Gateway to Better Health Demonstration

Demonstration Extension Application

December 31, 2015

Number: 11-W-00250/7

Gateway to Better Health Demonstration: Extension Request

The State of Missouri, Department of Social Services is requesting an extension of the Section 1115 Demonstration project "Gateway to Better Health", which is currently scheduled to expire December 31, 2016. The beginning date of the most recent Demonstration extension period is January 1, 2016. The State requests an extension of this waiver until such time as Missouri's Medicaid eligibility is expanded to include the waiver population, or up to one year, whichever is first.

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Section I: Summary and Objectives

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

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

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

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

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

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

From July 1, 2012, to December 31, 2013, the Pilot Program provided primary, urgent, and specialty care coverage to uninsured[1] adults in St. Louis City and St. Louis County, aged 19-64, who were below 133% of the Federal Poverty Level (FPL). The Demonstration was scheduled to expire December 31, 2014.

The Missouri legislature did not expand Medicaid eligibility during its 2013-2015 legislative sessions. CMS approved an extension of the Demonstration on September 27, 2013, July 16, 2014, and December 11, 2015, for patients up to 100% FPL, for up to one-year or until Missouri's Medicaid eligibility is expanded to include the waiver population.

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

Extension of the Gateway Demonstration

At this time, it is not known if the Missouri legislature will expand Medicaid eligibility during the 2016 legislative session. If not, beginning January 1, 2017, Gateway patients will no longer have access to coverage, since all Gateway patients are under 100% of the FPL. The providers serving the Gateway population will also experience a significant reduction in revenue, preventing them from maintaining their current staffing or service levels.

Without Medicaid expansion and without the Gateway Demonstration, the Gateway population will have limited options for accessing outpatient health care services. As of September 30, 2015, the Gateway program provides outpatient coverage for nearly 20,000 individuals, which is nearly 50 percent of all uninsured residents under 100 percent of the federal poverty level in St. Louis City and County. Previous studies have indicated that the care provided through this Demonstration prevents more than 50,000 emergency department visits per year.

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

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

The proposed objectives for the new extension period are:

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

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

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

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

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

- **Demonstration Population:** Expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between the ages of 19-64 years of age with income up to 100 percent of the FPL to pay for primary care provided by a designated primary care provider or specialty care provider when referred by a designated primary care provider.

- **Expenditure for Managing the Coverage Model:** Expenditures pursuant to a memorandum of understanding and not to exceed $4,500,000 for costs incurred by the SLRHC to activities related to the continued administration of the coverage model during the extension period.

Historical Background

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

The SLRHC 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 SLRHC is charged with improving health care access and delivery to the uninsured and underinsured in the St. Louis region, and is the fiscal agent for this Demonstration.

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

Demonstration Summary

Beneficiaries and Eligibility Criteria

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

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

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

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

Delivery System

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

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

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

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

Benefits

Beneficiaries will continue to receive the following benefits:

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

This application proposes that all the benefits approved for the Gateway to Better Health Demonstration continue during the proposed extension period. The final actuarial rates for the extension period will be established in 2016.

Cost Sharing

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

Section II: Progress to Date

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

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

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

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

    - Approximately 20,000 individuals are enrolled in Gateway to Better Health, which is approximately 50 percent of those uninsured and living below the federal poverty level in St. Louis City and County. Over the life of the program, approximately 45,600 unique individuals have received services from the program.

    - More than 100,000 medical visits (primary care/urgent care, dental, specialty care, diagnostic services and outpatient hospital services) and more than 220,000 prescriptions are funded each year through Gateway to Better Health. Previous studies have indicated that the care provided through this Demonstration prevents more than 50,000 emergency department visits per year.

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

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

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

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

- Preventative health and screening services (such as cervical screening, adult weight following up, flu shots, breast cancer screening, etc.) improved on average by 9% from year one (7/1/12-6/30/13) to year two (7/1/13-6/30/14), with more patients utilizing these services.

- Management of hypertension improved by 20% in year two (7/1/13-6/30/14) as compared to year one (7/1/12-6/30/13).

- Management of diabetes in year two (7/1/13-6/30/14) also improved by 4% compared to year one (7/1/12-6/30/13).

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

- As part of their pay-for-performance measures, health centers are required to follow up with hospital patients within seven days of discharge, when they are notified of the admission via the Gateway call center. During the last incentive period, this follow up occurred 78% of the time.
- Of the members who attended member orientations, 93% felt very confident or somewhat confident that they can navigate receiving health care service at their health center.
- A survey conducted by Princeton Survey Research Associates International (PSRAI) in 2014 found that, of those who have visited a specialist, more than 70% report that they received help from someone at their health center coordinating their care, and of those, 80% report being “very satisfied” with the help they received. Respondents who reported that they received help coordinating care are more likely to report that their health has improved throughout the demonstration, are more likely to report ease in obtaining a visit with a specialist and consistently rate specialist staff more positively.

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

   - In March 2015, Gateway started providing member orientations to educate new members about the Gateway program. Approximately, 414 members have attended member orientation to date.
   - As a result of attending member orientations, 91% of attendees felt very confident or somewhat confident that they understood how to use their benefits and 93% felt very confident or somewhat confident that they can navigate receiving health care services at their health center.
   - On a recent satisfaction survey, 90% of respondents indicate they would recommend their health center to others. On a 5-point scale, respondents rated the quality of service received as a 3.9 on average and how well the doctor listened and explained things as a 4.0 on average (4.0 represents "very good").

The data provided below is based on the objectives the State, SLRHC and safety net providers have been working to achieve over the life of the Demonstration:

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

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

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

IV. Have the affiliation partners provide health care services to an additional 2 percent of uninsured individuals over the current service levels by July 1, 2012; and

V. Transition the affiliation partner community to a coverage model, as opposed to a direct payment model, by July 1, 2012.

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

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

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

To date, the Demonstration has shown that the St. Louis region can continue to provide access to ambulatory health care for the uninsured in the St. Louis region under a coverage model. The Safety Net Pilot Program, specifically, has provided access to outpatient health services for more than 45,600 unique individuals over the life of the program.

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

In 2014, a total of 126,369 uninsured and Medicaid patients received care at Gateway primary care providers.

The Community Referral Coordinator (CRC) program funded by the Demonstration through December 31, 2013, resulted in approximately 27,000 new scheduled appointments for Medicaid and uninsured individuals at a primary care home since the beginning of the Demonstration. As of September 30, 2015, through the Safety Net Pilot Program, nearly 20,000 individuals are enrolled at a primary care home. Although the CRC program is no longer funded by the Gateway program, Gateway continues to partner with the program to ensure uninsured and Medicaid patients are connected to a primary care home. The CRC program serves more than 15,000 individuals annually.

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

The continuation of the funding for the St. Louis safety net of health care providers through this Demonstration helps ensure access to health care for those living in traditionally underserved communities. 74% of all members of the pilot coverage model are African-American, 19% are Caucasian, less than 1% are members of other races, and 8% did not report their race. (Other races and ethnicities – reporting as one race -- make up 4.58% of individuals in St. Louis City and County.)

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

As measured through pay-for-performance metrics, African Americans enrolled in the Pilot Program are experiencing comparable or better outcomes compared to Whites enrolled in the program:

- Of those newly enrolled patients, 72% of African Americans had at least one office visit within 1 year of enrollment date, as compared to 44% of Whites.
- 88% of African Americans with chronic conditions had at least two office visits within 1 year, which is the same as that found for Whites.
- 87% of African Americans with diabetes had at least one HgbA1c test within 6 months, as compared to 94% of Whites.
- Of all patients with diabetes, 59% of African Americans and 56% of Whites had HgbA1c levels less than or equal to 9% on their most recent test.

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

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

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

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

Gateway primary care providers are consistently performing comparatively to their peers across the State of Missouri as measured by UDS quality measures. A review of standard quality measures in UDS reports indicates that Gateway health centers on average perform on par (+1%) with their peers across the state.

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

Objective IV: Have the affiliation partners provide health care services to an additional 2 percent of uninsured individuals over the current service levels by July 1, 2012.

There was a seven percent increase in total Medicaid and uninsured persons receiving services at the Affiliation Partner providers from 89,343 patients in 2009 to 95,712 patients in 2012. Over this time period, the number of uninsured patients declined slightly (0.4%) from 60,971 in 2009 to 60,727 in 2012.

The small decline in uninsured patients from 2009 to 2012, and the coinciding increase in Medicaid patients, can be attributed to strong outreach efforts to enroll eligible patients into available coverage.

Screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more than 32,000 individuals in MO HealthNet programs, including:

- More than 16,500 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- More than 9,200 adults approved for Uninsured Women's Health Services;
- 3,052 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 2,895 adults approved for MO HealthNet for Families.

Objective V: Transition the affiliation partner community to a coverage model, as opposed to a direct

payment model, by July 1, 2012.

The community transitioned to a coverage model as opposed to a direct payment model by July 1, 2012, thereby meeting Objective V. Approximately 15,000 individuals were enrolled in Gateway to Better Health as of the program's July 1, 2012 start date. The implementation of the Safety Net Pilot Program represented a significant milestone for the State, the providers, patients and the rest of the community. As of September 30, 2015, nearly 20,000 individuals were enrolled in Gateway.

Two of the affiliation partners, Affinia Healthcare (formerly known as Grace Hill Health Centers) and Myrtle Hilliard Davis Comprehensive Health Center, both Federally Qualified Health Centers, have successfully demonstrated financially sustainability through the coverage model pilot of the Gateway Demonstration.

The third affiliation partner, St. Louis ConnectCare, was not able to demonstrate financial sustainability during the coverage model pilot and closed operations in late 2013. However, all Gateway patients successfully transitioned care to other specialty care providers in the Gateway network, demonstrating that the St. Louis region can continue to provide access to ambulatory health care for the uninsured under a coverage model program, despite ConnectCare's closure. The extension of the Gateway Demonstration until such time as Missouri's Medicaid eligibility is expanded to include the waiver population will maintain the safety net network in St. Louis, preserve access to primary, preventative, and other ambulatory care services for the otherwise uninsured, and continue to demonstrate the region's ability to successfully operate and innovate under coverage model parameters until coverage for this population under Medicaid expansion provisions is available in the State.

Section III: Compliance with Each of the STCs

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

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

Table I: STC's Related to Monitoring and Reporting

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

Furthermore, the State reviews the status of the program monthly as part of its own administrative functions but also as participates on the board of the SLRHC and its planning committees. Through these efforts, the State maintains a close working relationship with the SLRHC, its vendors and the providers. The State reviews and approves any information distributed by the SLRHC or its enrollment broker to patients, issues all payments to providers via the SLRHC based on the State's enrollment and claims data, reviews monthly financial data from the SLRHC related to the Demonstration and reviews the monthly call center report from the SLRHC's enrollment broker.

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

Section IV: Waiver and Expenditure Authorities

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

It is anticipated the Waiver and Expenditure Authorities would include:

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

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

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

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

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

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

To the extent necessary, to permit the state to offer benefits to the demonstration population that differ from the benefits offered under the Medicaid state plan.

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

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

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

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

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

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

Section V: Quality

Clinical Quality

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

Primary Care Health Center Pay-for-Performance Incentive Eligibility

Primary Care Pay-for-Performance Incentive Measures

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

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

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

Pay-for-Performance Measures for Distribution of Remaining Funds

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

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

Primary care providers will be eligible for the remaining funds based on the percentage of patients enrolled at their health centers. Payments will not be redirected for administrative or infrastructure payments.

Within the first quarter following the end of the reporting period, the State will issue incentive payments to the health centers. Incentive payments will be calculated based on the data received and the approved methodology.

Program Quality

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

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

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

SECTION VI: Compliance with the Budget Neutrality Cap

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

See Appendix IV for a completed budget neutrality worksheet.

SECTION VII: Interim Evaluation Findings

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

Evaluation Design Summary

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

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

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

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

IV. Have the affiliation partners provide health care services to an additional 2 percent of uninsured individuals over the current service levels by July 1, 2012; and

V. Transition the affiliation partner community to a coverage model, as opposed to a direct payment model, by July 1, 2012.

Objectives IV and V are not relevant to the extension period. However, results from all five objectives will be reported in the evaluation.

From July 1, 2012, when the pilot coverage model went into effect, through December 31, 2013, the Demonstration: (1) provided primary, urgent, and specialty care coverage to uninsured[3] adults in St. Louis City and St. Louis County, aged 19-64, who are below 133% of the Federal Poverty Level (FPL) through a coverage model known as Gateway to Better Health Blue; and (2) provided individuals otherwise meeting the same requirements but with income up to 200% of the FPL with urgent and specialty care services, excluding the primary care benefit, through a coverage model known as Gateway to Better Health Silver.

On September 27, 2013, CMS approved a one-year extension of the Gateway Demonstration program until December 31, 2014, or until Missouri's Medicaid eligibility is expanded to include the waiver population. As of January 1, 2014, the coverage model provides primary, urgent and specialty care coverage to one population: uninsured adults, aged 19-64, in St. Louis City and St. Louis County with incomes up to 100% FPL. Individuals with incomes between 100% and 200% FPL were not eligible for Gateway coverage as of January 1, 2014. CMS approved a one-year extension on July 16, 2014 and again on December 11, 2015 of the Gateway Demonstration program for individuals up to 100% FPL until December, 31, 2016, or until Missouri's Medicaid eligibility is expanded to include the waiver population.

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

Determination of Evaluator

In cooperation with MO HealthNet staff, SLRHC selected Mercer Government Human Services Consulting (formerly known as Alicia Smith & Associates) to perform the evaluation of the Gateway to Better Health Demonstration Project. This resource was selected because of the team's experience with

- Conducting evaluations of 1115 demonstration projects and other similar federal programs;
- Urban safety net health care provider organizations and their required federal reporting;
- Programs designed to increase access to primary and specialty care among the uninsured; and
- Medicaid programs around the country and specific experience in Missouri.

Populations Evaluated

The Demonstration project is designed to maintain and increase access to primary and specialty care for the uninsured in St. Louis City and County. As a result, the evaluation will focus on uninsured patients who are served by the health care safety net in St. Louis. The evaluation will examine clinical activities for the following population groups, as defined in the amended Special Terms and Conditions:

Original Demonstration Period

Original Demonstration Period Populations

Population 1: Uninsured individuals receiving both Primary and Specialty Care through the Demonstration	Uninsured individuals, ages 19-64 years, residing in St. Louis City or St. Louis County, with family incomes between 0 and 133 percent of the Federal poverty level (FPL) who do not meet eligibility requirements of the Medicaid State Plan and eligible to receive care through a designated primary care provider under the Demonstration and/or are referred to ConnectCare for specialty care.
Population 2: Uninsured individuals receiving only Specialty Care through the Demonstration	Uninsured individuals, ages 19-64, residing in St. Louis City or St. Louis County, with family incomes between 0 and 133 percent of the FPL who do not meet eligibility requirements of the Medicaid State Plan who have been referred to ConnectCare for specialty care, and are not enrolled for primary care benefits by a primary care provider under the Demonstration. (through December 31, 2013)
Population 3: Uninsured individuals receiving only Specialty Care through this Demonstration	Uninsured individuals, ages 19-64, residing in St. Louis City or St. Louis County, with family incomes between 134 and 200 percent of the FPL who do not meet eligibility requirements of the Medicaid State Plan who have been referred to ConnectCare for specialty care, and are not enrolled for primary care benefits from a designated primary care provider under the Demonstration. (through December 31, 2013)

Extension Period

For the extension period, the evaluation will focus on Demonstration Population 1, as defined by the STCs and limited to uninsured adults, aged 19-64, in St. Louis City and St. Louis County with incomes up to 100% FPL.

Isolation of Outcomes

Because the program serves uninsured patients of a select provider network within St. Louis City and St. Louis County, the program will be able to track outcomes for safety net delivery systems, provider organizations and patients. The patients targeted by this program have very little access to health care services beyond those available from the provider organizations who are members of the St. Louis Integrated Health Network. This fact makes it easier to isolate the outcomes of this program. Furthermore, the "coverage model" provides utilization data and quality metrics for the three populations enrolled in the Pilot Program beginning July 1, 2012, enabling the project team to isolate outcomes to the targeted populations. Performance and health indicator outcomes will be compared with the average of other community health centers in the State.

Approach to Demonstration Project Evaluation

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

Demonstration Questions and Areas of Analysis by Objective

Demonstration Objective	**Key Questions**	**Key Measures/Data Sources**	**Analysis**
I. Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act (ACA).	Were primary health care services maintained in the neighborhoods where they existed at the beginning of the demonstration project (July 2010)? Did St. Louis City and St. Louis County uninsured individuals maintain access to specialty care services at a level provided at the beginning of the demonstration project? Did the types of services available (i.e. nutrition education, lab tests, radiology) in July 2010 remain available until December 31, 2014?	Health center locations and hours of operation. Primary care encounters by payor and by service line at Gateway primary care organizations on an annual basis. Specialty care, urgent care and diagnostic services encounters by payor and by service line at St. Louis ConnectCare on an annual basis (as applicable). Specialty care encounters provided by Gateway specialty care providers. Services available at other Gateway provider organizations on an annual basis.	Description of changes in service and impact of changes on the patient community.
II. Connect the uninsured and Medicaid	How many uninsured and how many Medicaid patients had a medical	Number of primary care patients seen by Gateway providers who are uninsured	Description of trends in connecting

Demonstration Objective	Key Questions	Key Measures/Data Sources	Analysis
populations to a primary care home which will enhance coordination, quality, and efficiency of health care through patient and provider involvement.	home at Gateway primary care organizations each year of the Demonstration project? How many new patients were established at primary care homes as a result of outreach of the Community Referral Coordinators (CRC)? (Through 2013)	or covered by Medicaid. Number of patients referred by Community Referral Coordinators at area hospitals by payor, race/ethnicity and age. (Through 2013) Show rates for referrals from Community Referral Coordinators by payor, race/ethnicity and age. (Through 2013) Number of new patients established at a primary care home through the Community Referral Coordinator Program by organization, payor, race/ethnicity and age. (Through 2013)	uninsured and Medicaid populations to a primary care home.
III. Maintain and enhance quality service delivery strategies to reduce health disparities.	By race and ethnicity, how many and what percentage of patients with hypertension have controlled blood pressure? By race and ethnicity, percentage of patients with Type I or Type II diabetes with Hba1c < 9%. In response to CMS comments, the RHC and MPCA are currently evaluating the validity of MPCA's income, age, gender, and race/ethnicity data for each of the proposed health indicators in Appendix I. This testing is required to confirm the MPCA's ability to report this information. Updates will be provided in future reports to CMS.	UDS quality measures for each year of the demonstration project from participating organizations.	Description of trends presented in UDS data, including how that data compares to state and national averages for other community health centers.

Demonstration Objective	Key Questions	Key Measures/Data Sources	Analysis
IV. Have the affiliation partners provide health care services to an additional 2 percent of uninsured individuals over the current services levels by July 1, 2012.	How many primary care, specialty care and urgent care visits by site did the Affiliation Partners provide to the uninsured each year of the first two years of the demonstration project? How many uninsured patients (unique individuals) by site did the Affiliation Partners provide services to each year of the first two years of the demonstration?	Survey data and UDS data on users and encounters from the Affiliation Partners. Beginning July 1, 2012, annual uninsured users and encounters at each of the Gateway primary care provider organizations.	Description of trends presented by encounter data.
V. Transition the affiliation partner community to a coverage model, as opposed to a direct payment model, by July 1, 2012.	Did a coverage model become available for uninsured parents and other adults, aged 19-64, who are not otherwise eligible for Medicaid or Medicare who reside in St. Louis City or St. Louis County as of July 1, 2012? Were patients enrolled and provider organizations contracted to provide services under the coverage model as of July 1, 2012?	Number of applications received and patients enrolled as of July 1, 2012. Number of patients enrolled as of July 1, 2013. Enrollment targets established by Pilot Plan. Number and types of provider organizations contracted to provide services.	Review the effectiveness of the Pilot Plan development process and implementation to determine what went well and what could have been improved. Were there challenges that were not foreseen by the Pilot Plan? Discussion with key stakeholders as to "lessons learned" from the transition to a coverage model.
i. Achieve financial sustainability of the St. Louis Regional Health Commission	As of December 31, 2014, did the St. Louis Regional Health Commission identify its priorities and the required funding to accomplish those priorities?	Identification of priorities for the St. Louis Regional Health Commission and necessary funding by July 1, 2013. Approval of 2015 priorities and budget for the St. Louis Regional Health Commission by its board at its December 2014 meeting.	Explanation of the priorities of the St. Louis Regional Health Commission after December 31, 2014.

Demonstration Objective	Key Questions	Key Measures/Data Sources	Analysis
ii. Achieve financial sustainability of the CRC program	Did the CRC identify funding for continued operations after December 31, 2013? Did the CRC program conduct an analysis of the effectiveness of its program in order to identify funding sources (using measures from Objective III)?	Identify funding sources for continued operations by July 1, 2013. Approval of 2014 CRC budget at August 2013 IHN board meeting.	Explanation of the case made and the value provided by the CRC program for the organization(s) that provide funding to secure continued operations.
iii. Achieve financial sustainability of the Affiliation Partners (St. Louis ConnectCare, Myrtle Hilliard Davis Comprehensive Health Centers, Affinia Healthcare (formerly Grace Hill Health Centers)	Did the Affiliation Partners achieve financial sustainability? The revised Standard Terms and Conditions defines financial sustainability as "the provider continuing operations and providing quality services to the safety-net community absent funding from an 1115 demonstration." Were there any changes in operations/patient services due to the change in funding streams and the new payment methodology?	Breakeven or positive financial position in the year following the end of the Demonstration for each of the Affiliation Partners.	Description of changes in the Affiliation Partners operations/patient services as a result of the coverage model. Review of affiliation partner sustainability plans.

In addition to the stated objectives of the demonstration project, CMS' special terms and conditions specify that the draft evaluation design shall address the evaluation questions and topics listed below. Interim evaluation findings for these questions and topics are provided later in this report section.

I. To what extent, has the State met the milestones listed in section XII?

The evaluation will document the State's progress in completing milestones as specified by CMS.

II. How successful have the FQHCs and ConnectCare been at developing a business model that is based on receiving reimbursement through a claims-based system rather than receiving direct payments to the facilities?

As addressed in the description of Objective V, the following information will be tracked:

- Whether or not the FQHCs and Connectcare break even or achieve a positive financial position in the fiscal year following the completion of the Demonstration.

This information will provide insights about the financial sustainability of the FQHCs and ConnectCare absent receiving direct payments via the 1115 Demonstration.

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

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

- Health center locations and hours of operation;
- Primary care encounters by payor and by service line at Gateway primary care organizations;
- Specialty care, urgent care, and diagnostic services encounters by payor and by service line at St. Louis ConnectCare on an annual basis (as applicable);
- Specialty care encounters by payor and by service line at medical schools, hospitals, and community specialist providers;
- Services available at Affiliation Partner sites and other primary care organizations on an annual basis.

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

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

As addressed in the description of Objective IV, the following information will be tracked throughout the Demonstration through July 1, 2012:

- Primary care, specialty care, and urgent care encounters among the uninsured at FQHCs and ConnectCare (as applicable); and
- Uninsured patients receiving services at FQHCs and ConnectCare during the first two years of the Demonstration.

Due to recent Medicaid enrollment efforts among safety net providers in the St. Louis region, as well as eligibility screening for Gateway to Better Health, monitoring the number of encounters and unique patients served among the Medicaid population will also be an important factor in determining the success of expanding coverage to the region's uninsured.

Coinciding with the time period of the Demonstration, providers outreach efforts to enroll eligible patients into Medicaid programs. In addition, the first step in the Gateway to Better Health enrollment process is eligibility screening for MO HealthNet programs. Screening for

Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more the 32,000 individuals in MO HealthNet programs.

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

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

VI. Describe provider incentives and activities.

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

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

The sixth pay-for-performance reporting period ended on June 30, 2015. The complete results are provided in Appendix III. The evaluation will provide an analysis of provider performance against the performance incentive criteria and discuss provider payments. The evaluation will also compare outcomes with data from health centers statewide as described in Item VII below.

VII. Determine if performance incentives have impact on population metrics with a comparison of Gateway providers to other community health centers in the State. Include comparable FQHC population/providers to compare effectiveness of provider payment incentives.

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

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

- Percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy;
- Proportion of patients born between January 1, 1927, and December 31, 1993, with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading;
- Proportion of adult patients born between January 1, 1937, and December 31, 1993, with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading in the measurement year.

VIII. Provide financial analysis of the Legacy and ConnectCare providers for the pre- and post-coverage phase of the Demonstration.

The work to transition the St. Louis community to a coverage model is integrated with other efforts of the health centers that will help them prepare for the changes that will or are expected to occur as a result of the Affordable Care Act. The evaluation will provide an analysis of provider finances under direct provider payments and under the coverage model implemented on July 1, 2012. An analysis of provider sustainability plans will be provided, assessing provider efforts in transitioning to the new payment methodology.

The evaluation will also address relevant questions outlined in the Interim Transition Plan submitted to CMS on June 27, 2012. Key areas of analysis will include:

- What are the projected provider payment rates and covered services post-Demonstration?
    - How will these changes impact provider financial projections?
- What will be the role of the Medicaid managed care plans in ensuring access to the patient populations previously served by these providers under the Demonstration?
- How have the individual provider sustainability plans changed since initial submission to CMS?
- Health center patient population
    - How many St. Louis residents will become eligible for Medicaid and where will they access services?
    - What proportion of the current health center patients will become eligible for Medicaid or for any other health insurance options that may be available?

IX. Analyze the cost of care and access to services at the Legacy FQHC providers, comparing the first 18 months of the Demonstration when the providers received direct payments to the last 18 months of the Demonstration when the providers were paid on a capitated basis with incentive payments.

As noted in the discussion of Demonstration objective I, the ability of services to remain available and accessible to patients will be a critical factor in evaluating the success of the Demonstration project. The project team will report on any change in health center locations, significant changes in service offerings, or significant changes in hours of operation, comparing the first two years of the Demonstration to the coverage model portion of the Demonstration. The cost-per-encounter under the direct payment model will be compared to the cost-per-encounter when providers were paid on a capitated basis.

Approach to Pilot Program Evaluation

The Pilot Program coverage model was implemented as planned on July 1, 2012. The evaluation will address the following objectives and hypotheses for the Pilot Program:

Pilot objectives

I. To provide a basic set of medical services for as many uninsured patients as possible

II. To provide a bridge to health care reform for the legacy clinics to help ensure financial sustainability

III. To place a particular emphasis on providing coverage to low-income individuals:
   a. who have chronic medical conditions such as diabetes, heart disease and hypertension
   b. who are aging out of Medicaid and link them to health care coverage

IV. To decrease the use of community emergency departments for non-emergent visits

Pilot hypotheses

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

II. Uninsured patients who receive coverage under the pilot program will use community emergency departments for non-emergent visits at a lower rate than other uninsured patients.

III. The prevalence of preventable hospitalizations, hospital re-admissions and ED utilization will be reduced among patients with chronic medical conditions.

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

The following information will be collected and analyzed:

Enrollment

- By zip code
- By age, sex, race, ethnicity
- Length of time without insurance prior to enrollment (for a sample of patients through 2013)

Financial

- Number of patients enrolled by organization by month
- Provider revenue data by each Federal fiscal year
- Pay for performance withholds and payments

Utilization

- Primary care encounters by site
- Specialty care encounters and referrals
- Number of patients with chronic conditions (i.e. diabetes Type I and II; hypertension; asthma; COPD and congestive heart failure)
- Urgent care encounters
- Emergency department encounters (through December 31, 2013)
- Inpatient professional fees associated with inpatient stays

Quality

- Ease of access (wait times for appointments)
- Patient satisfaction
- Primary care provider satisfaction
- UDS and other measures relevant to patient population*

Outcomes

- Enrollment in wellness initiatives (smoking cessation; diabetic nutrition counseling)
- Percentage who transition to coverage as of January 1, 2014

**For a complete list of proposed quality measures, see Appendix II.*

Methodology

Most of this information will be gathered in the enrollment process, through the claims data, in the UDS data reported annually by federally qualified health centers, MO HealthNet data, and through the annual reporting of the safety net provider organizations, including St. Louis ConnectCare, to the St. Louis Regional Health Commission. Patient and provider satisfaction will be measured through semi-annual surveys.

Evaluation Activities

Evaluation activities to date include the following:

- Collection and reporting of baseline data for all Demonstration objectives for 2009-2014 as applicable
- Collection and reporting of proposed health indicator data baselines (see Appendix I)
- Analysis of interim progress in meeting Demonstration objectives comparing 2009-2014 data as provided in this report section
- Analysis and reporting of enrollment data for the eighteen months of the Pilot Program (7/01/12-12/31/13) and the extension period (1/1/14-9/30/15), as provided in this report section.
- Analysis and reporting of financial data for the Demonstration (07/01/2012 – 9/30/2015) as provided in this report section.
- Analysis and reporting of claims-based utilization data for the Demonstration (07/01/2012–9/30/2015) as provided in this report section.
- Analysis and reporting of preliminary quality data for the Demonstration (07/01/2012–9/30/2015) as provided in this report section.

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

Interim Evaluation Findings for Demonstration Objectives

Based on data gathered to date, all Demonstration objectives have been met or significant progress can be demonstrated. Provided below are interim evaluation findings for each Demonstration objective. Unless otherwise noted, findings are based on reported data through calendar year 2014.

The Demonstration objectives are as follows:

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

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

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

IV. Have the affiliation partners provide health care services to an additional 2 percent of uninsured individuals over the current service levels by July 1, 2012.

V. Transition the affiliation partner community to a coverage model, as opposed to a direct payment model, by July 1, 2012.

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

The funding provided by the Gateway to Better Health Demonstration Project is critical to maintaining access to primary and specialty care services for the uninsured in the St. Louis region, particularly for those who live in the urban core where few options exist for health care services.

Key questions for this demonstration objective include:

- Were primary health care services maintained in the neighborhoods where they existed at the beginning of the Demonstration project (July 2010)?
- Did St. Louis City and St. Louis County uninsured individuals maintain access to specialty care services at a level provided at the beginning of the demonstration project?
- Did the types of services available (i.e., nutrition education, lab tests, radiology) in July 2010 remain available until December 31, 2014?

Findings to Date

The Demonstration has met Objective I, as evidenced by:

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

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

C. Primary care services were maintained at Gateway providers through 2014.

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

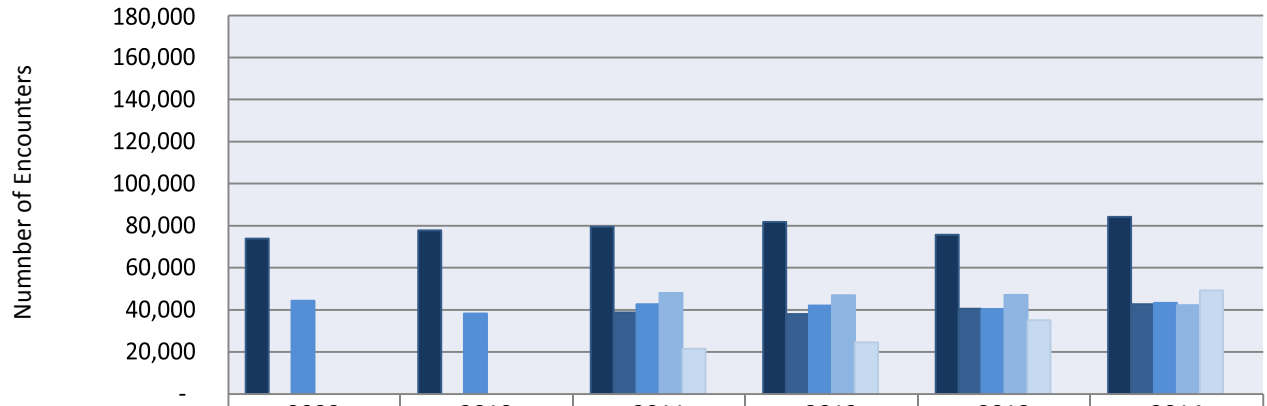
E. Access to urgent care locations for the safety-net population has been expanded throughout the demonstration.

Each of these findings is reviewed in detail below:

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

Uninsured primary care encounters at primary care affiliation sites increased (+3.2%) from 118,327 in 2009 (baseline) to 122,114 in 2011 (the year before the coverage model was implemented). Additional safety net providers funded by Gateway were added to the primary care network of the coverage model in 2012. Uninsured encounters at Gateway primary care providers increased (+13.6%) from 230,455 in 2011 (coverage model baseline) to 261,816 in 2014.

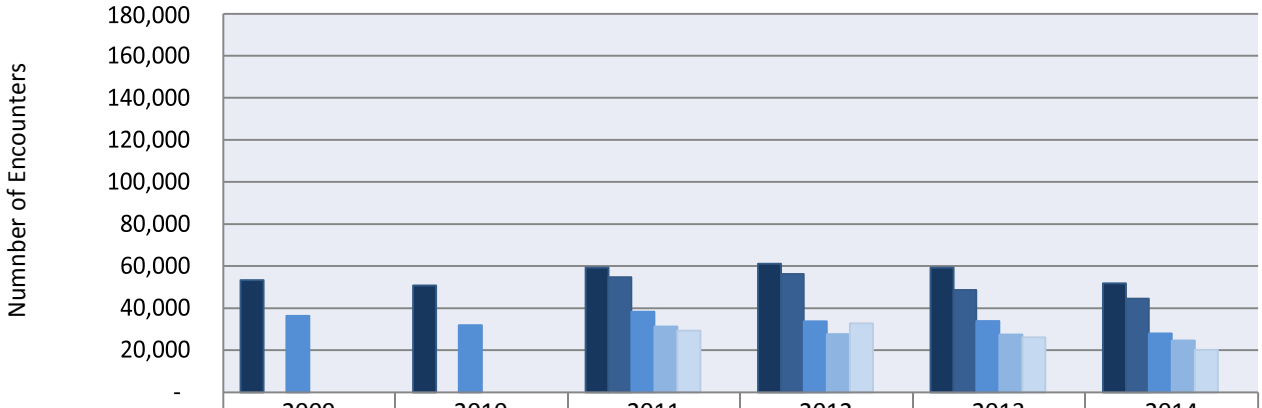
Uninsured Encounters Provided by Gateway Primary Care Providers, 2009-2014



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

Medicaid primary care encounters at primary care affiliation sites increased (+8.8%) from 89,567 in 2009 (baseline) to 97,449 in 2011 (the year before the coverage model was implemented). Additional safety net providers funded by Gateway were added to the primary care network of the coverage model in 2012. Medicaid encounters at Gateway primary care providers decreased from 212,870 in 2011 (coverage model baseline) to 169,190 in 2014.

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



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

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

Primary care providers' locations and hours of operation were maintained in the neighborhoods where they were located in from 2009 through 2014. As of February 2014, Affinia's (formerly known as Grace Hill Health Centers) Soulard-Benton site and Myrtle Hilliard Davis Comprehensive Health Centers' Comp I site have expanded their hours to provide urgent care services seven days a week.

Hours of Operation at Gateway Primary Provider Locations

Partner Site	***2014***	***2013***	***2012***	***2011***	***2010***	***2009***
Affinia Healthcare (formerly known as Grace Hill Health Centers)						
Murphy-O'Fallon	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M,T,TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm
Soulard-Benton	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa- 9am-1pm Urgent Care: M, T, W, TH, F 9am – 7pm; Sa-9a-5pm; Su-9am-1pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa- 9am-1pm Urgent Care: M, T, W, TH, F 9am – 7pm; Sa-9a-5pm; Su-9am-1pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm
Water Tower	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	NA	NA
Affinia Healthcare South	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm	NA	NA
BJC Behavioral Health	T-8:30am-3pm	M-8:30am-4:30pm	M-F-8:30am-5pm	M-F-8:30am-5pm	NA	NA
Myrtle Hilliard Davis Comprehensive Health Centers						
Homer G. Phillips	M, T, W, TH, F-8am-5pm	M, T, W, TH, F-8am-5pm	M, T, W, F-8am-5pm; Th-8am-8pm	M, T, W, F-8am-5pm; Th-8am-8pm	M, T, W, F - 8am-5pm; TH-8am-8pm	M, T, W, F - 8:00am-5:00pm; TH-8am-8pm
Florence Hill	M, T, W, TH, F-8am-5pm	M, T, W, TH, F-8am-5pm	M-8am-8pm; T, W, Th, F-8am-5pm	M-8am-8pm; T, W, Th, F-8am-5pm	M-8am-8pm; T, W, TH, F- 8am-5pm	M-8am-8pm, T, W, TH, F- 8am-5pm

Partner Site	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*
Comp I	M, T, W, TH, F-8am-5pm Urgent Care: M, T, W, TH, F- 10a-7pm; Sa- 9am-5pm; Su-1pm-5pm	M, T, W, TH, F-8am-5pm; Sa 10am-2pm Urgent Care: M, T, W, TH, F-10a-7pm; Sa-9am-5pm; Su-1pm-5pm	M, T, Th, F-8am-5pm; W-8am-8pm	M, T, Th, F-8am-5pm; W-8am-8pm	NA	NA
BJK People's Health Centers						
Central	M, W, TH, F-8am-5:30pm; T-8am-8:30pm	M, W, TH, F-8am-5:30pm; T-8am-8:30pm	M-F-8:30am-5:30pm; Sa (When Scheduled)	M-F-8:30am-5:30pm; Sa (When Scheduled)	NA	NA
North	M, T, TH, F-8am-5:30pm; W-9am-8:30pm	M, T, TH, F-8am-5:30pm; W-9am-8:30pm	M, T, Th, F-8:30am-5:30pm; W-11:30am-8:30pm; Sa (When Scheduled)	M, T, Th, F-8:30am-5:30pm; W-11:30am-8:30pm; Sa (When Scheduled)	NA	NA
West	M, T, W, F-8am-5:30pm; TH-11am-8pm	M, T, W, F-8am-5:30pm; TH-11am-8pm	M, T, W, F-8:30am-5:30pm; Th-11:30am-8:30pm; Sa (When Scheduled)	M, T, W, F-8:30am-5:30pm; Th-11:30am-8:30pm; Sa (When Scheduled)	NA	NA
Family Care Health Centers						
Carondelet	M, W, F-8am-5pm; T, TH- 8am-8pm; Sa-8am-1pm	M, W, F- 8am-5pm; T, TH- 8am-8pm; Sa- 8am-1pm	M, W, F-8am-4:30pm; T, Th-8am-8pm; Sa-8am-1pm	M, W, F-8am-4:30pm; T, Th-8am-8pm; Sa-8am-1pm	NA	NA
Forest Park	M, W, TH, F-8:30am-5pm; T- 8:30am-7pm; Sa-9am-1pm	M, W, TH, F-8:30am-5pm; T-8:30am-7pm; Sa- 9am-1pm	M, W, Th, F-8am-4:30pm; T-8am-7pm; Sa-9am-2pm	M, W, Th, F-8am-4:30pm; T-8am-7pm; Sa-9am-2pm	NA	NA
St. Louis County Department of Public Health Centers						
North Central	M, T, Th, F-8am-5pm; W-8am-6pm	-	M, T, F-8am-5pm; W, Th-8am-9pm	M, T, F-8am-5pm; W, Th-8am-9pm	NA	NA
South County	M, W, Th, F-8am-5pm; T-8am-6pm	-	M, T-8am-9pm; W, Th, F-8am-5pm	M, T-8am-9pm; W, Th, F-8am-5pm	NA	NA
John C. Murphy	M, T, W, F-8am-5pm; Th-8am-6pm	NA	NA	NA	NA	NA

C. Primary care services were maintained at Gateway providers sites through 2014.

Primary care services at the Gateway primary care sites have been maintained or expanded from 2009 to 2014, ensuring patients in areas of highest need maintained access to the breadth of services available from community health centers.

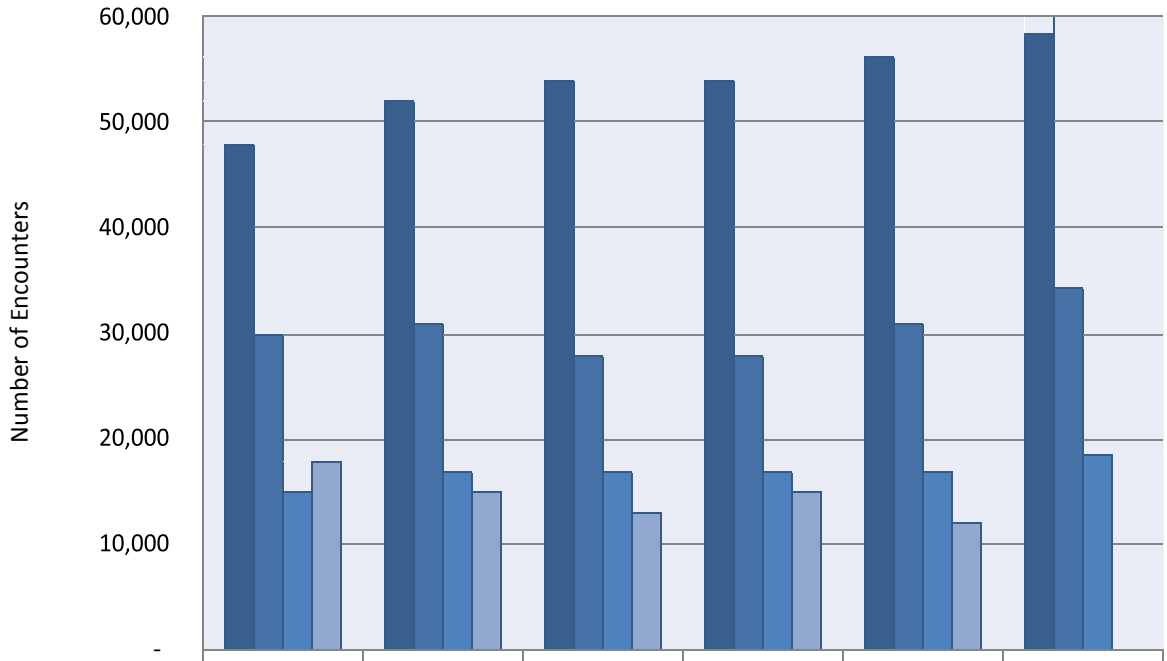
Primary Care Sites	***2014***	***2013***	***2012***	***2011***	***2010***	***2009***
Affinia Healthcare	Added: Urgent Care services	No change	No change	No change	No change	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care.
Myrtle Hilliard Davis Comprehensive Health Centers	Added: Urgent Care services	Added: health insurance coverage enrollment assistance.	No change	No change	No change	Primary medical care, podiatry, ophthalmology, dental care, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.

Primary Care Sites	***2014***	***2013***	***2012***	***2011***	***2010***	***2009***
Family Care Health Centers	No change	No change	No change	Primary medical care, podiatry, ophthalmology, dental care, behavioral health, nutrition, pharmacy, laboratory services, and enabling services (Community outreach services, community and patient health education), case management (for pregnant women), social services, assistance, referral for specialty services, and HIV counseling and testing.	N/A	N/A
Betty Jean Kerr Peoples Health Centers	No change	No change	No change	Primary medical care, podiatry, ophthalmology, dental care, behavioral health, nutrition, pharmacy, laboratory services, and enabling services (Community outreach services, community and patient health education, WIC services (lactation and nutrition), and HIV/AIDS counseling and testing.)	N/A	N/A

Primary Care Sites	***2014***	***2013***	***2012***	***2011***	***2010***	***2009***
St. Louis County Department of Public Health	No change	No change	No change	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	N/A	N/A

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

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



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

The St. Louis safety net providers funded by Gateway were able to increase specialty care encounters for all uninsured and Medicaid patients at their locations by 2% during the Demonstration from 2009-2014. Gateway specialty care providers provided 112,870 specialty care encounters to uninsured and Medicaid patients in 2014, compared to 110,540 in 2009, an increase of 2,330 encounters. Gateway to Better Health's specialty care provider network, including medical schools, hospitals, and some community specialist providers has been successful at absorbing ConnectCare's volume and thus, maintaining access to specialty care for the safety net population in the St. Louis region.

From 2009 to 2013, St. Louis ConnectCare maintained the hours of operation and range of specialty and diagnostic services, as well as urgent care.

St. Louis Connect Care Hours of Operation, 2009-13

	2013	*2012*	*2011*	*2010*	*2009*
St. Louis ConnectCare*	M-F-8am-7pm; Sa/Su-8am- 5pm (Urgent Care and General X-ray); M-F- 8am-5pm (All other services)	M-F-8am-7pm; Sa/Su-8am- 5pm (Urgent Care and General X-ray); M-F- 8am-5pm (All other services)	M-F-8am-7pm; Sa/Su-8am- 5pm (Urgent Care and General X-ray); M-F- 8am-5pm (All other services)	M-F 8am-7pm; Sa/Su-8am- 5pm (Urgent Care and General X-ray); M-F-8am-5pm (All other services)	M-F 8am-7pm; Sa/Su-8am- 5pm (Urgent Care and General X-ray); M-F-8am-5pm (All other services)

St. Louis Connect Care Services, 2009-13

	2013	***2012***	***2011***	***2010***	***2009***
St. Louis ConnectCare	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.

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

After the closure of St. Louis ConnectCare (including its urgent care facility) in late 2013, it was decided that primary care providers should provide urgent care services for their Gateway patients to ensure the coordination of care with the primary care provider. As a result, Myrtle Hilliard Davis and Affinia Healthcare (formerly known as Grace Hill Health Centers) started offering urgent care services in 2014, and the other Gateway primary care providers contracted with SSM Urgent Care for their Gateway patients. To date, Affinia Healthcare and Myrtle Hilliard Davis have provided 7,140 urgent care visits to Gateway patients, showing urgent care services have successfully been maintained during ConnectCare's closure. An additional 1,724 urgent care visits were provided by SSM Urgent Care.

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

The Community Referral Coordinator (CRC) Program, funded by the Demonstration Project through December 31, 2013, as well as the ongoing efforts of the Gateway providers, has positioned participating organizations to reach uninsured and Medicaid populations and enroll them in a primary care home.

The CRC Program uses Referral Coordinators to connect non-emergent, hospital patients with a primary care provider for follow-up and preventive care. The program is also focusing efforts on patients with chronic care needs to increase the utilization of preventive care services available in the community.

Key questions for this objective include:

- How many uninsured and how many Medicaid patients had a medical home at Gateway primary care organizations each year of the Demonstration project?
- How many new patients were established at primary care homes as a result of outreach of the Community Referral Coordinators?

Findings to Date:

The Demonstration has met Objective II, evidenced by:

A. Primary care providers funded by the Gateway Demonstration served as medical homes for more than 126,000 uninsured and Medicaid patients.

B. The Community Referral Coordinator Program consistently reported strong outcomes during the Demonstration, resulting in a total of more than 27,000 appointments scheduled from 2009 to 2013.

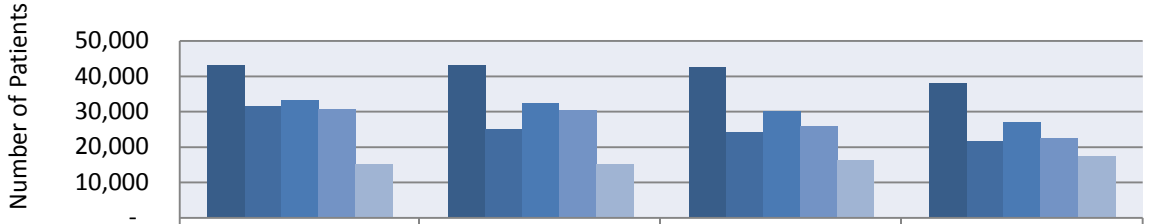
C. The CRC program improved its “show rate” for primary care appointments from 31 percent in 2009 to 39 percent in 2013.

Each of these findings is reviewed in detail below:

A. Primary care providers funded by the Gateway Demonstration served as medical homes for more than 126,000 uninsured and Medicaid patients.

Gateway primary care providers served as a medical home to a total of 126,369 uninsured and Medicaid patients in 2014, as follows:

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



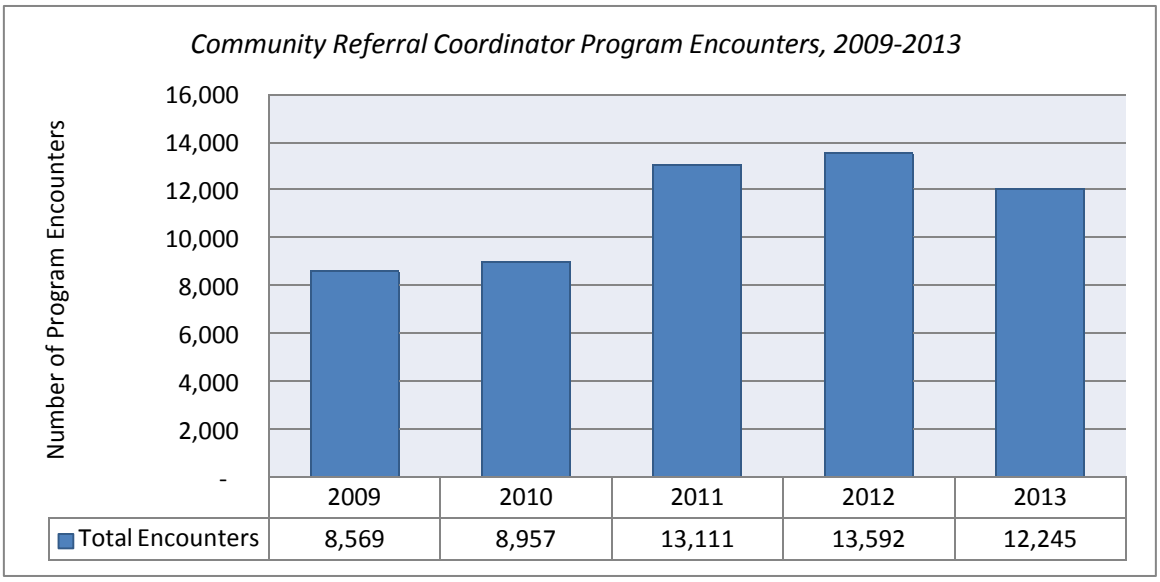
	2011	2012	2013	2014
Affinia	42,973	43,039	42,429	37,997
Myrtle Hilliard	31,658	25,094	24,133	21,684
BJK People's	33,258	32,492	30,013	27,065
St. Louis County	30,701	30,486	25,979	22,335
Family Care	15,167	15,078	16,304	17,288
Total	153,757	146,189	138,858	126,369

In addition, nearly 45,600 unique individuals have been enrolled into Gateway since the implementation of the pilot program in July 2012. The Gateway primary care sites have also successfully enrolled more than 32,000 individuals into MO HealthNet programs including:

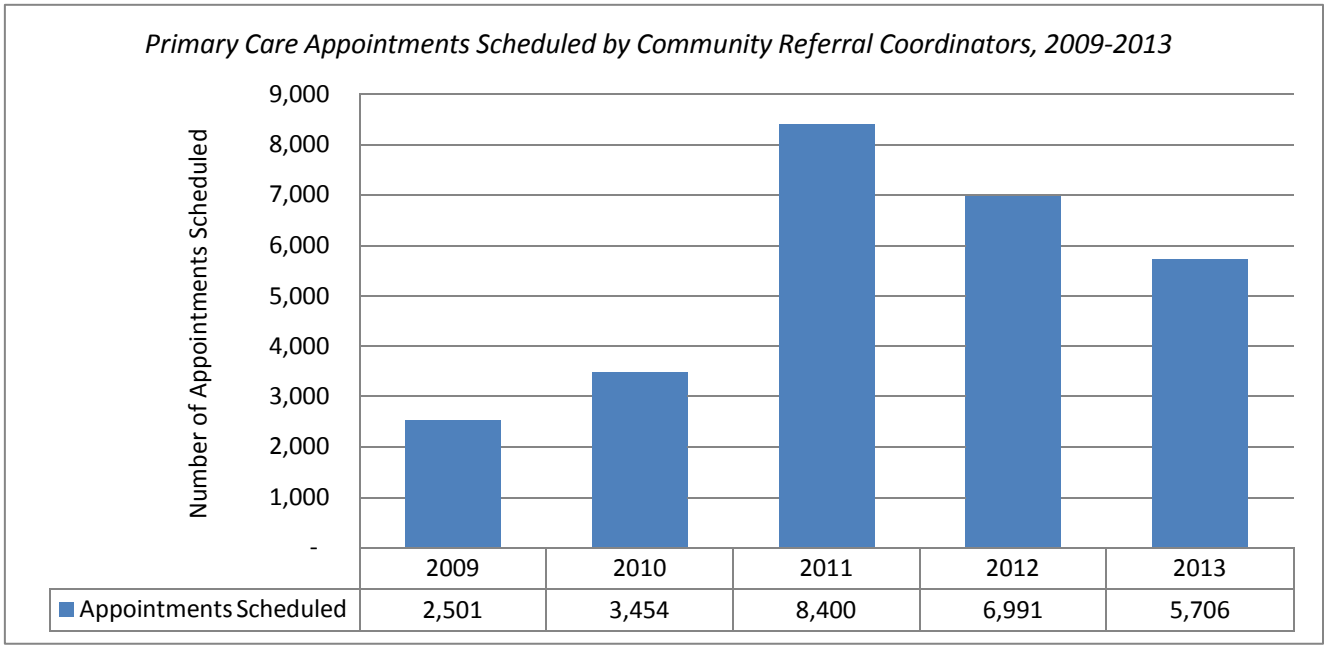
- More than 16,500 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- More than 9,200 adults approved for Uninsured Women's Health Services;
- 3,052 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 2,895 adults approved for MO HealthNet for Families.

B. The Community Referral Coordinator Program consistently reported strong outcomes during the Demonstration, resulting in a total of more than 56,000 patient encounters and 27,000 appointments scheduled from 2009 to 2013.

The CRC program increased annual encounters by 43% from 2009 to 2013. In 2013, the program provided 12,254 encounters, exceeding its 2013 Demonstration goal of 9,600 annual encounters.

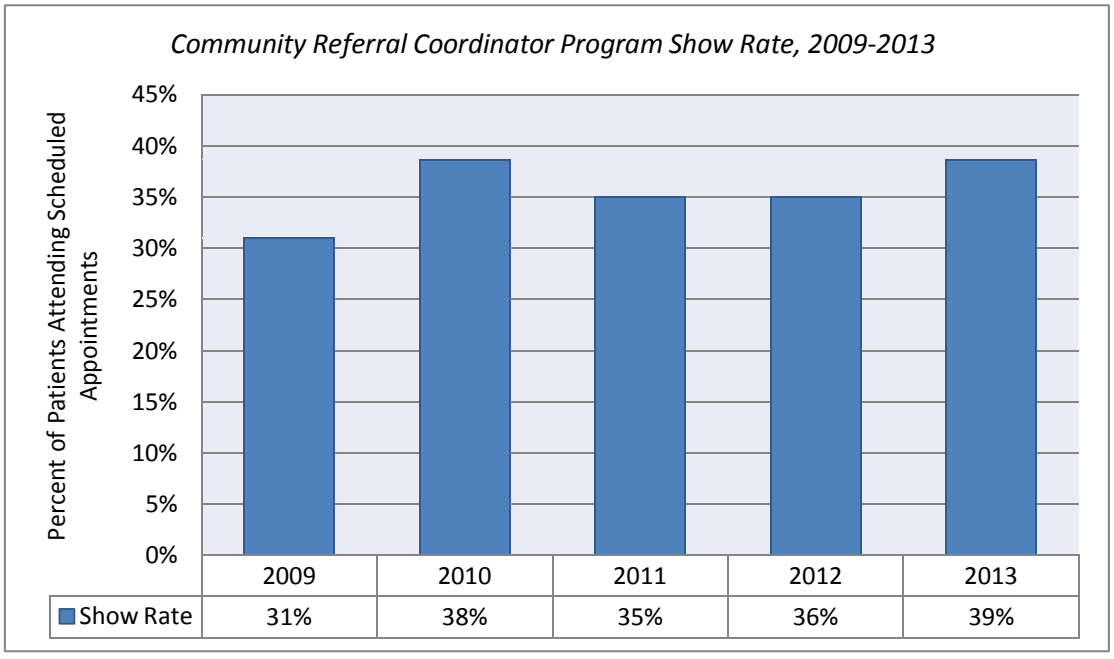


In 2013, the CRC program scheduled 5,706 primary care appointments, exceeding its 2013 Demonstration goal of 4,800 annual referrals.



C. The CRC program improved its "show rate" for primary care appointments from 31 percent in 2009 to 39 percent in 2013.

The 2013 "show rate" for primary care appointments scheduled through a Community Referral Coordinator was 39%, surpassing the 2013 Demonstration goal of a 35% show rate.



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

Key questions for this objective include:

- By race and ethnicity, how many and what percentage of patients with hypertension have controlled blood pressure?
- By race and ethnicity, what percentage of patients have Type I or Type II diabetes with Hgba1c <9%?

A complete list of quality measures is provided in Appendix I.

Findings to date:

The demonstration has met objective III, as evidenced by:

A. Successful enrollment of African-American patients, who report high satisfaction with the program and show positive health outcomes.
B. Increasing quality of care as measured by the program's pay-for-performance measures.
C. A review of standard quality measures in UDS reports indicates that Gateway health centers on average perform on par (average difference +1%) with their peers across the state.

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

The continuation of the funding for the St. Louis safety net of health care providers through this Demonstration helps ensure access to health care for those living in traditionally underserved communities. 74% of all members of the pilot coverage model are African-American, 19% are Caucasian, less than 1% are members of other races, and 8% did not report their race. (Other races and ethnicities – reporting as one race -- make up 4.58% of individuals in St. Louis City and County.)

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

As measured through pay for performed metrics, African Americans enrolled in the Pilot Program perform well, and often better, than Whites enrolled in the program:

- Of those newly enrolled patients, 72% of African Americans had at least one office visit within 1 year of enrollment date, as compared to 44% of Whites.

- 88% of African Americans with chronic conditions had at least two office visits within 1 year, which is the same as that found for Whites.

- 87% of African Americans with diabetes had at least one HgbA1c test within 6 months, as compared to 94% of Whites.

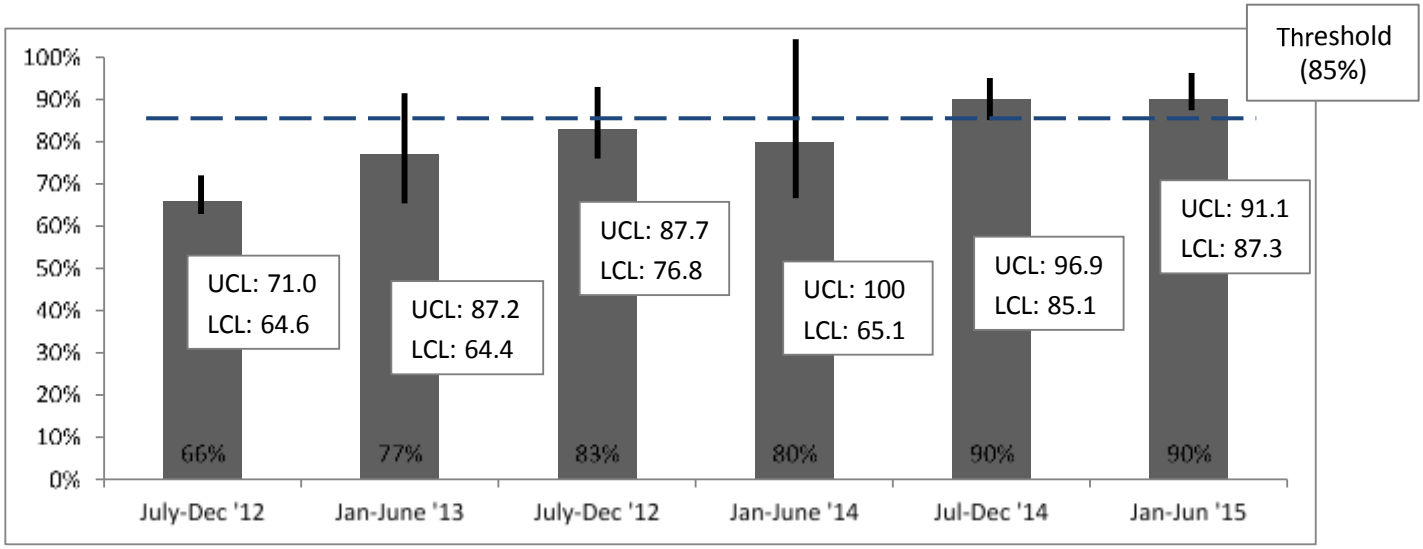
- Of all patients with diabetes, 59% of American Americans and 56% of Whites had HgbA1c levels less than or equal to 9% on their most recent test.

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

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

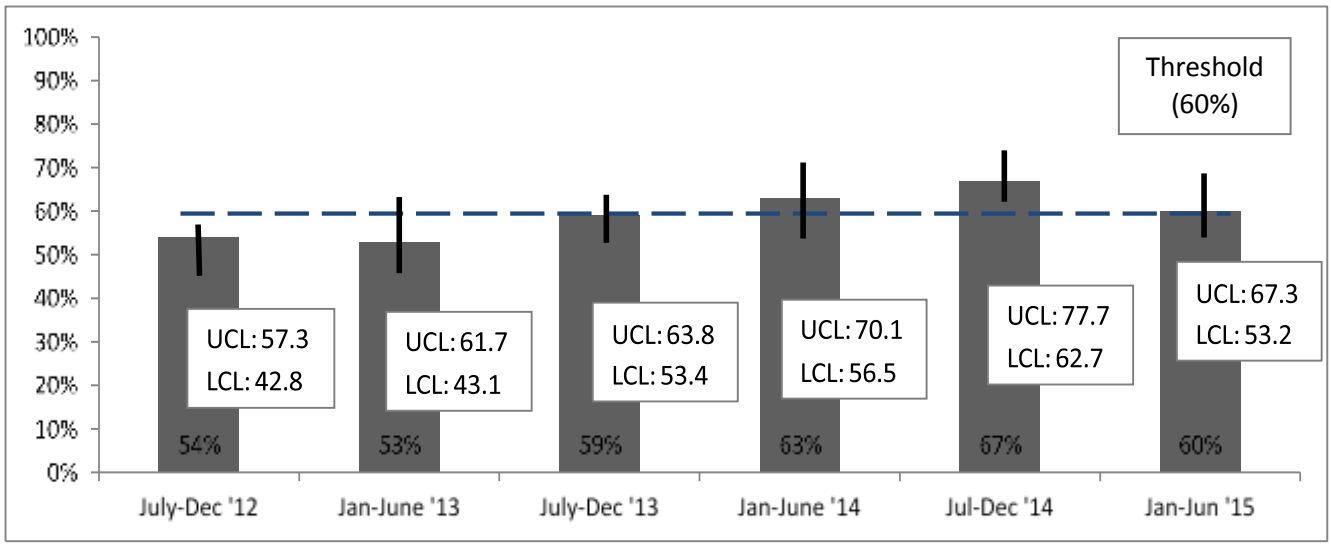
Patients with Diabetes HgbA1c: HgbA1c testing performed within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis

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



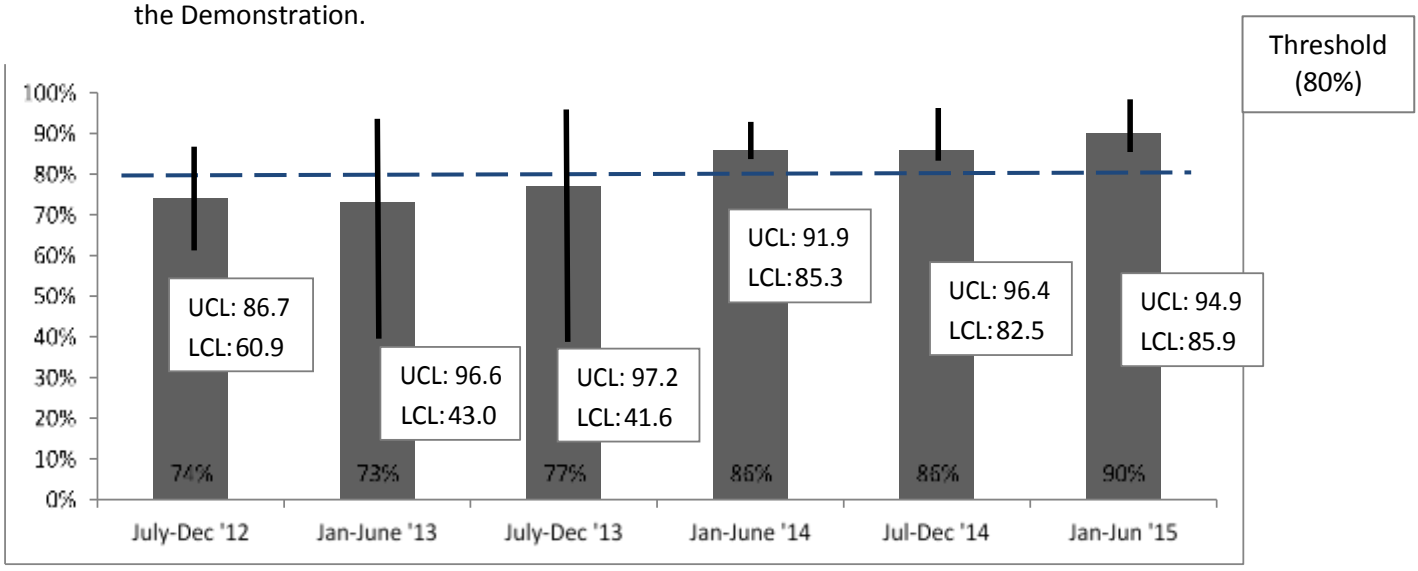
Patients with Diabetes HgbA1c <9%: percentage of diabetics who have a HgbA1c <9% within six months following the latter of either: a) initial enrollment, or b) initial diagnosis

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



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

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



C. A review of standard quality measures in UDS reports indicates that in 2014 Gateway health centers on average perform on par (average difference of +1%) with their peers across the state.

Quality Measure	2014		Difference
	Gateway CHCs	State	
Tobacco Use Assessment & Cessation Intervention Percentage of patients age 18 and older assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy	73%	77%	-2%
Hypertension: Controlling High Blood Pressure Proportion of patients aged 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading	62%	59%	+3%
Cervical Cancer Screening Percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer	55%	47%	+8%
Diabetes: HbA1c Control Proportion of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading in the measurement year. Results are reported in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9%	72%	72%	-
Adult Weight Screening and Follow-Up Percentage of patients aged 18 and over who had documentation of a calculated BMI during the most recent visit or within the 6 months prior to that visit	47%	55%	-8%

Objective IV: Have the affiliation partners provide health care services to an additional 2 percent of uninsured individuals over the current service levels by July 1, 2012.

Key questions for this objective include:

- How many primary care, specialty care and urgent care visits by site did the Affiliation Partners provide to the uninsured each year of the first two years of the Demonstration project?
- How many uninsured patients by site did the Affiliation Partners care for each year of the first two years of the demonstration?

Findings to Date:

The Demonstration has met Objective IV, as evidenced by:

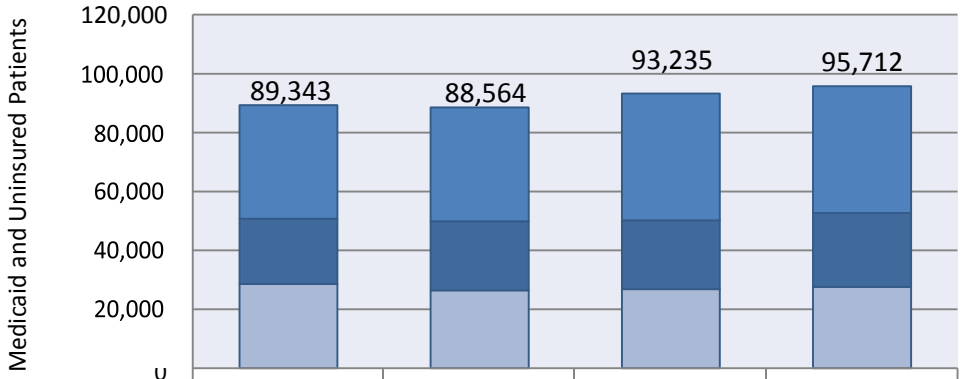
A. Access at affiliation partner sites increased for uninsured and Medicaid patients prior to July 1, 2012.

This finding is reviewed in detail below:

A. ***Access at affiliation partner sites increased for uninsured and Medicaid patients prior to July 1, 2012.***

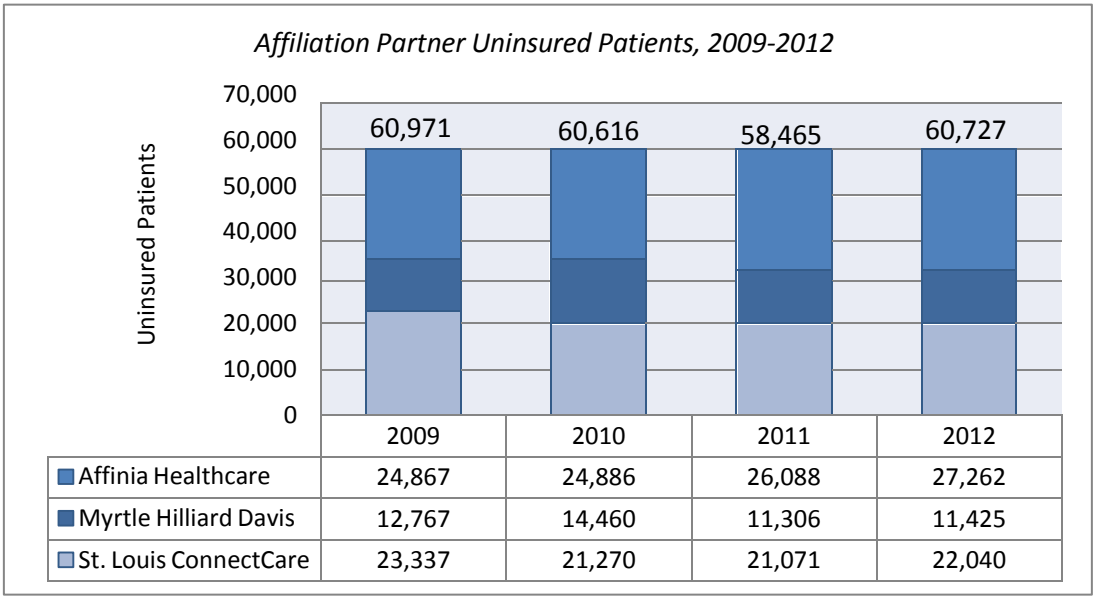
There was a seven percent increase in total Medicaid and uninsured patients receiving services at the Affiliation Partner providers from 89,343 patients in 2009 to 95,712 patients in 2012.

Affiliation Partner Medicaid and Uninsured Patients, 2009-2012



	2009	2010	2011	2012
Affinia Healthcare	38,603	38,643	42,973	43,039
Myrtle Hilliad Davis	22,178	23,477	23,415	25,094
St. Louis ConnectCare	28,562	26,444	26,847	27,579

Over this time period, the number of uninsured patients declined slightly (0.4%) from 60,971 in 2009 to 60,727 in 2012.



	2009	2010	2011	2012
Affinia Healthcare	24,867	24,886	26,088	27,262
Myrtle Hilliard Davis	12,767	14,460	11,306	11,425
St. Louis ConnectCare	23,337	21,270	21,071	22,040

The slight decline in uninsured patients from 2009 to 2012, and the coinciding increase in Medicaid patients, can be attributed to strong outreach efforts to enroll eligible patients into Missouri Medicaid, MO HealthNet.

Screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more than 32,000 individuals in MO HealthNet programs, including:

- More than 16,500 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- More than 9,200 adults approved for Uninsured Women's Health Services;
- 3,052 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 2,895 adults approved for MO HealthNet for Families.

Objective V: Transition the affiliation partner community to a coverage model, as opposed to a direct payment model, by July 1, 2012.

On July 1, 2012, the Demonstration Project transitioned to a coverage model pilot program as opposed to a direct payment model. Objective V evaluates this transition to a coverage model by July 1, 2012, along with financial sustainability efforts of the St. Louis Regional Health Commission, the Community Referral Coordinator Program and the Affiliation Partner organizations.

Key questions for this demonstration objective include:

- Did a coverage model become available for uninsured parents and other adults, ages 19-64, who are not otherwise eligible for Medicaid or Medicare who reside in St. Louis City or St. Louis County as of July 1, 2012?
- Were patients enrolled and able to receive covered benefits under the coverage model as of July 1, 2012?

- As of December 31, 2014, did the St. Louis Regional Health Commission identify its priorities and the required funding to accomplish those priorities?
- Did the Community Referral Coordinator Program identify funding for continued operations after December 31, 2013?
- Did the Affiliation Partners achieve financial sustainability?
- Were there any changes in operations/patient services due to the change in funding streams and the new payment methodology?

Findings to date:

The Demonstration has met Objective V, as evidenced by:

A. The St. Louis safety net funded by Gateway successfully transitioned to a coverage model by July 1, 2012 and has enrolled approximately 45,600 individuals into coverage over the life of the program to date.

B. The CRC program has achieved financial sustainability, and the SLRHC and primary care affiliation partners continue to be engaged in planning for financial sustainability.

Each of these findings is reviewed in detail below:

A. The St. Louis safety net funded by Gateway successfully transitioned to a coverage model by July 1, 2012, and has enrolled approximately 45,600 individuals into coverage over the life of the program to date.

The Pilot Program coverage model was implemented as planned on July 1, 2012, ensuring patients of the St. Louis safety net maintained access to primary care and specialty care. The Pilot Program provides a defined health coverage benefit to low-income, uninsured individuals residing in St. Louis City and St. Louis County who do not meet the eligibility requirements of the Missouri State Medicaid plan. Under the original Pilot Program, individuals up to 133 percent of the Federal Poverty Level who met other eligibility requirements were eligible for primary care and specialty care services through a coverage model known as Gateway to Better Health Blue. Additionally, individuals otherwise meeting the same requirements but with income up to 200% of the FPL could be enrolled into Gateway to Better Health Silver coverage, which included urgent and specialty care services but excluded the primary care benefit.

As of January 1, 2014, the coverage model provides primary, urgent and specialty care coverage to one population: uninsured adults in St. Louis City and St. Louis County with incomes up to 100% FPL. Individuals with incomes between 100% and 200% FPL were not eligible for Gateway coverage as of January 1, 2014. This change in eligibility resulted in the disenrollment of approximately 4,000 individuals. As of September 30, 2015, nearly 20,000 individuals were enrolled into Gateway coverage.

Gateway to Better Health Enrollment by Population, as of September 30, 2012, 2013 and 2014

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

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

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

In the STCs, the original enrollment target for the Blue Plan was 16,894. Due to higher than anticipated demand for the "Blue Plan" and lower than anticipated enrollment and utilization of the "Silver Plan," the State raised the enrollment target to 20,500 on January 1, 2013 and to 22,600 on April 1, 2013. Nearly 72,000 applications have been collected for the Gateway to Better Health program as of October 2015. Approximately 70% of applications collected are approved for coverage through the Pilot Program.

Screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more than 32,000 individuals in MO HealthNet programs, including:

- More than 16,500 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- More than 9,200 adults approved for Uninsured Women's Health Services;
- 3,052 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 2,895 adults approved for MO HealthNet for Families.

B. The CRC program has achieved financial sustainability, and the SLRHC and primary care affiliation partners continue to be engaged in planning for financial sustainability.

With the extension of the Demonstration, the primary care affiliation organizations have been able to maintain operations and extend their services to offer urgent care, seven days a week. The long-term sustainability of these organizations is dependent on coverage options being available to those living in poverty in St. Louis. While St. Louis ConnectCare was unable to demonstrate sustainability, the funding and access to the services ConnectCare provided has been sustainable throughout the Demonstration.

Key question for this Demonstration topic include:

- As of December 31, 2014, did the St. Louis Regional Health Commission identify its priorities and the required funding to accomplish those priorities?
- Did the Community Referral Coordinator Program identify funding for continued operations after December 31, 2013?
- Did the Community Referral Coordinator Program conduct an analysis on the effectiveness of its program in order to identify funding sources?
- Did the Affiliation Partners achieve financial sustainability?
- Were there any changes in operations/patient services due to the change in funding streams and the new payment methodology?

Updates are provided below:

St. Louis Regional Health Commission

Currently, the SLRHC's major priorities are (1) the successful management of the Gateway program, and (2) informing the public about the criticality of Medicaid expansion in Missouri. Once these duties have been successfully discharged, the SLRHC will reassess its priorities at that time. The SLRHC continues to sustain its non-Gateway operations through contributions from St. Louis City and County.

Community Referral Coordinator Program

The Community Referral Coordinator (CRC) program has had considerable success in transitioning patients from a hospital setting to a primary care home model. The program serves approximately 15,000 individuals annually, with 54% of the individuals scheduling an appointment with a community health center after their interaction with a CRC in an Emergency Department or hospital inpatient setting. Approximately 74% of all patients served have at least one chronic disease.

Due to the success of the model with Gateway patients, hospitals and health centers have successfully migrated the model to other populations to assist with patient transitions, with the intent to lower readmission rates and improve patient care for Medicare and Medicaid patients. The St. Louis Integrated Health Network has secured ongoing funding to continue the CRC model in hospitals in St. Louis' urban core. *Affiliation Partner Primary Care Providers*

The primary care Affiliation Partner organizations continue to work towards the benchmarks outlined in their respective sustainability plans, submitted in June 2011, as part of the Pilot Plan. Long-term sustainability for the Affiliation Partners is dependent on coverage options being available for their patients at the end of the Demonstration.

The move to a coverage model has required the providers supported by the Demonstration to understand underlying cost structures and streamline operations in preparation for the post-Demonstration environment. Evaluation efforts will address any changes to operations or patient services that may become necessary due to the changes in the funding stream or payment methodology.

In February 2013, the SLRHC commissioned a Transition Team to evaluate the impact of the pilot program on partner institutions and assess the long-term sustainability of the health care safety net in the St. Louis region. Findings were submitted to CMS in the form of a transition plan on June 25, 2014.

St. Louis ConnectCare

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

Additional Demonstration Evaluation Questions and Topics

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

I. To what extent has the State met the milestones listed in section XII?

The State has met all Demonstration milestones to date, as shown in the table below:

Progress toward Achieving Demonstration Milestones

Date – Specific	Milestone	STC Reference	Date Submitted
10/01/2010	Submit strategic plan for developing the pilot plan	Section XII (#55a)	09/24/2010
11/25/2010	Submit Draft Evaluation Design	Section XII (#57)	11/19/2010
01/01/2011	Submit draft plan for the pilot program including business plans for the SLRHC, CRC Program, and each of the Affiliation Partners	Section XII (#55b)	12/30/2010
01/28/2011	Submit draft annual report for DY 1 (July 2010 – September 2010)	Section IX (#38)	1/28/2011
07/01/2011	Submit plan for the pilot program, including any needed amendments to the Demonstration and final business plans for the SLRHC, CRC Program, and each of the Affiliation Partners	Section XII (#55c)	6/30/2011
07/01/2011	Submit financial audit of ConnectCare	Section XII (#55d)	6/30/2011
10/01/2011	Submit draft operational plan for the pilot program	Section XII (#55e)	9/29/2011
01/01/2012	Submit operational plan for the pilot program	Section XII (#55f)	12/30/2011
01/27/2012	Submit draft annual report for DY 2 (October 2010 – September 2011)	Section IX (#38)	01/27/2012
07/01/2012	State must implement the pilot program, contingent on CMS approval	Section XII (#56a)	Implemented 07/1/2012
07/01/2012	Submit draft Transition Plan	Section III (#16)	6/27/2012
08/01/2012	Submit MOU between the State and SLRHC for CMS review	Section XIV	7/30/2012
09/01/2012	Incentive protocol	Section V (#21)	8/16/2012
10/31/2012	Submit revised evaluation design	Section XIII, (#57)	10/31/2012
01/28/2013	Submit draft annual report for DY 3 (October 2011 – September 2012)	Section IX, (#38)	01/28/2013
12/31/2013	ConnectCare, Affinia Healthcare, and Myrtle Davis attain financial sustainability	Section XII (#56b)	See discussion of item II below.
12/31/2013	SLRHC and CRC must attain financial sustainability	Section XII (#56d)	12/31/2013
01/28/2014	Submit draft annual report for DY 4 (October 2012 – September 2013)	Section IX (#38)	1/28/2014
01/29/2014	Submit revised Evaluation Design	Section XIII (#57)	1/29/2014
06/30/2014	Submit Transition Plan	Section III (#16)	6/25/2014
	Submit revised Evaluation Design	Section XIII (#55)	11/19/2014
	Submit draft annual report for DY5 (October 2013-September 2014)	Section IX (#36)	1/20/2015
07/01/2017	Submit Draft Final Report	Section IX (#39)	
Ongoing through 07/01/2012	Ensure that there is a 2 percent increase in the number of uninsured persons receiving services at Affiliation Partners	Section XII (#56e)	See discussion of Demonstration objective IV.

Ongoing	Ensure that all individuals who present at the Affiliation Partners are screened for Medicaid and CHIP and assisted in enrolling, if eligible	Section XII (#56f)	Ongoing

II. How successful have the FQHCs and ConnectCare been at developing a business model that is based on receiving reimbursement through a claims-based system rather than receiving direct payments to the facilities?

The primary care affiliation partners have successfully transitioned to the coverage model. For calendar year 2014, Myrtle Hilliard Davis finished with a positive financial position while Affinia Healthcare (formerly known as Grace Hill) ended with a slight deficit. Affinia Healthcare has made some adjustments in the first quarter of 2015 and expects to return to a positive financial position going forward.

As discussed above, ConnectCare closed all operations in late 2013. After the closure, other health care providers contracted with Gateway to Better Health continued to provide services to Gateway patients and have maintained continuity of care for these patients through a managed transition process.

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

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

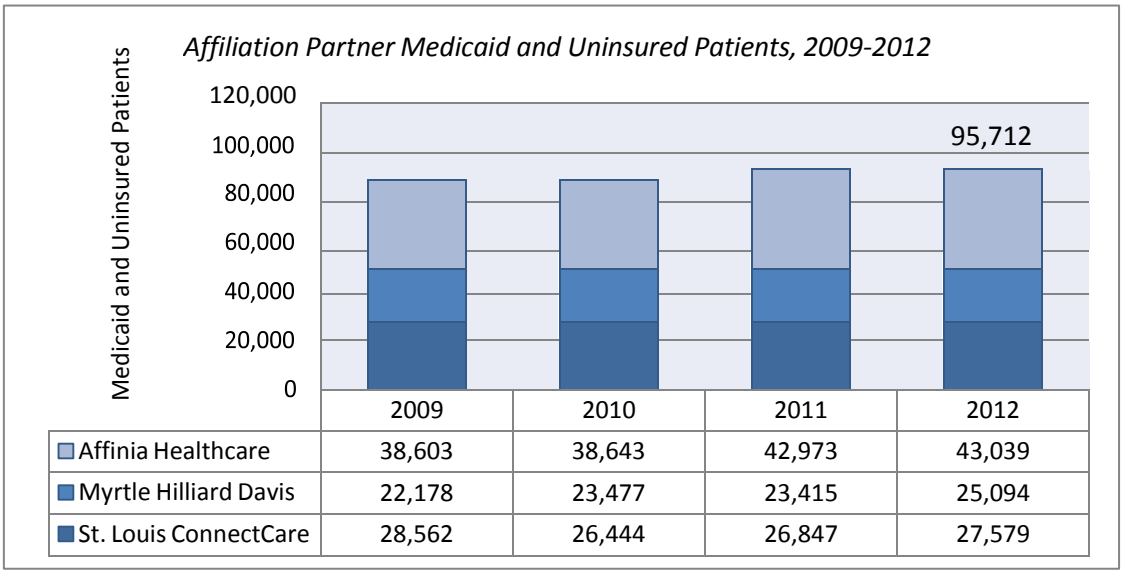
- Approximately 20,000 individuals are enrolled in Gateway to Better Health, which is approximately 50 percent of those uninsured and living below 100% of the federal poverty level in St. Louis City and County. Over the life of the program, approximately 45,600 unique individuals have received services from the program.

- More than 100,000 medical visits (primary care/urgent care, dental, specialty care, diagnostic services and outpatient hospital services) and more than 220,000 prescriptions are funded each year through Gateway to Better Health. Previous studies have indicated that the care provided through this Demonstration prevents more than 50,000 emergency department visits per year.

- Uninsured encounters at Gateway primary care providers increased by 13.6% (+31,361 encounters) from 2011 (coverage model baseline) to 2014.

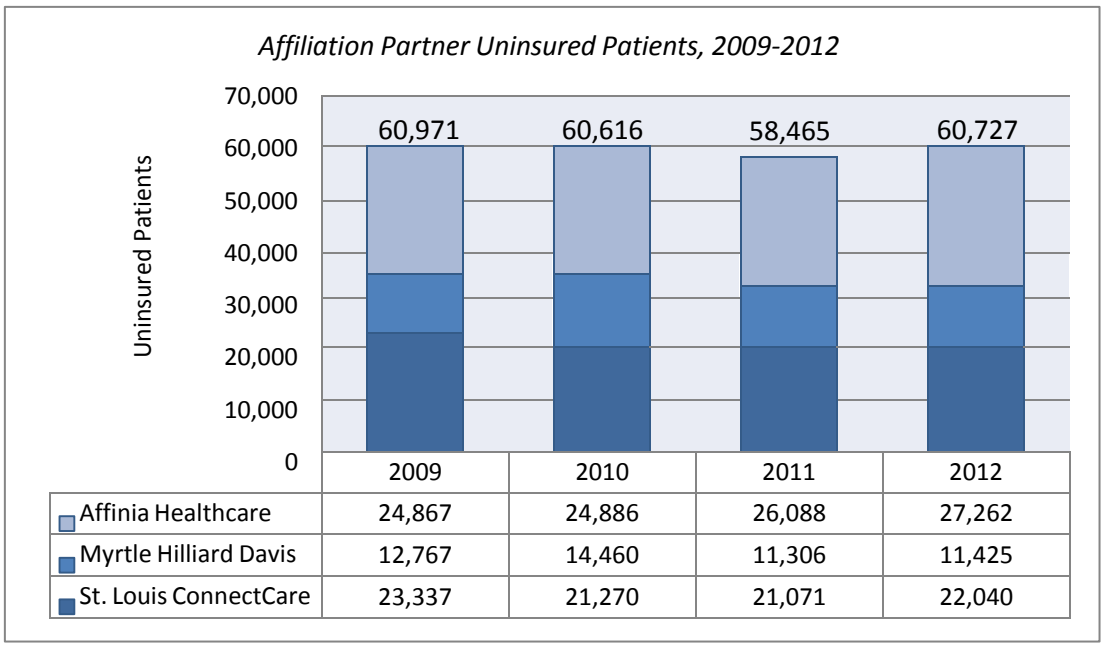
IV. How successful is the Demonstration in expanding coverage to the region's uninsured by 2 percent each year by July 1, 2012?

There was a seven percent increase in total Medicaid and uninsured persons receiving services at the Affiliation Partner providers from 89,343 patients in 2009 to 95,712 patients in 2012.



	2009	2010	2011	2012
Affinia Healthcare	38,603	38,643	42,973	43,039
Myrtle Hilliard Davis	22,178	23,477	23,415	25,094
St. Louis ConnectCare	28,562	26,444	26,847	27,579

Over this time period, the number of uninsured patients declined slightly (0.4%) from 60,971 in 2009 to 60,727 in 2012.



	2009	2010	2011	2012
Affinia Healthcare	24,867	24,886	26,088	27,262
Myrtle Hilliard Davis	12,767	14,460	11,306	11,425
St. Louis ConnectCare	23,337	21,270	21,071	22,040

The slight decline in uninsured patients from 2009 to 2012, and the coinciding increase in Medicaid patients, can be attributed to strong outreach efforts to enroll eligible patients into Missouri Medicaid, MO HealthNet. Screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more the 32,000 individuals in MO HealthNet programs.

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

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

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

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

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

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

- Preventative health and screening services (such as cervical screening, adult weight following up, flu shots, breast cancer screening, etc.) improved on average by 9% from year one (7/1/12-6/30/13) to year two (7/1/13-6/30/14), with more patients utilizing these services.

- Management of hypertension improved by 20% in year two (7/1/13-6/30/14) as compared to year one (7/1/12-6/30/13).

- Management of diabetes in year two (7/1/13-6/30/14) also improved by 4% compared to year one (7/1/12-6/30/13).

VI. Describe provider incentives and activities.

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

The sixth pay-for-performance reporting period ended on June 30, 2015. The complete results are provided in Appendix III. In general, the providers continued to build off gains from the first reporting period and made great strides in attaining the clinical quality measures. It is expected that the participating providers will continue to improve results as the program continues. As of

January 2014, pay-for-performance measures only apply to the participating primary care providers.

In the sixth reporting period, individually, all primary care providers achieved at least five of the six clinical quality measures. St. Louis County Department of Public Health achieved all six measures. Across all primary providers, 74% of patients enrolled for six months had a primary care visit during that time, with a threshold of 80%. Ninety percent of patients with chronic conditions enrolled six months had two primary care visits during that time, with a threshold of 80%. In addition, 60% of the patients with diabetes had HgbA1c measures <9%, with a threshold of 60%. Of all newly diagnosed or enrolled diabetic patients, 90% had their HgbA1c drawn within six months. Among enrollees whose primary care home was notified of a recent hospitalization, 78% were contacted by their primary care home's staff within (7) days after hospital discharge.

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

VII. Determine if performance incentives have impacted population metrics with a comparison of Gateway providers to other community health centers in the State. Include comparable FQHC population/providers to compare effectiveness of provider payment incentives.

- **Tobacco Use Assessment & Cessation Intervention**: the percentage of patients aged 18 and over who were queried about tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy at health centers participating in the Gateway Pilot Program remained relatively unchanged throughout the program. In 2014, the Gateway health centers rate of screening was comparable to the state average (77% state average vs. 75% Gateway average).
- **Controlling High Blood Pressure**: the proportion of hypertension patients whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading declined at health centers participating in the Gateway Pilot Program from 59% in 2013 to 55% in 2014. This measure declined across the state from 61% in 2011 to 59% in 2014.
- **Diabetes HbA1c Control (<9%)**: the proportion of adult patients with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading in the measurement year at health centers participating in the Gateway Pilot Program remained relatively stable from 2011 to 2014. The percent of adult diabetes patients with HbA1c readings less than 9% at health centers statewide remained stable as well. Gateway providers performed similarly to the Missouri health center average for this metric from 2011-2014.

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

- Preventative health and screening services (such as cervical screening, adult weight following up, flu shots, breast cancer screening, etc.) improved on average by 9% from year one (7/1/12-6/30/13) to year two (7/1/13-6/30/14), with more patients utilizing these services.

- Management of hypertension improved by 20% in year two (7/1/13-6/30/14) as compared to year one (7/1/12-6/30/13).

- Management of diabetes in year two (7/1/13-6/30/14) also improved by 4% compared to year one (7/1/12-6/30/13).

VIII. Provide financial analysis of the Legacy and ConnectCare providers for the pre- and post-coverage phase of the Demonstration.

The primary care affiliation partners have successfully transitioned to the coverage model. For calendar year 2014, Myrtle Hilliard Davis finished with a positive financial position while Affinia Healthcare (formerly known as Grace Hill) ended with a slight deficit. Affinia Healthcare has made some adjustments in the first quarter of 2015 and expects to return to a positive financial position going forward.

As discussed above, ConnectCare closed all operation in late 2013. After the closure, other health care providers contracted with Gateway to Better Health continued to provide services to Gateway patients and have maintained continuity of care for these patients through a managed transition process.

IX. Analyze the cost of care and access to services at the legacy FQHC providers, comparing the first 18 months of the Demonstration when the providers received direct payments to now when providers are paid on a capitated basis with incentive payments.

While the cost of care at Affinia Healthcare (formerly known as Grace Hill Health Centers) increased slightly (+8%) from 2011 to 2014, after implementation of the Gateway coverage model, costs decreased by 16% at Myrtle Hilliard Davis during this period.

Cost Per Medical Encounter at Affinia Healthcare and Myrtle Hilliard Davis, 2011-2014*

Legacy FQHC Provider	Cost per Encounter, 2011	Cost per Encounter, 2012	Cost per Encounter, 2013	Cost per Encounter, 2014
Affinia Healthcare	$152	$161	$162	$164
Myrtle Hilliard Davis Health Centers	$139	$136	$105	$117

*The above costs exclude lab, radiology, and pharmaceuticals.

Interim Evaluation Findings for the Coverage Pilot Program

The following objectives and hypotheses were identified for the Pilot Program:

Pilot objectives

I. To provide a basic set of medical services for as many uninsured patients as possible

II. To provide a bridge to health care reform for the legacy clinics to help ensure financial sustainability

III. To place a particular emphasis on providing coverage to low-income individuals:

   a. who have chronic medical conditions such as diabetes, heart disease and hypertension

   b. who are aging out of Medicaid and link them to health care coverage

IV. To decrease the use of community emergency departments for non-emergent visits

Pilot hypotheses

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

II. Uninsured patients who receive coverage under the pilot program will use community emergency departments for non-emergent visits at a lower rate than other uninsured patients.

III. The prevalence of preventable hospitalizations, hospital re-admissions and ED utilization will be reduced among patients with chronic medical conditions.

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

Pilot Program Findings to Date

The Pilot Program began on July 1, 2012. Analysis and reporting of initial program findings for some evaluation metrics are discussed below as follows:

- Enrollment data for the Pilot Program (7/01/12-9/30/15), as provided in this report section.
- Financial data for the Pilot Program (7/01/12-9/30/15), as provided in this report section.
- Claims-based utilization data for the Pilot Program (7/01/12-6/30/15), as provided in this report section.
- Quality data for the Demonstration (7/01/12-6/30/15), as provided in this report section.

I. Enrollment

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

As of January 1, 2014, the coverage model provides primary, urgent and specialty care coverage to uninsured adults in St. Louis City and St. Louis County with incomes up to 100% FPL. Individuals with incomes between 100% and 200% FPL are not eligible for Gateway coverage as of January 1, 2014, and therefore the Blue Plan is the only Gateway plan. When the income requirements changed for the program, approximately 4,000 individuals lost coverage through Gateway. Significant outreach was conducted helping to enroll these individuals in other coverage options. As of September 30, 2015, nearly 20,000 individuals were enrolled in Gateway.

In the approval for 2016, CMS approved the addition of insulin and inhalers that are not available in a generic alternative to the program's benefit package. With the additional cost of this benefit, the enrollment target for 2016 was lowered to 21,400.

Outlined below are the key statistics related to enrollment in the demonstration at the end of each federal fiscal year.

Gateway to Better Health Enrollment by Population, as of September 30, 2012, 2013 and 2014

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

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

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

Gateway to Better Health "Blue Plan" Enrollment by Health Center, as of September 30, 2015

Health Center	**Unique Individuals Enrolled as of September 30, 2015**	**Member Months July 2012 - September 2015**
BJK People's Health Centers	3,440	112,181
Family Care Health Centers	1,451	56,238
Affinia Healthcare	8,560	362,348
Myrtle Hilliard Davis Comp. Health Centers	3,412	141,951
St. Louis County Dept. of Health	2,917	117,861
Total	19,780	790,579

**Enrollment numbers are based on MO HealthNet enrollment data as of September 30, 2015.*

Gateway to Better Health Enrollment by Gender, as of September 30, 2015

Gender	**Count**	**Percentage**
Female	10,425	52.7%
Male	9,355	47.3%
Total	***19,780***	***100.0%***

*Top 15 Zip Codes by Member Count as of September 30, 2015**

ZIP	Member Count	City or County
63136	1,579	St. Louis County (Jennings, MO)
63115	1,275	St. Louis City
63118	1,069	St. Louis City
63116	995	St. Louis City
63107	795	St. Louis City
63113	786	St. Louis City
63121	758	St. Louis City
63106	720	St. Louis City
63111	720	St. Louis City
63112	720	St. Louis City
63103	700	St. Louis City
63137	580	St. Louis County (Bellefontaine Neighbors, MO)
63104	564	St. Louis City
63120	550	St. Louis City
63033	544	St. Louis City
All Others	7,425	St. Louis City and St. Louis County
Total	***19,780***	-

**These 15 zip codes account for 62.5% of the total Gateway population*

Members by Age Group as of September 30, 2015

Age Groups	Members	% of Total
19-20	561	2.8%
21-44	10,172	51.4%
45-64	9,047	45.7%
Total	***19,780***	***100.0%***

Members by Race as of September 30, 2015

Race	Members	% of Total
African American	14,560	73.6%
Caucasian	3,687	18.6%
Other	25	<1%
Unknown	1,508	7.6%
Total	19,780	100.0%

II. **Financial**

Outlined below are the financial results from demonstration.

*Summary of Medical Payments through the Demonstration (July 2012 - September 2015)**

Payment Type	FFY 2012	FFY 2013	FFY 2014	FFY 2015
Primary Care	$ 2,272,716	$ 12,243,427	$ 14,441,757	$ 13,503,717
Specialty Care	$ 2,373,722	$ 11,125,574	$ 8,104,522	$ 7,318,760
Transportation	$ -	$ -	$ 333,839	$ 327,795
Total	$ 4,646,438	$ 23,369,001	$ 22,880,118	$ 21,150,272

*The data above is as of 9/30/15 and is subject to change as additional claims are submitted and recoupments occur.

*Infrastructure Payments Made to St. Louis ConnectCare July 2012 – September 2013***

Program Quarter	**Infrastructure Payments Made**
July-September 2012	$ 975,000
October-December 2012	$ 600,000
January-March 2013	$ 450,000
April-June 2013	$ 425,000
July-September 2013	$ 450,000
October-December 2013	N/A
Total	$ 2,900,000

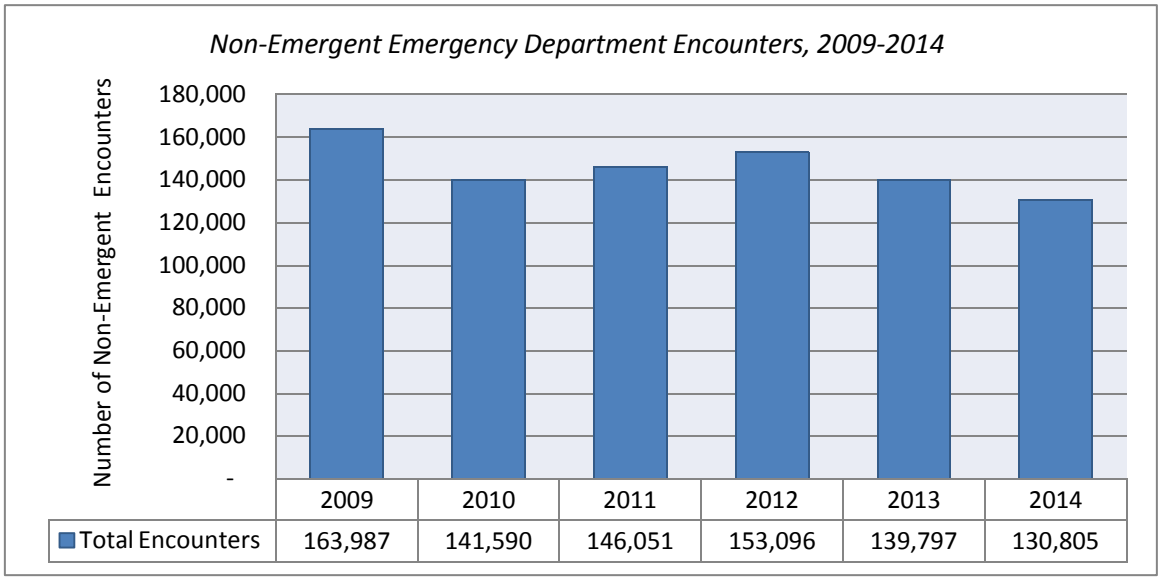
**Infrastructure payments ended 9/30/13.

III. Utilization

Outlined below are key findings from an initial review of claims throughout the Demonstration (July 2012 – September 2015).

As of September 9, 2015, approximately 14% of all reported diagnoses at primary and specialty care network sites were related to the management of chronic diseases. Of those reported diagnoses related to chronic conditions, 55% were for hypertension, 34% were for diabetes mellitus, 7% were for asthma and 4% were for chronic obstructive pulmonary disease.

One of the objectives of the Pilot Program is to decrease the use of community emergency departments for non-emergent visits through connecting patients to primary care homes and increasing access to primary and specialty care services for the uninsured and Medicaid population. In 2009 (prior to the Pilot Program), St. Louis safety net emergency departments had 163,987 non-emergent emergent department encounters as compared to 130,805 non-emergent encounters in 2014 (-20.2%).



IV. Quality

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

Patient Satisfaction Survey

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

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

Overall, Gateway patients were satisfied with the primary care services, and 90% of respondents indicated that they would recommend their health center to others. In addition, Gateways patients who utilize transportation and urgent care services report satisfaction with transportation service and ability to get in to be seen at urgent care centers. Results of the patient survey are outlined below.

Survey questions also solicited feedback related to patients' overall experience with the Gateway to Better Health program. Those results are outlined below:

*Patient Satisfaction Survey Results for Primary Care Services, January - June 2015**

Survey Item	Average Ratings*
Overall ease of scheduling an appointment	3.1
Staff listened and explained things	3.7
Doctor listened and explained things	4.0
Staff kind and respectful	3.8
Doctor kind and respectful	4.2
Overall quality of service	3.9
Ease of getting prescription filled	3.5

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

*Patient Satisfaction Survey Results for Specialty Care Services, January - June 2015**

Survey Item	Average Ratings*
Overall ease of scheduling an appointment	3.3
Staff listened to needs	3.9
Staff explained things well	4.1
Staff kind and respectful	4.0
Overall quality of service	3.8

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

*Patient Satisfaction Survey Results for Urgent Care Services, January - June 2015**

Survey Item	Average Ratings*
Ability to be seen	3.5
Understanding of payment	4.1
Staff kind and respectful	4.0
Overall quality of service	3.9

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

*Patient Satisfaction Survey Results for Transportation Services, January - June 2015**

Survey Item	Average Ratings*
Ease of requesting transportation	3.3
Satisfaction with transportation services	3.5

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

*Results of Gateway to Better Health Patient Experience Survey, July 2012 – June 2015**

Survey Item	Patient Agreement (%)			
	July – September 2012	**October – December 2012**	**January – March 2013**	**January - April 2014**
More likely to see doctor	100%	97%	100%	93%
Would recommend health center to family and friends	98%	86%	92%	N/A
Understand services covered by Gateway	85%	87%	78%	N/A
Time without insurance before Gateway**:	1 month: 0% 6 months: 4% 12 months: 6% > 1 year: 19% 2 to 4 years: 30% > 4 years: 42%	< 1 year: 27% 1 to 2 years: 31% > 3 years: 60%	N/A	N/A

* *This data is no longer collected and will not be included in future reports.*
***Response choices in the second reporting period survey related to the "time without insurance before Gateway" were simplified into three categories for ease of patient completion.*

Member Orientation Results

The Gateway to Better Health program enrolls 600 to 1600 new members each month. In an effort to educate these new members about program and health center processes, the Pilot Program began holding orientation sessions for those members enrolled in the program in the last six months. Topics discussed during the sessions include program background, application process, member handbook and ID card, covered and non-covered benefits, transportation scheduling, redetermination and disenrollment, as well as health center specific policies. Member orientations were conducted at various sites for all Gateway primary care organizations: Betty Jean Kerr People's Health Center, Myrtle-Hilliard Davis Comprehensive Health Centers, Family Care Health Centers, Affinia Healthcare, and St. Louis County Department of Public Health. A total of 414 members attended the sessions. Participants were asked to evaluate the effectiveness of each orientation session at its conclusion. Those results are summarized below:

- 91% of members felt very confident or somewhat confident that they understood how to use their benefits
- 93% of members felt very confident or somewhat confident that they can navigate receiving health care service at their health center
- 93% of members felt the orientation sessions was very helpful or somewhat helpful

As response to the implementation of member orientations have been positive from both providers and patients, the SLRHC and the Pilot Planning Team has elected to continue holding member orientations on a quarterly basis at each participating health center.

Provider Satisfaction Survey Results

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

Provider Satisfaction surveys were distributed to the five primary care health centers in the Gateway provider network to assess providers' experience with the referral process for the program. In the July-September 2012 reporting period, a total of 17 surveys were collected; in the October-December 2012 reporting period, a total of 44 surveys were collected; in January-March 2013 reporting period, a total of 37 surveys were collected; in the April-June 2013 reporting period, a total of 34 surveys were collected; in the January-April 2014 reporting period, a total of 62 surveys were collected; in a survey conducted by PSRAI in October 2014, a total of 93 were collected; and in the January-June 2015 reporting period, a total of 56 surveys were collected. Overall throughout the pilot program, providers tend to have a good experience when referring Gateway patients to specialty care providers.

The lowest scores for most providers during the January-June 2015 reporting period were related to the information needed for scheduling and the availability of the rendering specialist to speak with the health center. Results from January-June 2015 surveys are outlined below:

*Provider Satisfaction Survey Results, January - June, 2015**

Survey Item	Average Ratings*
Overall ease of scheduling a consultation	2.08
Ease of contacting the rendering provider	2.25
Helpfulness and courtesy of staff when scheduling	2.44
Timeliness of available appointments	2.01
Report from consultation provider, did you receive it?	1.88
Report from consultation provider, was it meaningful?	2.10
Rendering specialist available to speak with you?	1.90

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

Prior to October 2012, the Provider Survey tool focused primarily on referring providers. In the October 2012, the Provider Survey tool was updated to capture information from both support staff and referring providers. During the most current reporting period, the lowest scores for most support staff were related to the timeliness of available appointments. Results from January – June 2015 reporting period for support staff respondents are outlined below:

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

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

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

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

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

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

In addition to the financial oversight and reporting provided by the State to CMS, the State and SLRHC also monitor call center performance, access to specialty care and wait times for medical appointments.

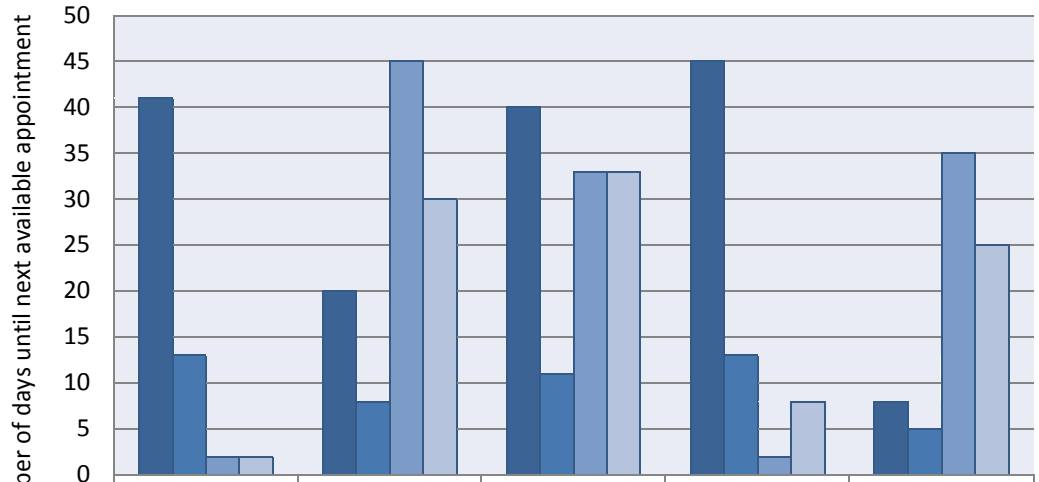
Call Center Performance, July 2012 – September 2015

Key Performance Measure	Outcome
Calls Received	64,217
Calls Answered	61,693
Average Abandonment Rate	3.9%
Average Answer Speed (*seconds*)	28 sec.
Length of Time per Call (*minutes: seconds*)	3:31

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

Month	Referrals to St. Louis ConnectCare	Referrals to other Specialty Providers	Total
July 2012	1350	417	1,767
August 2012	1515	638	2,153
September 2012	1004	618	1,622
October 2012	1171	850	2,021
November 2012	984	878	1,862
December 2012	1059	803	1,862
January 2013	1357	1108	2,465
February 2013	1230	970	2,200
March 2013	1394	1347	2,741
April 2013	1616	1239	2,855
May 2013	1287	1141	2,430
June 2013	1248	1364	2,612
July 2013	1336	1202	2,538
August 2013	858	1568	2,426
September 2013	79	1662	1,741
October 2013	69	2310	2,379
November 2013	8	2041	2,049
December 2013	0	1855	1,855
January 2014	N/A	1804	1,804
February 2014	N/A	1988	1,988
March 2014	N/A	2067	2,067
April 2014	N/A	2366	2,366
May 2014	N/A	2120	2,120
June 2014	N/A	2524	2,524
July 2014	N/A	2263	2,263
August 2014	N/A	2202	2,202
September 2014	N/A	2301	2,301
October 2014	N/A	2349	2,349
November 2014	N/A	1767	1,767
December 2014	N/A	1879	1,879
January 2015	N/A	1871	1,871
February 2015	N/A	1983	1,983
March 2015	N/A	2178	2,178
April 2015	N/A	2334	2,334
May 2015	N/A	1955	1,955
June 2015	N/A	2222	2,222
July 2015	N/A	2101	2,101
August 2015	N/A	1964	1,964
September 2015	N/A	1845	1,845

Primary Care Wait Times for Regular (Non-Urgent) Appointments as of 9/30/15*



	Affinia Healthcare**	St. Louis County	Family Care	BJK People's	Myrtle Hilliard Davis
Adult Patient-New	41	20	40	45	8
Adult Patient-Returning	13	8	11	13	5
Adult Dental-New	2	45	33	2	35
Adult Dental-Return	2	30	33	8	25

**Wait times self-reported by individual health center as of September 30, 2015 and are calculated for Gateway patients only.*
***Affinia Healthcare was formerly known as Grace Hill Health Centers.*

*Adult Wait Times by Specialty**

	# of Days Until the Next Available Appointment	
Appointment Type	**New Patient**	**Return Patient**
Cardiology	9.3	18.6
Dermatology	24.5	16.3
Endocrinology	35.3	29.3
Endoscopy	7.0	7.0
ENT/Otolaryngology	14.8	9.5
Gastroenterology (GI)	32.0	40.3
Gynecology	30.5	15.5
Hematology	28.5	23.5
Hepatology	66.0	37.0
Infectious Disease	29.5	20.0
Mental/Behavioral Health	33.6	20.3
Nephrology	24.0	21.0
Neurology	31.3	16.5
Neurosurgery	27.5	15.8
Obstetrics/Prenatal Care	9.0	10.6
Oncology	12.0	12.6
Ophthalmology/Eye Care	49.6	31.6
Orthopedics	13.3	19.3
Pain Management	27.0	25.0
Pathology	0.0	0.0
Physical Therapy	1.0	8.0
Podiatry	79.0	79.0
Pulmonology	27.5	21.0
Rheumatology	47.0	30.3
Surgery -- General	8.6	9.6
Urology	27.3	18.8

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

Evaluation Activities during the Extension Period

During the extension period, the Demonstration will be evaluated against the established Demonstration objectives, as well as the Pilot Program objectives and hypotheses.

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

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

Pilot objectives

I. To provide a basic set of medical services for as many uninsured patients as possible

II. To provide a bridge to health care reform for the legacy clinics to help ensure financial sustainability

III. To place a particular emphasis on providing coverage to low-income individuals:
   a. who have chronic medical conditions such as diabetes, heart disease and hypertension
   b. who are aging out of Medicaid and link them to health care coverage

IV. To decrease the use of community emergency departments for non-emergent visits

Pilot hypotheses

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

II. Uninsured patients who receive coverage under the pilot program will use community emergency departments for non-emergent visits at a lower rate than other uninsured patients.

III. The prevalence of preventable hospitalizations, hospital re-admissions and ED utilization will be reduced among patients with chronic medical conditions.

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

There are no additional evaluation objectives at this time.

Section VIII: Compliance with Public Notice Process

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

In compliance with 42 C.F.R. § 431.408, The State's public notice and comment period began on November 25, 2015, and ran for 30 days, until December 30, 2015. On November 25, 2015, the State published the full public notice document (See Appendix VIII) in a prominent location on its website at http://dss.mo.gov/mhd/ and on November 30, 2015 and December 1, 2015 published the abbreviated public notice (see Appendix VII) in the newspapers of widest circulation in each city in Missouri with a population of 50,000 or more. In addition, the SLRHC notified via email past participants of community meetings regarding Gateway to Better Health.

The public was invited to review and comment on the State's proposed waiver extension request from November 25, 2015, through December 30, 2015. Comments concerning the State's plan to submit a waiver extension request were accepted at:

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

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

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

Tuesday, December 1, 2015, 7:30-8:30AM
Ethical Society of St. Louis
9001 Clayton Road
St Louis, MO 63117

This meeting is part of the regularly scheduled Provider Services Advisory Board meeting of the St. Louis Regional Health Commission. Individuals wanting to participate in the December 1st public hearing via conference call may dial 888-808-6929, access code: 9158702.

Wednesday, December 2, 2015, 10 a.m. – 11:30 a.m.
BJK People's Health Centers
5701 Delmar Blvd.
St. Louis, MO 63112

The State and the St. Louis Regional Health Commission accepted verbal and written comments at the public hearings.

At the first public hearing, there were approximately 40 people in attendance. The second hearing was

held December 2, 2015, at a community event open to the public. Approximately, 18 people were in attendance.

An update on Gateway was provided at both hearings, along with copies of the public notice and the full extension document. Participants expressed support of the State's request for an extension of the Gateway to Better Health Demonstration project, and felt that Gateway should continue until Medicaid is expanded in Missouri. One participant expressed gratitude for the program because it fulfills her insurance requirement for nursing school. Overall, positive feedback for the extension of the program, in the event Medicaid is not expanded in Missouri, was expressed at both meetings.

In addition, on June 16, 2015, a Post Award Public Input Forum was held to inform the public on the progress of the Gateway Demonstration, in compliance with 42 C.F.R. § 431.420(c). This meeting was held as part of the regularly scheduled Community Advisory Board of the St. Louis Regional Health Commission. Approximately, 25 people attended the meeting. Attendees received information about the number of people served and the number of services and visits provided by Gateway each year. The current membership of the program, including a demographic profile of Gateway members, and an overview of patient and provider satisfaction feedback also was presented. The notice for the Post Award Public Input Forum may be found in Appendix VII.

Gateway to Better Health Demonstration

Demonstration Extension Application Appendices

December 31, 2015

Number: 11-W-00250/7

Appendix I

Quality Measures

Baselines are provided using data from calendar year 2011. These quality measures will be reviewed for evaluation purposes.

Quality Measures

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

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

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
3. Tobacco Use Assessment & Cessation Intervention[2] Percentage of adults age 18 and older assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy	Number of patients for whom documentation demonstrates that patients were queried about their tobacco use at least once within 24 months of their last visit (during measurement year) about any and all forms of tobacco use AND received tobacco cessation counseling intervention and/or Pharmaco-therapy if identified as a tobacco user	Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least two medical visits ever, or a sample of these patients.	-	-	-	-	-	-	72%	77%	TBD	UDS

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

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
2. Hypertension: Controlling High Blood Pressure Proportion of patients aged 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading	Number of patients whose last systolic blood pressure measurement was less than 140 mm Hg and whose diastolic blood pressure was less than 90 mm Hg	All patients 18 to 85 years of age as of December 31 of the measurement year: -with a diagnosis of hypertension (HTN), and -who were first diagnosed by the health center as hypertensive at some point before June 30 of the measurement year, and -who have been seen for medical services at least twice during the reporting year -or a statistically valid sample of 70 of these patients	59%	61%	62%	61%	56%	59%	76%	59%	64%	UDS
3. Hypertension: Blood Pressure Measurement Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits	54%	NA	NA	NA	99%	NA	97%	NA	59%	HITECH Meaningful Use / MPCA

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
4. Cervical Cancer Screening Percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer	Number of female patients 24-64 years of age receiving one or more documented Pap tests during the measurement year or during the two years prior to the measurement year	Number of all female patient 24-64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sampling of these women	61%	52%	51%	48%	49%	49%	66%	47%	66%	UDS
5. Diabetes: HbA1c Control Proportion of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading in the measurement year. Results are reported in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9%	Number of adult patients whose most recent hemoglobin A1c level during the measurement year is less than or equal to 9%	Number of adult patients aged 18 to 75 as of December 31 of the measurement year: -with a diagnosis of Type I or II diabetes and, -who have been seen in the clinic for medical services at least twice during the reporting year, -or a statistically valid sample of 70 of these patients	70%	73%	68%	70%	69%	71%	69%	72%	75%	UDS

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
6. Adult Weight Screening and Follow-Up Percentage of patients aged 18 and over who had documentation of a calculated BMI during the most recent visit or within the 6 months prior to that visit	Number of patients who had their BMI (not just height and weight) documented during their most recent visit or within 6 months of the most recent visit and if the most recent BMI is outside parameters, a follow-up plan is documented	Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, or a sample of those patients	19%	31%	47%	44%	53%	53%	46%	55%	24%	UDS
9. Primary Care Visits for Patients with Chronic Diseases Percentage of enrolled patients with diabetes, hypertension, CHF or COPD with 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	Number of enrollees with diabetes, hypertension, CHF or COPD with 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	Number of enrollees with diabetes, hypertension, CHF or COPD	NA	NA	73%	NA	71%	NA	78%	NA	80%	Claims data
10. Primary Care Follow-Up After Hospitalization Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff	Number of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days of hospital discharge.	Number of enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center during the measurement year.	NA	NA	79%	NA	66%	NA	65%	NA	50%	Claims data

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
member from the primary care home within 7 days of hospital discharge												

APPENDIX II

Incentive Payment Protocol

Incentive Payments

The state will withhold 7% from payments made to the primary care health centers (PCHC) through December 31, 2017, and the amount withheld will be tracked on a monthly basis. The St. Louis Regional Health Commission (SLRHC) will be responsible for monitoring the PCHC performance against the pay-for-performance metrics outlined below.

Pay-for-performance incentive payments will be paid out at six-month intervals of the Pilot Program based on performance during the reporting period.

Reporting Periods:

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

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

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

TABLE 1

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
All Newly Enrolled Patients- Minimum of at least 1 office visit within 1 year (6 months before/after enrollment date)	80%	20%	EHR Data
Patients with Diabetes, Hypertension, CHF or COPD – Minimum of at least 2 office visits within 1 year (6 months before/after reporting period start date)	80%	20%	EHR Data
Patients with Diabetes - Have one HgbA1c test within 6 months of reporting period start date	85%	20%	EHR Data
Patients with Diabetes – Have a HgbA1c less than or equal to 9% on most recent HgbA1c test within the reporting period	60%	20%	EHR Data

Hospitalized Patients - Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days after hospital discharge.	50%	20%	Self-reported by health centers and AHS Call Center Data
TOTAL POSSIBLE SCORE		**100%**	

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

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

TABLE 2

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

The primary care providers will be eligible for the remaining funds based on the percentage of patients enrolled at their health centers. For example, if Affinia Healthcare (formerly known as Grace Hill) has 60% of the primary care patients and Myrtle Hilliard Davis 40%, they would each qualify up to that percentage of the remaining funds. Funds not distributed will be used to create additional enrollment slots where demand and capacity exist. Payments will not be redirected for administrative or infrastructure payments.

Within the first quarter following the end of the reporting period, the state will issue incentive payments to the health centers. Incentive payments will be calculated based on the data received and the methodology described below.

Primary Care Health Center (PCHC) Calculations:

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

- IP = PCHC Payments Earned x 7%

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

- Identify which performance metrics were achieved
- Determine the total Incentive Pool Weights (IPW) by adding the weights of each performance metric achieved

- *Example:* If the PCHC achieves 3 of the 5 performance metrics, then: IPW = 20% + 20% + 20% = 60%
- IPEP = IP x IPW

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

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

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

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

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

- PS = RPCIF x (CMM/TMM)

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

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

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

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

- RPCIFP = PS x IPW

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

SCENARIO 1

Key assumptions:

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

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

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

Remaining Primary Care Incentive Funds

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

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

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

Step 6

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

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

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

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

SCENARIO 2

Key assumptions:

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

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

STEP 3

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

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

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

Step 6

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

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

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

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

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

APPENDIX III

Pay-for-Performance Incentive Payment Results
Reporting Period: January – June 2015

Background

The State withholds 7% from payments made to the primary care health centers. The amount withheld is tracked on a monthly basis. Primary care health centers provided self-reported data to SLRHC within 30 days of the end of the reporting period for those patients who were enrolled for the entire reporting period. SLRHC validated the data by taking a random sample of the self-reported data and comparing it to the claims data. SLRHC has calculated the funds due to the providers based on the criteria and methodologies described in the Incentive Protocol, approved by CMS. Results for the sixth reporting period, January – June 2015, are summarized below.

Primary Care Health Center Pay-for-Performance Results

The potential incentive payment amount totaled $475,659.97 and 100% will be paid to primary care providers. The following table outlines the pay-for-performance thresholds in comparison to the actual results of each metric.

Table 1 Pay-for-Performance Criteria	Threshold	*Actual Outcomes Achieved*					
		GH	MHD	FC	BJKP	County	Total
1 - All Patients (1 visit)	80%	74%	83%	78%	58%	89%	74%
2 - Patients with Chronic Disease (2 visits)	80%	86%	94%	85%	90%	97%	90%
3 - Patients with Diabetes HgbA1c Tested	85%	92%	86%	89%	90%	89%	90%
4 - Patients with Diabetes HgbA1c < 9%	60%	60%	47%	68%	61%	65%	60%
5 - Hospitalized Patients	50%	85%	64%	67%	60%	80%	78%

The number of metrics met by each health center for the first round of metrics is depicted by the green highlighted fields in Table 1 above. The health centers earned $394,233.14 of the initial incentive pool leaving a remaining balance of $81,426.83.

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

Table 2 Pay-for-Performance Criteria	Threshold	*Actual Outcomes Achieved*					
		GH	MHD	FC	BJKP	County	Total
Referral Rate to Specialists	680/1000	280	322	528	337	536	351

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

Table 3 – Amount Due to Each Health Center				
Health Center	**Incentive Pool**	**First Round Earnings**	**Second Round Earnings**	**Total Due to Providers**
GH	$ 213,567.57	$ 170,854.06	$ 36,560.01	$ 207,414.07
MHD	$ 81,870.75	$ 65,496.60	$ 14,015.21	$ 79,511.81
FC	$ 34,681.44	$ 27,745.15	$ 5,937.01	$ 33,682.16
BJKP	$ 77,014.42	$ 61,611.54	$ 13,183.87	$ 74,795.41
County	$ 68,525.79	$ 68,525.79	$ 11,730.73	$ 80,256.52
Total	**$ 475,659.97**	**$ 394,233.14**	**$ 81,426.83**	**$ 475,659.97**

SUMMARY OF CALCULATIONS

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

Step 1: Determine the initial pool amount.
Step 2: Determine which of the following first-tier performance metrics were achieved for each organization:

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

Step 3: Calculate the earnings for the initial pool based on the number of first-tier metrics achieved.
Step 4: Determine the second pool amount, which is unearned amount from the initial pool.
Step 5: Calculate health center's share of available earnings based on enrollment.
Step 6: Determine which of the following second-tier performance metrics were achieved:

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

Step 7: Calculate the earnings for the second pool based on the number of second-tier metrics achieved.
Step 8: Calculate the total payment to the health center by summing the earnings from both pool

PRIMARY CARE TRENDING REPORT

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

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

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

Appendix IV

Projected Budget Neutrality Impact Through 2017

	DY 1 FFY 2010 07/28/2010 - 09/30/2010	DY 2 FFY 2011 10/01/2010 - 09/30/2011	DY 3 FFY 2012 10/01/2011- 9/30/2012	DY 4 FFY 2013 10/01/2012- 09/30/2013	DY 5 FFY 2014 10/01/2013- 9/30/2014	DY 6 FFY 2015 10/01/2014- 09/30/2015	DY 7 FFY 2016 10/01/2015- 09/30/2016	DY 8 FFY 2017 10/01/2016- 09/30/2017	DY 9 FFY 2018 10/01/2017- 12/31/2017	Total - 7.5 year demonstration 07/28/2010 to 12/31/2017
No. of months in DY	3 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	3 months	
No. of months of direct payments to facilities	3 months	12 months	9 months	0 months	0 months	0 months	0 months	0 months	0 months	
No. of months of Pilot Program (will be implemented on 07/01/2012)	0 months	0 months	3 months	12 months	12 months	12 months	12 months	12 months	3 months	
Without Waiver Projections										
Estimated DSH Allotment**	$189,681,265	$748,599,611	*$766,126,399*	*$811,102,775*	$814,509,721	*$809,021,633*	*$813,628,633*	*$768,570,551*	*$203,407,158*	**$5,924,647,746**
Without Waiver Total	**$189,681,265**	**$748,599,611**	**$766,126,399**	**$811,102,775**	**$814,509,721**	**$809,021,633**	**$813,628,633**	**$768,570,551**	**$203,407,158**	**$5,924,647,746**
With Waiver Projections										
Residual DSH	*$167,785,998*	*$679,083,062*	*$675,602,811*	*$735,329,474*	*$713,152,789*	*$714,046,801*	*$787,294,778*	*$742,534,487*	*$196,898,142*	*$5,411,728,342*
St. Louis ConnectCare	*$4,850,000*	*$18,150,000*	*$14,879,909*	*$3,148,648*	*$118,489*	*$0*	*$0*	*$0*	*$0*	*$41,147,045*
Grace Hill Neighborhood Health Centers	*$1,462,500*	*$5,850,000*	*$5,071,706*	*$5,016,507*	*$6,073,656*	*$6,147,313*	*$6,011,196*	*$5,943,010*	*$1,485,752*	*$43,061,639*
Myrtle Davis Comprehensive Health Centers	*$937,500*	*$3,750,000*	*$3,097,841*	*$2,108,161*	*$1,838,040*	*$2,364,279*	*$2,396,051*	*$2,368,873*	*$592,218*	*$19,452,963*
Contingency Provider Network	*$0*	*$0*	*$379,372*	*$4,254,902*	*$5,469,199*	*$5,539,520*	*$5,806,076*	*$5,740,224*	*$1,435,056*	*$28,624,350*
Voucher	*$0*	*$0*	*$0*	*$4,541,262*	*$6,358,786*	*$8,121,788*	*$8,170,454*	*$8,078,548*	*$2,019,637*	*$37,290,476*
Infrastructure	$0	$0	$975,000	*$1,925,000*	*$0*	$0	$0	$0	$0	$2,900,000
SLRHC Administrative Costs	$75,000	$300,000	$300,000	*$300,000*	*$75,000*	*$0*	*$0*	*$0*	*$0*	$1,050,000
SLRHC Administrative Costs Coverage Model			$584,155	*$4,328,950*	*$3,692,463*	$3,581,906	*$3,950,078*	*$3,905,410*	*$976,352*	$21,019,315
CRC Program Administrative Costs	$91,684	$700,000	$700,000	*$700,000*	*$175,000*	*$0*	*$0*	*$0*	*$0*	$2,366,684
Actual expenditures for DY3 DOS				$2,670,607	*$33,308*	*$0*	*$0*	*$0*	*$0*	$2,703,915
Projected expenditures for DY4 DOS*				$0	*$0*	*$0*	*$0*	*$0*	*$0*	$0
Actual expenditures for DY4 DOS				$0	*$2,540,653*	*$6,559*	*$0*	*$0*	*$0*	$2,547,212
Projected expenditures for DY5 DOS*						*$138,030*	*$0*	*$0*	*$0*	$138,030
Actual expenditures for DY5 DOS						*$2,402,336*	*$0*	*$0*	*$0*	$2,402,336
Total With Waiver Expenditures	**$175,202,682**	**$707,833,062**	**$701,590,793**	**$764,323,513**	**$739,527,383**	**$742,348,532**	**$813,628,633**	**$768,570,551**	**$203,407,158**	**$5,613,891,943**
Amount under (over) the annual waiver cap	$14,478,583	$40,766,549	$64,535,605	$46,779,262	$74,982,338	$66,673,100	$0	$0	$0	$310,755,803
Annual expenditure by DY Payment Date as reported on CMS 64s (Demo expenses NOT including residual DSH)			$25,987,982	$28,994,039	$26,374,594	$28,301,731	$26,333,855	$26,036,064	$6,509,016	
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$7,416,684	$28,750,000	$28,691,897	$28,870,644	$26,340,999	$25,754,806	$26,333,855	$26,036,064	$6,509,016	

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

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

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

Note: FFY 2010 FMAP for MO = 64.51%; FFY 2011 FMAP for MO = 63.29%; FFY 2013 FMAP = 61.37%. FFY 2014 FMAP = 62.03; FFY 2015 FMAP= 63.45; FFY 2016 FMAP=63.28

Assumptions for 2017 Extension:

1. **Funding for the program is consistent with 2016.**
2. **Insulin and inhalers are included in the benefit package.**
3. **Program costs are consistent with the 2016 projected costs per the actuarial report.**
4. **FMAP for medical services is the same as FFY 2016 (63.28%)**

Appendix V

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

The State of Missouri, Department of Social Services (DSS), hereby notifies the public of its intent to request a one-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2016. A copy of the demonstration extension application under consideration may be found at http://dss.mo.gov/mhd/. We are providing this notice pursuant to Centers for Medicare & Medicaid Services (CMS) requirements in 42 C.F.R. 431.408.

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

Public Comments and Hearings

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

Comments will be accepted 30 days from the publication of this notice. The comment period ends December 30, 2015. Comments may be sent to:

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

Public hearings are scheduled for:

Tuesday, December 1, 2015, 7:30-8:30 a.m.*
Ethical Society of St. Louis
9001 Clayton Road
St. Louis, MO 63117

Wednesday, December 2, 2015, 10-11:30 a.m.
BJK People's Health Centers
5701 Delmar Blvd.
St. Louis, MO 63112

**This meeting is part of the regularly scheduled Provider Services Advisory Board meeting of the St. Louis Regional Health Commission. Individuals wanting to participate in the December 1st public hearing via conference call may dial 888-808-6929, access code: 9158702.*

Appendix VI

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

November 30, 2015

The State of Missouri, Department of Social Services (DSS), hereby notifies the public that it intends to apply for a one-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2016. A copy of the draft Demonstration extension application may be found at http://dss.mo.gov/mhd/. We are providing this notice pursuant to Centers for Medicare and Medicaid Services (CMS) requirements in 42 C.F.R. § 431.408.

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

I. Program Description and Goals

On July 28, 2010, CMS approved the State of Missouri's "Gateway to Better Health" Demonstration, which includes the following main objectives:

I. Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act;
II. Transition the "St. Louis model" to a coverage model as opposed to a direct payment model by July 1, 2012;
III. Connect the uninsured and Medicaid populations to a primary care home which will enhance coordination, quality, and efficiency of health care through patient and provider involvement;
IV. Maintain and enhance quality service delivery strategies to reduce health disparities; and
V. For the first two years of the Demonstration, ensure that there is a 2 percent increase in the number of uninsured persons receiving services at St. Louis ConnectCare, Affinia Healthcare (formerly known as Grace Hill) and Myrtle Hilliard Davis Comprehensive Health Centers.

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

The Demonstration was amended in June 2012 to enable the Safety Net Pilot Program to be implemented by July 1, 2012. The July 1, 2012 implementation of the Pilot Program ensured patients of the St. Louis safety net maintained access to primary care and specialty care through a coverage model.

The Pilot Program is designed to provide primary, urgent and specialty care coverage to uninsured[4] adults in St. Louis City and St. Louis County, aged 19-64, who are below 100 percent of the FPL through a coverage model known as Gateway to Better Health. The Demonstration also includes a performance and incentive structure for the primary care providers and tracks health outcomes.

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

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

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

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

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

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

I. Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available in Missouri under the Affordable Care Act;
II. Connect the uninsured and Medicaid populations to a primary care home which will enhance coordination, quality, and efficiency of health care through patient and provider involvement;
III. Maintain and enhance quality service delivery strategies to reduce health disparities.

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

II. Beneficiaries and Eligibility Criteria

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

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

III. Delivery System

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

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

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

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

IV. Benefits

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

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

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

V. Cost Sharing

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

VI. Aggregate and Historical Budgetary and Expenditure Data

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

VII. Anticipated Changes in Enrollment

It is anticipated that approximately 21,400 individuals would be enrolled in Gateway to Better Health during the extension period. These projections are subject to change when additional actuarial analysis is conducted in the third quarter of 2016.

VIII. Waiver and Expenditure Authorities

It is anticipated the Waiver and Expenditure Authorities would include:

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

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

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

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

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

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

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

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

Standards and Methods **Section 1902(a)(17)**

To the extent necessary, to permit the State to extend eligibility for the Demonstration population for a period of up to eighteen months without redetermining eligibility.

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

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

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

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

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

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

IX. Evaluation of the Gateway to Better Health Demonstration

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

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

II. Uninsured patients who receive coverage under the pilot program will use community emergency departments for non-emergent visits at a lower rate than other uninsured patients.

III. The prevalence of preventable hospitalizations, hospital re-admissions and ED utilization will be reduced among patients with chronic medical conditions.

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

X. Public Notice and Input Process

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

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

Comments will be accepted until December 30, and may be sent to the following address:

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

Public hearings are scheduled for:

Tuesday, December 1, 2015, 7:30-8:30 a.m.*
Ethical Society of St. Louis
9001 Clayton Road
St Louis, MO 63117

Wednesday, December 2, 2015, 10-11:30 a.m.
BJK People's Health Centers
5701 Delmar Blvd.
St. Louis, MO 63112

**This meeting is part of the regularly scheduled Provider Services Advisory Board meeting of the St. Louis Regional Health Commission. Individuals wanting to participate in the December 1st public hearing via conference call may dial 888-808-6929, access code: 9158702.*

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

In addition, on June 16, 2015, a Post-Award Public Input Forum was held to inform the public on the progress of the Gateway demonstration, in compliance with 42 C.F.R. § 431.420(c). This meeting was held as part of the regularly scheduled Community Advisory Board of the St. Louis Regional Health Commission. Approximately, 25 people attended the meeting. Attendees received information on the number of people served and the number of services and visits provided by Gateway each year. The current membership of the program, including a demographic profile of Gateway members, and an overview of patient and provider satisfaction feedback was also presented. The highlight of the presentation was the overview of the member orientations Gateway started offering this year to assist new members with navigating the Gateway program. The notice for the Post-Award Public Input Forum may be found in Appendix VII of the full extension request.

Appendix VII

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

In July 2015, The State of Missouri, Department of Social Services (DSS), received a one-year extension of its Gateway to Better Health Demonstration from the Centers for Medicare and Medicaid Services (CMS). The Gateway to Better Health Demonstration provides coverage for certain outpatient care to low-income, uninsured adults residing in St. Louis City and St. Louis County who do not qualify for Medicaid. This program provides a bridge for safety net providers and approximately 20,000 uninsured patients to Medicaid coverage available through the Affordable Care Act.

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

Hearing

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

Tuesday, March 15, 2015
8:30 – 10:00 AM
Employment Connection
2838 Market Street
St. Louis, MO 63103

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

The State and the SLRHC will take verbal and written comments at the public hearing. The community input provided will be summarized for CMS.