancy	$ 278,969	$ 58,674	$ 35,432	$ 373,075		$ 373,075
Depreciation	$ 403,813	$ 175,174	$ 98,182	$ 677,170		$ 677,170
Contributed services	$ 786,709	$ 343,514	$ 271,152	$ 1,401,375		$ 1,401,375
Other	$ 417,235	$ 43,592	$ 14,701	$ 475,527		$ 475,527
Total Expenses	**$ 9,685,987**	**$ 4,847,833**	**$ 4,255,410**	**$ 18,789,230**		**$ 18,789,230**
Surplus / (Deficit)	**$ 39,805**	**$ 10,064**	**$ 40,592**	**$ 90,461**		**$ 90,461**

Myrtle Hilliard Davis Comprehensive Health Centers

Projected Statistical Information for July 1, 2012 – June 30, 2013

	Clinical Operations				Other Programs	
	Center #1 MHDCHC-Main Site	Center #2 Homer G. Phillips	Center #3 Florence Hill	Total Clinical	(optional) [Name]	Total
Number of Users						
Medical users	12,651	3,833	3,682	**20,166**		20,166
Dental users	5,565	2,626	2,615	**10,805**		10,805
Other users	1,174	576	531	**2,281**		2,281
Total Users	**19,390**	**7,035**	**6,828**	**33,253**		**33,253**
Users by payor class						
Medicaid	7,368	1,196	1,345	9,909		9,909
Medicare	873	429	395	1,697		1,697
Pilot Program	-	3,555	3,415	6,970		6,970
Commercial Insured	1,548	760	700	3,008		3,008
Uninsured	9,601	1,091	977	11,669		11,669
Total Users (equals row 15)	**19,390**	**7,031**	**6,832**	**33,253**	-	**33,253**
Encounters						
Primary Medical Care	44,278	12,266	11,784	68,328		68,328
Dental	8,347	3,938	3,923	16,208		16,208
Mental Health						-
Substance Abuse						-
Enabling Services	4,821	2,904	1,371	9,096		9,096
Other (Podiatry and Optometry)	4,692	1,200	1,200	7,092		7,092
Total Encounters	**62,138**	**20,308**	**18,277**	**100,723**		**100,723**

Myrtle Hilliard Davis Comprehensive Health Centers
Projected Statement of Revenue and Expenses
Calendar Year Jan 1, 2014 through December 31, 2014

	Clinical Operations				
	Center #1	Center #2	Other Centers	Total Clinical	Total
	MHDCHC-Main Site	Home G. Phillips	Florence Hill		
Revenues					
HRSA Grants	$ 3,142,000.00	$ -	$ -	$ 3,142,000.00	$ 3,142,000.00
Other Federal Revenue	$ 40,000.00			$ 40,000.00	$ 40,000.00
Hospital existing	$ -	$ -	$ -	$ -	$ -
Medicaid existing	$ 5,731,016.23	$ 2,005,855.68	$ 1,814,821.81	$ 9,551,693.72	$ 9,551,693.72
Medicaid newly insured adults	$ 4,700,144.96	$ 1,115,901.04	$ 759,195.15	$ 6,575,241.15	$ 6,575,241.15
Medicare	$ 153,682.00	$ 32,273.00	$ 29,199.58	$ 215,154.58	$ 215,154.58
"Exchange"	$ 32,273.22	$ 6,777.33	$ 6,131.91	$ 45,182.46	$ 45,182.46
Commercial	$ 74,535.77	$ 15,652.41	$ 14,161.80	$ 104,349.97	$ 104,349.97
Other Patient Revenue	$ 235,133.46	$ 189,365.00	$ 165,478.00	$ 589,976.46	$ 589,976.46
Community Funding				$ -	$ -
Other Funding	$ 441,215.63	$ 2,624.67	$ 8,292.53	$ 452,132.82	$ 452,132.82
Contributed Services	$ 802,764.37	$ 361,593.30	$ 285,423.56	$ 1,449,781.22	$ 1,449,781.22
Total Revenues	**$ 15,352,765.63**	**$ 3,730,042.42**	**$ 3,082,704.33**	**$ 22,165,512.38**	**$ 22,165,512.38**
Expenses					
Salaries, employee benefits and payroll taxes	$ 10,393,822.33	$ 2,338,736.60	$ 1,994,509.70	$ 14,727,068.63	$ 14,727,068.63
Professional and contractual services	$ 1,184,531.74	$ 236,604.81	$ 224,151.92	$ 1,645,288.47	$ 1,645,288.47
Supplies	$ 659,711.56	$ 237,541.19	$ 132,887.88	$ 1,030,140.63	$ 1,030,140.63
Insurance	$ 48,022.15	$ 14,482.86	$ 13,720.61	$ 76,225.62	$ 76,225.62
Pharmaceuticals	$ 702,564.38	$ 264,946.70	$ 287,979.92	$ 1,255,490.99	$ 1,255,490.99
Occupancy	$ 392,143.49	$ 61,762.42	$ 37,296.42	$ 491,202.33	$ 491,202.33
Depreciation	$ 425,066.73	$ 184,393.71	$ 103,349.86	$ 712,810.30	$ 712,810.30
Contributed services	$ 802,764.37	$ 361,593.30	$ 285,423.56	$ 1,449,781.23	$ 1,449,781.23
Other	$ 490,864.43	$ 45,885.92	$ 15,474.81	$ 552,225.16	$ 552,225.16
Total Expenses	**$ 15,099,491.18**	**$ 3,745,947.52**	**$ 3,094,794.68**	**$ 21,940,233.38**	**$ 21,940,233.38**
Surplus / (Deficit)	**$ 253,274.45**	**$ (15,905.10)**	**$ (12,090.35)**	**$ 225,279.01**	**$ 225,279.01**

Myrtle Hilliard Davis Comprehensive Health Centers
Statistical Information for the 12 Months Ending December 31, 2014

	Clinical Operations				
	Center #1	**Center #2**	**Center #3**	**Total Clinical**	**Total**
	MHDCHC-Main Site	**Homer G. Phillips**	**Florence Hill**		
Number of Users					
Medical users	13,378	5,909	6,259	25,546	25,546
Dental users	4,609	1,991	2,390	8,990	8,990
Other users	1,543	574	294	2,411	2,411
Urgent Care users					
Specialty Care users					
Total Users	**19,530**	**8,474**	**8,943**	**36,947**	**36,947**
Users by payor class					
Medicaid (assuming up to 133% of poverty for adults)	14,257	6,847	7,226	28,330	28,330
Medicare	1,016	441	465	1,921	1,921
Exchange (assume current uninsured > 133% FPL)	332	102	107	541	541
Commercial Insured	781	312	298	1,391	1,391
Uninsured	3,144	888	732	4,764	4,764
Total Users	**19,530**	**8,589**	**8,828**	**36,947**	**36,947**
Encounters					
Primary Medical Care	49,048	17,167	15,532	81,747	81,747
Dental	10,140	4,380	5,258	19,778	19,778
Mental Health					
Substance Abuse					
Enabling Services	4,821	2,904	1,371	9,096	9,096
Other (Podiatry and Optometry)	3,600	1,260	1,140	6,000	6,000
Urgent Care users					
Specialty Care					
Cardiology					
Dermatology					
Endocrinology					
Other					
Total Encounters	**67,609**	**25,711**	**23,301**	**116,621**	**116,621**
Project 2% increase in patients per year from 2009-2014					

St. Louis ConnectCare

St. Louis ConnectCare operates from one location and provides services in seven lines of business, as follows:

- Urgent Care
- Community Health (testing and treatment of STDs; testing for TB; immunization for Hep A)
- Specialty Care (twelve medical surgical specialties)
- Radiology (five modalities)
- Ambulatory Surgery Center (Level II, primarily GI procedures)
- Pharmacy
- Transportation

As noted on the following financial statements, St. Louis ConnectCare provides "enabling services." These are services provided to patients that assist them in receiving medical care. These services consist of interpretation services, transportation to and from the provider and social service consults. There is no charge to the patient for the use of these services. St. Louis ConnectCare does not provide mental health or substance abuse services.

Regarding the funding projections and questions received from CMS March 3, 2011, ConnectCare does not receive HRSA grant funding. Projected "other Federal revenue" includes anticipated federal grants for transportation services.

Background and Assumptions: July 1, 2012 – December 31, 2013

The projection of the operating plan for the eighteen month period ending December 31, 2013 reflects a deficit of $4,251,391 from operations based on revenue of 21,322,675 and expenses of 25,574,065.

The following assumptions were built into the financial projections:

Revenue:

- Collaborating with other medical transportation carriers to increase our transportation income.
- Meeting with providers to increase our ASC referrals.
- Increasing the number of tenants in our building.

- Following the actuary suggestions regarding the volume projections for Pilot patients.
- Developing a marketing plan to increase our more favorable “payer mix” business.

Expenses:

- A 2% cost increase is projected each year from 2010.
- The elimination of voucher expenses will impact multiple areas which will lower expenses.
- If the supportive/Ancillary Services don’t breakeven, the elimination of the services will be considered to decrease expenses.
- Replacing some physician coverage with mid-level coverage.
- Implementing a billing software upgrade for improved efficiency.
- Reviewing our staffing levels for all disciplines which should result in a 15% staffing reduction from our 2010 fiscal year level.
- Completed an HVAC upgrade which replaces a sixty year old high-pressure boiler system.

The total number of users is projected to be 79,226, which are comprised of 22,068 Urgent Care, 22,754 Specialty, 17,327 Radiology, 2,300 Endoscopy, 7,697 STD and 7,080 TB and HepA. A 2% annual increase is projected for the period July 2010-December 2013.

The pilot plan funding we proposed was to utilize a payer level reimbursement of 167% of Medicare payment for the first four quarters. We then proposed 150% for the fifth quarter and 100% for the sixth quarter. We feel that it was best to address the patients consistently for one year prior to shifting them into a different payer level.

In summary, we will continue to monitor our progress on all of our ongoing activities to reduce the proposed four million dollar deficit. We estimate that we should have enough in reserves to assist us through the pilot plan and still have some reserves available for our 2014 calendar year.

Background and Assumptions: January 1, 2014 – December 31, 2014

Saint Louis ConnectCare projects financial sustainability through December 31, 2014. The projected revenue budget for the year 2014 is $18,306,289. There were several assumptions taken into consideration such as:

Revenue

- Additional tenants will increase the tenant revenue.
- Due to Exchange and Medicaid coverage additional pharmacy revenue will be obtained.
- Additional transportation revenue will be received from Medicaid.
- Additional revenue generated through the leasing of the ASC suites.

Expenses

- A 2% cost increase is projected each year from 2010 through 2014.
- The elimination of voucher expenses will impact multiple areas which will lower expenses.
- If the supportive/ Ancillary Services don't breakeven, the elimination of the services will be considered to decrease expenses.

Overall, Saint Louis ConnectCare projects a profit of $679,749 for the year 2014.

The number of users is projected to be 54,936 for the year 2014. A 2% annual increase is projected for the period July 2010-December 31, 2013. For 2014 it is assumed that Saint Louis ConnectCare will have a 10% increase of users. This 10% increase is made up of 60% Medicaid payer mix and 40% Exchange payer mix. There is also the assumption that the encounter to user ratio will remain the same.

An assumption regarding our users is that 15% of our total users will remain uninsured. This population will consist of homeless, chronically health care illiterate and mentally or developmentally challenged.

We assume that our payment rates for Medicare and Exchange payer class will cover our cost. We anticipate that Medicaid will continue to pay us at 75% of what Medicare pays. Our assumption regarding Commercial payers is that they will cover our cost plus 15%.

St. Louis ConnectCare
Statement of Revenue and Expense
For Calendar Year January 1, 2010 – December 31, 2010

	Clinical Operations				Other Programs	
	Center #1 [Name]	Center #2 [Name]	Other Centers [Name]	Total Clinical	(optional) [Name]	Total
Revenues						
HRSA Grants						
Other Federal Revenue						$ 110,576
Medicaid/Medicare						$ 1,295,501
Other Patient Revenue						$ 1,148,841
DSH Funding						$ 14,100,000
Community Funding						$ 5,000,000
Other Funding						$ 2,876,881
Contributed Services[1]						
Total Revenues						**$ 24,531,799**
Expenses						
Salaries, employee benefits and payroll taxes						$ 9,948,669
Professional and contractual services[2]						$ 5,639,091
Supplies						$ 504,858
Insurance						$ 803,828
Pharmaceuticals						$ 1,018,687
Occupancy						$ 1,476,798
Depreciation						$ 831,966
Contributed services						
Other						$ 806,532
Total Expenses						**$ 21,030,429**
Surplus / (Deficit)[3]						**$ 3,501,370**

** (Revenue) Contributed Buildings Space of $1,729,500.00 - (Expenses) - Contributed Building Rent SLCC of $1,729,500.00

[1] SLCC is not required to and does not track the value of services provided by volunteers.

[2] Included $2,920,257.00 paid under the Voucher Program for services provided to patients at participating hospitals by the hospital, medical school faculty, and community physicians.

[3] $1.1 million contribution given by RHC for replacement Boiler system at Saint Louis ConnectCare included in the total amount.

St. Louis ConnectCare

Statistical Information for the 12 months ending December 31, 2010

	Urgent Care	Specialty	Radiology	Endoscopy					
Number of Users									
Other users					4,841	4,841	4,453		9,294
Urgent Care users	10,472					10,472			10,472
Specialty Care users		7,963				7,963			7,963
Diagnostic Services Users			6,470	1,191		7,661			7,661
Total Users	**10,472**	**7,963**	**6,470**	**1,191**	**4,841**	**30,937**	**4,453**		**35,390**
New Medical Users	6,521	3,644	3,112	512	2,418	16,207			16,207
Encounters									
Primary Medical Care									
Dental									
Mental Health									
Substance Abuse									
Enabling Services									
Screening for Life	0								
Interpreter Service								488	488
Transportation								36,880	36,880
SocServ/Drug Assist								2,159	2,159
Total Enabling Services								**39,527**	**39,527**
Other Program Encounters					5,898	5,898	4,453		**10,351**
Urgent Care	**13,265**					**13,265**			**13,265**
Specialty Care									
Cardiology		2,201				2,201			2,201
Dermatology		1,122				1,122			1,122
Endocrinology		1,130				1,130			1,130
Other		35				35			35
General Surgery		1,625				1,625			1,625
Gastroenterology		3,585				3,585			3,585
Urology		1,043				1,043			1,043
Infectious Disease		0				0			0
Nephrology		1,850				1,850			1,850
Neurology		1,702				1,702			1,702
Gynecology (Surgical)		50				50			50
Orthopedics		1,707				1,707			1,707
Otolaryngology		1,202				1,202			1,202
Pulmonary		579				579			579
Rheumatology		295				295			295
Total Specialty Care Encounters		**18,126**				**18,126**			**18,126**
Diagnostic Services									
Endoscopy				1,434		1,434			1,434
Radiology			10,801			10,801			10,801
Total Diagnostic Services Encounters						**12,235**			**12,235**
Total Encounters with Enabling Services	**13,265**	**18,126**	**10,801**	**1,434**	**5,898**	**49,524**	**4,453**	**39,527**	**93,504**
Total Encounters without Enabling Services	**13,265**	**18,126**	**10,801**	**1,434**	**5,898**	**49,524**	**4,453**		**53,977**

St. Louis ConnectCare

Projected Statement of Revenue and Expense

For July 1, 2012 – December 31, 2013

Projected Statement of Revenue and Expense												
July 1, 2012 through December 31, 2013												
(4 quarters @ 167, 1 quarter @ 150, 1 quarter @ 100)												
	Clinical Operations						Other Programs					
	Center #1	Center #2	Other Centers		Other Programs						Enabling	
	Urgent Care	Specialty	Radiology	Endoscopy	STD	Total Clinical	TB & Hep A	Pharmacy	Transportation	Voucher	Services	Total
Revenues												
HRSA Grants												
Other Federal Revenue												
Medicaid	$ 315,729	$ 768,705	$ 337,262	$ 373,340	$ 70,715	$ 1,865,751	$ -	$ 505,971	$ -	$ -		$ 2,371,722
Medicare	114,165	511,727	203,354	189,348	9,391	1,027,985	-	249,976	-	-		1,277,961
Pilot Program	2,549,690	5,202,235	3,187,663	2,322,849	-	13,262,438	-	275,654	843,718	-	-	14,381,809
Commercial	131,884	43,569	99,388	78,132	(31,952)	321,021	(633)	214,010	-	-		534,398
Other Patient Revenue	32,507	-	12,467	-	767,723	812,696	215,543	553,938	424,608	450,000		2,456,784
Uninsured	72,612	61,801	50,768	10,870	52,016	248,066	51,934	-	-	-		300,000
Other Funding												-
Contributed Services	-	-	-	-	-	-	-	-	-	-	-	-
Total Revenues	**3,216,586**	**6,588,037**	**3,890,902**	**2,974,539**	**867,893**	**17,537,957**	**266,843**	**1,799,548**	**1,268,326**	**450,000**	**-**	**21,322,675**
Expenses												
Salaries, employee benefits and payroll taxes	3,382,822	4,131,162	2,156,241	1,254,182	1,171,888	12,096,296	233,692	1,265,100	806,752	-		14,401,841
Professional and contractual services	361,924	2,018,217	184,172	133,193	76,492	2,773,999	29,294	8,385	42,255	-		2,853,933
Supplies	304,516	315,353	151,864	223,138	75,326	1,070,197	8,326	55,142	25,679	-		1,159,344
Insurance	599,510	286,570	248,145	44,824	37,193	1,216,242	16,141	25,867	92,157	-		1,350,407
Pharmaceuticals	79,982	380,607	60,500	23,793	63,981	608,863	145,296	1,081,392	(11)	-		1,835,539
Occupancy	343,957	515,419	215,521	171,125	127,081	1,373,103	8,345	192,644	31,115	-		1,605,207
Depreciation	194,946	260,490	103,620	91,326	70,953	721,335	5,269	111,839	11,064	-		849,507
Contributed services	-	-	-	-	-	-	-	-	-	-		-
Other	232,445	324,465	354,138	213,647	46,712	1,171,407	5,026	95,216	246,638	-		1,518,287
Total Expenses	**5,500,103**	**8,232,282**	**3,474,202**	**2,155,228**	**1,669,627**	**21,031,442**	**451,389**	**2,835,584**	**1,255,649**	**-**	**-**	**25,574,065**
Surplus / (Deficit)	**$ (2,283,517)**	**$ (1,644,245)**	**$ 416,699**	**$ 819,311**	**$ (801,735)**	**$ (3,493,486)**	**$ (184,546)**	**$ (1,036,036)**	**$ 12,677**	**$ 450,000**	**$ -**	**$ (4,251,391)**

St. Louis ConnectCare
Projected Statistical Information for July 1, 2012 – December 31, 2013

Planning Template for "Gateway Demonstration" Sustainability Plan											
St. Louis ConnectCare											
Projected Statistical Information for July 1, 2012 through December 31, 2013											
Assumed Medicare % for Pilot Program	100% (4 quarters), 150% - 1 quarter and 100% - 1 quarter)										
	Clinical Operations										
	Center #1	Center #2	Other Centers		Other Programs		Other Programs			Enabling	
	Urgent Care	Specialty	Radiology	Endoscopy	STD	Total Clinical	TB & Hep A	Pharmacy	Transportation	Services	Total
Number of Users											
Urgent Care users	22,068					22,068					22,068
Specialty Care users		22,754				22,754					22,754
Diagnostic Services Users											
Endoscopy				2,300		2,300					2,300
Radiology			17,327			17,327					17,327
Other users	-	-	-	-	7,697	7,697	7,080	-	-	-	14,777
Total Users	**22,068**	**22,754**	**17,327**	**2,300**	**7,697**	**72,144**	**7,080**	**-**	**-**	**-**	79,224
Users by payor class (See note 1, 2)											
Medicaid	1,095	1,548	949	83	51	3,726	366				4,092
Medicare	3,407	2,616	1,769	183	431	8,406	825				9,231
Other Insurance	2,239	364	799	44	124	3,570	351				3,921
Pilot Program	9,892	16,760	11,728	1,815	-	40,196	3,945				44,141
Uninsured	5,434	1,465	2,082	174	7,091	16,246	1,595				17,841
Total Users	22,068	22,754	17,327	2,300	7,697	72,144	7,082				79,226
Encounters											
Urgent Care	27,995				9,378	37,373	7,080				44,453
Specialty Care		50,555				50,555					50,555
Diagnostic Services											
Endoscopy				3,675		3,675					3,675
Radiology	-	-	27,682	-	-	27,682					27,682
Total Diagnostic Services Encounters	-	-	27,682	3,675	-	31,358					31,358
Enabling Services						-			57,101	4,209	61,310
Other Program Encounters	-	-	-	-	-	-	-	-	-	-	-
Total Encounters with Enabling Services	27,995	50,555	27,682	3,675	9,378	119,286	7,080	-	57,101	4,209	187,676
Total Encounters without Enabling Services	27,995	50,555	27,682	3,675	9,378	119,286	7,080	-	-	-	126,366

St. Louis ConnectCare
Projected Statement of Revenue and Expense
For Calendar Year January 1, 2014 – December 31, 2014

	Clinical Operations						Other Programs					
	Center #1	Center #2	Other Centers		Other Programs						Enabling	
	Urgent Care	Specialty	Radiology	Endoscopy	STD	Total Clinical	TB & Hep A	Pharmacy	Transportation	Other	Services	Total
Revenues												
HRSA Grants												
Other Federal Revenue												
Medicaid	$ 1,060,329	$ 3,889,971	$ 1,433,029	$ 1,259,519	$ 46,783	$ 7,689,630	$ 33,648	$ -	$ -			$ 7,723,278
Medicare	105,374	379,553	123,022	63,872	6,212	678,033	3,138	-	-			681,171
Exchange	444,283	305,491	227,031	128,619	735,985	1,841,410	11,629	1,307,272	-			3,160,311
Pilot Program	-	-	-	-	-	-	-	-	-		-	-
Commercial	188,749	78,154	90,839	30,022	13,274	401,038	2,635	-	-			403,673
Other Patient Revenue	21,671	-	8,311	-	511,815	541,797	143,695	369,292	283,072			1,337,856
Uninsured	-	-	-	-	-	-	-	-	-			-
Other Funding												-
Community Funding										5,000,000		5,000,000
Contributed Services	-	-	-	-	-	-	-	-	-	-	-	-
Total Revenues	**1,820,406**	**4,653,169**	**1,882,233**	**1,482,032**	**1,314,069**	**11,151,908**	**194,746**	**1,676,564**	**283,072**	**5,000,000**	**-**	**18,306,289**
Expenses												
Salaries, employee benefits and payroll taxes	2,317,945	2,832,395	1,477,089	859,399	802,720	8,289,547	160,450	869,305	552,332	-		9,871,634
Professional and contractual services	250,434	1,405,662	127,209	92,040	52,707	1,928,051	20,136	5,211	29,225	-		1,982,623
Supplies	214,080	219,557	106,630	157,698	52,986	750,951	5,838	38,672	17,981	-		813,443
Insurance	419,025	199,950	173,302	31,122	25,806	849,205	11,258	17,901	64,120	-		942,483
Pharmaceuticals	56,722	269,867	42,885	16,865	45,404	431,743	103,108	766,741	(8)	-		1,301,584
Occupancy	236,076	353,692	147,937	117,448	87,232	942,384	5,718	132,135	21,375	-		1,101,613
Depreciation	129,964	173,660	69,080	60,884	47,302	480,890	3,513	74,559	7,376	-		566,338
Contributed services	-	-	-	-	-	-	-	-	-			-
Other	159,682	222,950	244,762	147,727	32,054	807,176	3,455	65,602	170,591	-		1,046,823
Total Expenses	**3,783,928**	**5,677,732**	**2,388,894**	**1,483,182**	**1,146,211**	**14,479,948**	**313,475**	**1,970,126**	**862,992**	**-**	**-**	**17,626,541**
Surplus / (Deficit)	**$(1,963,523)**	**$(1,024,564)**	**$ (506,661)**	**$ (1,150)**	**$ 167,858**	**$ (3,328,040)**	**$ (118,729)**	**$ (293,562)**	**$ (579,920)**	**$ 5,300,000**	**$ -**	**$ 679,749**

St. Louis ConnectCare
Projected Statistical Information for the 12 months ending December 31, 2014

	Clinical Operations						Other Programs				
	Center #1	Center #2	Other Centers		Other Programs		Other Programs			Enabling	
	Urgent Care	Specialty	Radiology	Endoscopy	STD	Total Clinical	TB & Hep A	Pharmacy	Transportation	Services	Total
Number of Users											
Urgent Care users	15,521					15,521					15,521
Specialty Care users		15,565				15,565					15,565
Diagnostic Services Users											
Endoscopy				1,581		1,581					1,581
Radiology			11,905			11,905					11,905
Other users	-	-	-	-	5,644	5,644	4,720	-	-	-	10,364
Total Users	15,521	15,565	11,905	1,581	5,644	50,216	4,720	-	-	-	54,936
Users by payor class											
Medicaid	8,847	8,872	6,786	901	56	25,462	283				25,746
Medicare	776	778	595	79	282	2,511	614				3,124
Other Insurance	3,104	3,113	2,381	316	113	9,027	283				9,310
Pilot Program	466	467	357	47		1,337	2,549				3,886
Uninsured	2,328	2,335	1,786	237	5,193	11,878	991				12,870
Total Users	15,521	15,565	11,905	1,581	5,644	50,216	4,720	-	-	-	54,936
Encounters											
Urgent Care	19,690				6,252	25,942	5,192				31,134
Specialty Care		34,584				34,584					34,584
Diagnostic Services											
Endoscopy				2,525		2,525					2,525
Radiology	-	-	19,022	-	-	19,022					19,022
Total Diagnostic Services Encou	-	-	19,022	2,525	-	21,547					21,547
Enabling Services						-			39,745	3,087	42,832
Other Program Encounters	-	-	-	-	-	-	-	-	-	-	-
Total Encounters with Enabling Services	19,690	34,584	19,022	2,525	6,252	82,073	5,192	-	39,745	3,087	130,097
Total Encounters without Enabling Servic	19,690	34,584	19,022	2,525	6,252	82,073	5,192	-	-	-	87,265

IHN Community Referral Coordinator Program

Background

The St. Louis Integrated Health Network (IHN) was formed in 2003 based on the recommendation of the St. Louis Regional Health Commission (RHC) to, "form a permanent regional network or umbrella organization to coordinate and integrate the delivery of primary and specialty health services to the uninsured and underinsured populations in Saint Louis County and the City of St. Louis" and opportunities afforded by the Office of Health and Human Services.

The IHN's mission is: through collaboration and partnership to strive for quality, accessible and affordable healthcare services for all residents of Metropolitan St. Louis with an emphasis on the medically underserved. The Network is comprised of nine organizations including five federally qualified health centers, one safety net specialty care provider, two medical schools and the public health system. Together, the Network serves over 172,000 patients through 480,000 primary care encounters and 125,000 safety net specialty care encounters each year.

The Primary Care Home Initiative

All IHN programs and implementation teams work together under the umbrella of the Primary Care Home Initiative that focuses on improving patient care by:

- Connecting Medicaid and uninsured patients with a primary care home
- Reducing non-emergent use of Emergency Services
- Enhancing access to primary care homes and health resources
- Enhancing coordination, quality, and efficiency of care through secure electronic exchange of patient health information
- Strengthening communication and referral processes among safety net providers

Community Referral Coordinator (CRC) Program Benchmarks and Sustainability

As part of the Primary Care Home Initiative, the pilot CRC program began in 2007 in two urban area emergency departments of high need and expanded to a third ED in 2009. Referral coordinators work in the emergency departments to assist the patient in securing a primary care home for future non-emergent needs.

Draft Benchmarks

- Expand to four hospitals as outlined in the Demonstration Project by Quarter 1 calendar year 2011
- Convene CRC oversight committee comprised of hospital and health center leadership by Quarter 1 calendar year 2011. This committee is charged to identify and reduce systemic barriers, increase program utilization and efficiency, and confirm approach for sustaining the CRC program.
- The CRC Program will continue to encounter at least 2,000 patients per quarter and make 500 referrals per quarter.
- Finalize a cost-benefit analysis to determine hospital ROI by Quarter 4 calendar year 2011
- Finalize and publish evaluation conducted by the National Opinion Research Center (NORC) calendar year 2011

Current Approach for Sustainability

The RHC and the Center for Medicare and Medicaid Services provided initial funding to cover programmatic and evaluation costs from 2007 to 2010. The IHN's current approach to secure sustainable funding beyond 2013 are:

- Confirm pilot success based on the CRC cost-benefit analysis, which will be done with the coordination and oversight of stakeholders in the program including community health centers and hospitals. These organizations will work together to finalize the specific approach to sustainability based on their findings. Potential options include:
    - Pursue federal funding opportunities that may be created out of healthcare reform that focus on ER diversion and care coordination
    - Secure funds from local providers including hospitals that realize benefit from the program
    - As the program expands to pediatric sites and the CRCs build relationships with Medicaid managed care programs, the IHN plans to assess how patients with managed Medicaid respond to the intervention and how collaboration can be beneficial around connecting patients to a medical home, potentially making it a valuable service to the managed care plans
    - Identify additional funding opportunities based on the recommendation of the CRC oversight committee.

Budget Narrative

Attached is the projected budget for the CRC Program.

The estimated cost of the CRC program in 2014 is $747,750.

Salaries, employee benefits and payroll taxes: This expense consists of 9.2 FTEs plus 25% employee benefits.

Professional and contractual services: This expense consists of staff training, data analysis and costs associated with maintaining employees i.e. a portion of human resources, accounting, payroll service, and IT services.

Supplies: This expense consists of office and program supplies, printed materials including collateral materials, postage and travel.

Business Insurance: This expense consists of a portion of the organizations business and general liability insurance.

Occupancy: The only expense included in occupancy is telephone. The organization is provided office space free of charge and each hospital is providing space for the referral coordinators free of charge.

Depreciation: This is the cost associated with the CRC computers and server.

IHN Community Referral Coordinator Program

		CRC Program
Revenues		
Federal Grants (TBD)		
Partner Contributions	$	747,750
Total Revenues		
Expenses		
Salaries, employee benefits and payroll taxes	$	695,250
Professional and contractual services	$	28,700
Supplies	$	14,500
Insurance	$	5,000
Occupancy	$	1,300
Depreciation	$	3,000
Total Expenses	**$**	**747,750**
Surplus / (Deficit)		

Partner contributions are expected to come from those organizations that derive economic value from the program as determined by a cost-benefit analysis. It is anticipated these organizations will be willing to fund the program on an ongoing basis.

St. Louis Regional Health Commission

Throughout its history, the St. Louis region has identified priorities for the St. Louis Regional Health Commission (SLRHC), beginning with the crisis created by the closure of the area's last remaining public hospital -- St. Louis Regional Hospital. Since then, RHC has led major regional planning initiatives, including a four-year effort to improve the region's behavioral health system, a program that led to the formation of Health Literacy Missouri, the creation of the St. Louis Integrated Health Network, and a grant program that awarded funds for research projects co-sponsored by community organizations and local medical schools.

These represent only a sample of the programs SLRHC has been engaged with throughout its ten year history. These programs are in addition to the administration of the Disproportionate Share (DSH) funds directed to the health centers through the section 1115 waiver.

Each time the community has requested the SLRHC to assume responsibility for a new initiative, funding has been identified and built into the budget for the project. It is anticipated that SLRHC will continue to operate in this manner after the "Gateway to Better Health" Demonstration ends.

The commissioners and the community will determine the priorities for the SLRHC to address in a post-reform era, post January 1, 2014. With these priorities, the funding streams will be determined. It is anticipated that the commissioners will begin to identify these priorities in 2013.

Throughout its history, SLRHC has maintained a flexible staffing model, enabling it to scale its operations as needed for the work identified by the community. The healthcare and civic organizations in the region have actively supported the work of the Commission throughout the years. Currently, core funding is provided by the City of St. Louis, St. Louis County and Civic Progress in addition to the DSH funds provided by the State of Missouri. Funds for special projects have been provided by organizations such as BJC HealthCare, Saint Louis University, Washington University School of Medicine, Missouri Foundation for Health, and the State of Missouri, Department of Mental Health.

These organizations believe the SLRHC provides a unique, neutral forum in which regional healthcare issues can be addressed. At this time, it is not possible to accurately assume what those issues may be in 2014. However, if the community believes there are healthcare issues to be addressed by a neutral body on behalf of the patients of the region, the leaders of the St. Louis region will identify the funding for that work.

At this time, funds provided to the SLRHC through the section 1115 waiver account for approximately 25% percent of its total operating budget. It is anticipated that these funds will be replaced through grants or additional member contributions, assuming there are issues related to healthcare access and disparities that should be addressed by a regional planning body. If no issues and funding streams are identified to replace this funding, the RHC will reduce the scale of its operations appropriately.

The projected 2014 financials for the SLRHC are exhibited below, assuming that no additional issues and attached funding are secured. At this level, the SLRHC will be able to maintain its core mission of monitoring and publically reporting on the status of access to health care in St. Louis, and maintain its role as a neutral convener for regional health care leaders to coordinate health policy in the region. The sources of revenue from the City of St. Louis, St. Louis County, and Civic Progress are assumed to be constant from 2010 levels. If other functions are deemed necessary by the Commission in addition to this role, additional revenue streams will be identified and secured at that time.

Planning Template for "Gateway Demonstration" Sustainability Plan			
St. Louis Regional Health Commission			
Projected Statement of Revenue and Expense			
Calendar Year Jan 1, 2014 through Dec 31, 2014			
			Total
Revenues			
	Govermental (St. Louis City/County)		$ 270,000
	Community Funding (Civic Progress)		$ 100,000
Total Revenues			**$ 370,000**
Expenses			
	Salaries, employee benefits and payroll taxes		$ 276,000
	Professional and contractual services		$ 30,000
	Supplies		$ 9,000
	Insurance		$ 15,000
	Pharmaceuticals		$ -
	Occupancy		$ 40,000
	Depreciation		$ -
	Contributed services		$ -
	Other		$ -
Total Expenses			**$ 370,000**
Surplus / (Deficit)			**$ -**

Gateway to Better Health

Pilot Planning Team Roster

Pilot Program Planning Team Roster

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

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

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

Melody Eskridge
President and Chief Executive Officer, St. Louis ConnectCare

Alan Freeman
President and Chief Executive Officer, Grace Hill Neighborhood Health Centers

Dolores Gunn, MD
Director, St. Louis County Department of Health

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

Ian McCaslin, MD, MPH
Director, MO HealthNet Division, Department of Social Services, State of Missouri

James Sanger
President and Chief Executive Officer, SSM Health Care St. Louis

Joanne Volovar
President, Molina Healthcare of Missouri

Joe Yancey
Executive Director, Community Alternatives

Gateway to Better Health

Health Center's Outreach Plans

1. GBH Outreach Plan Summary
2. Grace Hill Outreach Plan
3. Myrtle Hilliard Davis Outreach Plan

Target Gateway Enrollment: 14,500
Myrtle Hilliard Davis Target Enrollment: 5,400
Grace Hill Target Enrollment: 9,100
St. Louis ConnectCare Target Enrollment: 18,000

Gateway to Better Health Demonstration Project
Outreach and Enrollment Plan

Appendix B

In/Outreach and Enrollment at Legacy Sites

November – March 2012						
	Grace Hill		**Myrtle Hilliard Davis**		**St. Louis ConnectCare**	
Objectives	• To inreach to eligible Gateway participants within legacy sites. • To begin Gateway enrollment at legacy sites. • To assist SLCC with enrollment of Gateway eligible Tier 2 only participants at legacy sites who receive specialty care services regularly				• To identify a list of Gateway eligible who receive specialty services on an ongoing basis due to chronic condition and enroll them. • To assist with the enrollment of people on MHD & GH lists, as needed.	
In/Outreach Activities	• Targeted mailings • Phone calls • Home visits • Displays and brochures at legacy sites only • Enrollment fairs targeted for existing legacy site patients only				• Provide target information as patient is identified eligible for Gateway or on GH and MHD lists • No displays in health center/urgent care center	
Enrollment Sites	• GH/Murphy O'Fallon • GH/Soulard-Benton		• Homer G. Philips • Florence Hill		• St. Louis ConnectCare	
Enrollment Targets	Total Potential Enrollees	Target Enrollment #	Total Potential Enrollees	Target Enrollment #	Total Potential Enrollees	Target Enrollment #
• **Nov**	9.100	1200	5,400	700		
• **Dec**	7,900	2370	4,700	1400		
• **Jan**	5,530	1660	3,300	990		
• **Feb**	3,870	1780	2,310	1040		
• **Mar**	2,090	2,090	1,270	1,270		

Evaluate the current status of enrollment in March 2012. If enrollment targets are not met or close to being met by March 31, 2012, enrollment will be opened to Myrtle Hilliard Davis and Grace Hill non-legacy sites on April 1, 2012. The pre-enrollment period for people applying for Tier 2 only benefits will begin in June 2012 and will target those patients with specialty care appointments scheduled for July 1 or later.

Target Gateway Enrollment: 14,500
Myrtle Hilliard Davis Target Enrollment: 5,400
Grace Hill Target Enrollment: 9,100
St. Louis ConnectCare Target Enrollment: 18,000

In/Outreach and Enrollment at Myrtle Hilliard Davis and Grace Hill Non-Legacy Sites

April - June 2012						
	Grace Hill		**Myrtle Hilliard Davis**		**St. Louis ConnectCare**	
Objectives	• To continue enrollment at legacy sites. • To begin inreach and enrollment at non-legacy sites. • To continue assisting SLCC with the enrollment of Tier 2 only eligible who receive specialty services regularly.				• To continue enrolling individuals who receive specialty services on an ongoing basis. • To assist with the enrollment of people on MHD & GH lists, as needed. •	
In/Outreach Activities	• Targeted mailings • Phone calls • Home visits • Displays at all sites • Enrollment fairs targeted for legacy and non-legacy site patients only				• Provide target information as patient is identified eligible for Gateway or on lists • No displays in health center/urgent care center	
Enrollment Sites	• All Grace Hill sites		• All Myrtle Hilliard Davis sites		• SLCC	
Enrollment Targets	Total Potential Enrollees	Target Enrollment #	Total Potential Enrollees	Target Enrollment #	Total Potential Enrollees	Target Enrollment #
• **Apr**	Reset to 1,500	500	Reset to 1500	500		
• **May**	1,000	500	1000	500		
• **Jun**	500	500	500	500		

Evaluate the current status of enrollment in May 2012. If enrollment targets are not met or close to being met by May 30, 2012, enrollment will be opened to all non-legacy primary care sites in the IHN on June 1, 2012. The pre-enrollment period for people applying for Tier 2 only benefits will begin in June 2012 and will target those patients with specialty care appointments scheduled for July 1 or later.

Enrollment for eligible Gateway Tier 2 only participants will begin July 1, 2012.

Grace Hill Health Centers, Inc.

Gateway Waiver Outreach/Inreach Plan

8-31-2011

Grace Hill Health Centers needs to enroll 9,100 existing patients who meet the qualifications of the Tier One benefit of the Gateway Waiver between November 1, 2011 and March 31, 2012, before enrollment becomes open to uninsured patients who do not have a Primary Care Provider. In order to reach our goal, approximately 1,800 patients per month, during winter months, need to come in for enrollment at a Grace Hill legacy site. Therefore, Grace Hill proposes to implement the following Outreach/Inreach Plan:

1) Grace Hill will identify potentially eligible patients based upon its patient database and send out mailers to such existing patients of Grace Hill Health Centers in order to inform them that they may be eligible for the benefits offered under the Gateway Waiver health plan.
2) Mailers - Each month, starting in November 2011 until June 2012, mailers will go out to potentially qualified Grace Hill patients. Mailers to existing GH patients who meet the Tier One criteria may go out after April 2012 as needed.
3) Phone calls – patients will receive Outreach phone calls in order to encourage them to come in to enroll. Grace Hill's Tele-vox for system generated phone calls may also be utilized for reminders to enroll.
4) Home visits – Outreach staff will conduct home visits to patients whom we are unable to reach by phone in order to expedite enrollment. Enrollment will be completed during home visits, if at all possible and enrollment forms brought back to the Outreach supervisors for submittal to FSD. Door hangers will be used if patients are not home at the time of the visit.
5) Walk-in registration – Patients who came into one of the Grace Hill legacy sites for health care appointments will receive enrollment assistance via Registration staff at the same time as their health care appointment. Patients who walk-in in response to mailers, phone calls or other Outreach effort will be assisted by temporary Registration staff added to our workforce for this effort.
6) Flyers, posters and banners within our health centers will be utilized to get the message to patients starting in December 2011.
7) Enrollment Fairs – Grace Hill will host 20 enrollment fairs from November to March at the legacy site locations for in-reach purposes.
8) Incentives – various items will be purchased to use as incentives to encourage patients to come in to our legacy sites to enroll.
9) Facebook, Twiter and Text messaging may be utilized, particularly to reach out to younger patients.
10) Contingency Plan – In the event that the targeted number of Grace Hill patients has not been reached by May 31, 2012, Grace Hill proposes to also use billboards and newspaper adds, as shown below:
    a. Targeted billboards – messaging specific to potentially eligible existing patients, such as "Grace Hill/Murphy O'Fallon Patients may be eligible for lower cost co-pays. Call 814-xxxx or walk in at MOF to find out …". Actual copy and artwork pending.
    b. Targeted newspaper ads – messaging specific to potentially eligible existing patients, similar to the billboard messaging is proposed.

MYRTLE HILLIARD COMPREHENSIVE HEALTH CENTERS, INC.

"Gateway to Better Health" Demonstration Pilot

Eligibility Screening and Enrollment Plan

November 1, 2011 – June 29, 2012

Number of Uninsured Users (Intergy System)

Legacy sites (Nov. 2010 – June 2011) 6,204 service users

Non-legacy sites (April – June 2011) 4,297

Goal and Target Population

Enroll at least 80% of the existing 5,400 uninsured service users at the Homer G. Phillips and Florence Hill legacy health center sites

GTBH Target Population Identification Strategies

1. The Myrtle Hilliard Davis database will be used as the primary demographic information source for the target population registered at the two legacy sites.

2. GTBH enrollment facilitator training will include:

    a. The Intergy system navigation to identify existing uninsured service users based on GTBH enrollment criteria
    b. The E-MOMED system to identify service users who were previously denied MO HealthNet coverage

3. The health center's registration and cashier desktop systems will be programmed to flash an alert to trigger staff to refer self-pay users directly to a GTBH enrollment facilitator for evaluation and application assistance.

Marketing Strategies

1. Use automated system to send initial notification letters to the target population

2. Manually mail *Invitation to Apply* letters and GTBH brochures service users denied MO HealthNet coverage in 6 month period prior to the November GTBH enrollment date (May 2011)
3. GTBH posters visible in Registration and Cashier areas at the legacy sites
4. GTBH brochures accessible in all waiting areas at the legacy sites

Proposed Workforce

HEALTH CENTER SITE	EXISTING OUTREACH STAFFING	ROLE AND RESPONSIBILITIES
Florence Hill	**(1)** W&M program funded position	GTBH involvement limited to conducting MO HealthNet pre-eligibility screening (per W&M contract guidelines)
Homer G. Phillips	**(2)** W&M program funded positions	
	PROPOSED ENROLLMENT FACILITATORS NEEDED	**ROLE AND RESPONSIBILITIES**
Florence Hill	**(4)** GTBH funded positions	1. Assist with MO HealthNet pre-eligibility screening 2. Forward completed applications and required documents to FSD worker for processing (track determination through E-MOMED) 3. Facilitate GTBH enrollment for MO HealtNet ineligible applicants 4. Track applications through to final coverage determination
Homer G. Phillips	**(5)** GTBH funded positions	
Floaters	**(5)** GTBH funded positions	1. Facilitate GTBH potential enrollee contact through various communication methods (calls, letters, and home visits) 2. Assist with GTBH enrollment activities to help manage application volume and reduce enrollment determination turn-around time 3. Facilitate tracking and reporting activity
Note: Myrtle Hilliard Davis plans to use a temporary staffing agency to fill the (12) GTBH enrollment facilitator positions		

Enrollment Readiness Activities and Timeline

TASKS	RESPONSIBLE PARTY	EXPECTED COMPLETE
Budget approval to support outreach costs	Archie Griffin, CEO Angela Archibald, CFO	By September 16, 2011
Manage data and computer system activities: 1. Electronic uninsured demographic report (spreadsheet format) 2. Setup electronic letter system 3. Program automated computer alert	Renee Brooks, CIO	By September 30, 2011
Enrollment team readiness 1. Recruit (12) GTBH enrollment facilitators 2. Train (3) existing W&M outreach workers and (12) GTBH enrollment facilitators	Sharon Foote, COO	By October 14, 2011

Enrollment Strategies

1. Solicit referrals from every service access point within the health center (especially registration and cashier)
2. Employ aggressive measures to make sure existing uninsured service users have the opportunity to apply for GTBH coverage (telephone calls, mailing letters, home visits, and distributing promotional materials)
3. In-house enrollment fairs (educate eligible service users on the benefits of GTBH coverage and disadvantages of refusing to apply
4. Conduct MO HealthNet pre-eligibility screening (if applicant has never applied)
5. Verify prior MO HealthNet coverage denial
6. Assist applicant with completing the appropriate health coverage program application
7. Make copies of required proof of income and proof of residency documents
8. Forward completed enrollment packet to the assigned FSD worker for processing
9. Track progress towards final eligibility determination

Gateway to Better Health

Outreach Materials