Gateway to Better Health Demonstration

Demonstration Extension Application

March 31, 2014

Number: 11-W-00250/7

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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 an extension of the Demonstration on September 27, 2013. 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). 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 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.

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, 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 for safety net providers and their uninsured patients in St. Louis City and St. Louis County to coverage options available through federal health care reform.

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

The Missouri legislature did not expand Medicaid eligibility during its 2013 legislative session. On September 27, 2013, CMS approved a one-year extension of the Gateway Demonstration program for patients up to 100% FPL until December 31, 2014, 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 2014 legislative session. If not, beginning January 1, 2015, none of the Gateway patients will have access to coverage, since all Gateway patients are under 100% FPL. The providers serving the Gateway population will also experience a significant reduction in revenue, and will not be able to maintain 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, 2013, the Gateway program provides outpatient coverage for over 23,000 individuals, which represents more than 40 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 two years. 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 two additional years, or when Medicaid eligibility expands in Missouri, whichever is first:

- **Demonstration Population 1:** Effective January 1, 2015, 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, 2015, 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, 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.

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 and have maintained access levels and continuity of care for these patients 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.

Demonstration Summary

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 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
- Grace Hill Health Centers
- Myrtle Hilliard Davis Comprehensive Health Centers
- St. Louis County Department of 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; gynecology; podiatry, generic prescriptions dispensed at primary care clinics; 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; urgent care (up to a maximum of 5 visits); non-emergency medical transportation; and generic prescriptions dispensed at an urgent care or specialty care clinic in the network.

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 will be established in the third quarter of 2014.

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 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 Health. Beneficiaries may be referred by their primary care physician for specialty care at participating hospitals, medical schools, and community specialist practices.

As of September 30, 2013, Gateway to Better Health has provided health coverage to more than 28,000 otherwise uninsured St. Louis area residents, ensuring these individuals access to basic medical services. As a result of this access to care:

- Primary care physicians see about 3,200 patients in their offices each month, providing everything from routine medical care to managing complicated chronic conditions.
- Dentists at community health centers see about 950 patients in their offices each month, providing basic preventative care, giving patients the opportunity to achieve better overall health.
- For those patients with more advanced medical needs, primary care physicians are able to refer their patients for diagnostic and specialty care services as well as outpatient surgeries. Doctors make about 2,400 of these referrals for advanced care each month.
- Gateway patients are accessing emergency care appropriately. Less than 5 percent of all Gateway patients who have accessed emergency room care have done so for low-severity medical concerns. In comparison, St. Louis hospitals reported in 2012 that of all emergency room visits 22 percent were for non-emergent reasons.
- Approximately 45 percent of all Gateway patients live with a chronic condition, such as diabetes or hypertension. These patients now have greater access to outpatient care and medications as well as care coordination and management programs that will keep them healthier and reduce preventable ED visits and hospitalizations. Medical outcomes related to this population will be measured over the life of the pilot program and extension period.
- Preliminary findings from the Community Referral Coordinator Program (CRC), a hospital-based intervention that connects uninsured and underinsured patients to a primary care home, indicate that when a Gateway-funded referral coordinator engages with patients in an inpatient setting, readmission rates range from 2-15 percent. This program was funded by the Demonstration through December 31, 2013, and made approximately 6,000 annual primary care referrals within the Gateway provider network. After demonstrating success during the initial Gateway pilot, the CRC Program has successfully achieved full financial sustainability through contracts with area hospitals and health departments.
- The Gateway coverage model is entering its 15th month at the writing of this document and health outcomes are beginning to emerge. One physician at Grace Hill studied a group of uninsured patients who had uncontrolled hypertension. Despite many attempts at intervention prior to the launch of the Safety Net Pilot Program, most patients continued to experience uncontrolled hypertension. Since the inception of the Safety Net Pilot Program, 75 percent of

those patients in the cohort who enrolled now have blood pressure less than 140/90. The physicians credit access to low-cost appointments and medications for the success rate.

Patients who responded to a patient satisfaction survey said they were happy with the care they were receiving through Gateway to Better Health.

- 91% have been without insurance for more than 1 year.
- 97% report they are more likely to see a doctor as a result of Gateway.
- 92% say they would recommend their health center to a family member or friend.

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

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

II. Connect the uninsured 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 28,000 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.

The total number of uninsured and Medicaid patients receiving care at the Affiliation Partner providers increased seven percent from 2009 to 2012.

In addition, the Community Referral Coordinator program funded by the Demonstration through December 31, 2013, resulted in approximately 16,000 new scheduled appointments for Medicaid and uninsured individuals at a primary care home since the beginning of the Demonstration. As of September 30, 2013, through the Safety Net Pilot Program, more than 23,000 individuals are enrolled at a primary care home.

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

Preliminary data indicate improvements in several quality measures from 2011 to 2012.

- Increase in tobacco cessation intervention: The percentage of tobacco using patients who received tobacco use intervention at the primary care health centers increased 6 percentage points from 57% in 2011 to 63% in 2012, exceeding the Demonstration goal of 62%.
- Improvement in controlling high blood pressure: The percentage of hypertensive patients whose blood pressure was less than 140/90 (adequate control) at the time of the last reading increased three percentage points from 59% in 2011 to 62% in 2012, approaching the Demonstration goal of 64%.
- Strong improvement in adult weight screening and follow-up: The percentage of adult patients who had documentation of a calculated BMI during the most recent visit or within the six months prior increased by 28 percentage points from 19% in 2011 to 47% in 2012, far exceeding the Demonstration goal of 24%.

Although the health metrics reviewed above are not currently available by racial/ethnic and age group, Gateway to Better Health enrollment data indicated that approximately 73 percent of all coverage program enrollees are African American and 54 percent are less than 45 years of age. More detailed outcomes concerning disparities will become available in 2014. The Safety Net Pilot Program will evaluate outcomes for patients by age and race across at least 9 indicators as described in Appendix I.

The SLRHC, through its other work and funding, completed a *Decade Review of Health Status.* This report was released in December 2012. It is a comprehensive review of changes in 14 leading health indicators and disparity metrics between 2000 and 2010 in St. Louis City and County. Featured health topics include heart disease, diabetes, COPD, stroke, cancer, HIV/AIDS, maternal and child health, and many others leading causes of poor health outcomes and health care system costs in the St. Louis region. Data over the last ten years shows that health outcomes have improved dramatically in St. Louis, and these improvements have been shared across gender and race populations. Mortality rates have declined for many chronic health conditions, including heart disease, COPD, and breast cancer mortality.

For example:

1. Between 2000 and 2010, the rate of heart disease deaths decreased 26% among Blacks in the City of St. Louis (compared to a similar 26% decrease among Whites).
2. Between 2000 and 2010, the rate of breast cancer deaths decreased 28% among Black females in the City (compared to a <1% change among White females).
3. Between 2000 and 2010, the rate of prostate cancer deaths decreased 26% among Black males in the City (compared to a 32% decrease among White males).

4. Between 2000 and 2010, the number of HIV/AIDS deaths decreased 51% among Blacks in the City (the number of annual HIV/AIDS deaths among Whites during this time is too small for a valid comparison).
5. Between 2000 and 2009, the rate of infant deaths (within the first year of birth) decreased 14% among Blacks in the City (compared to a 3% decrease among Whites).

Please visit www.STLRHC.org to learn more about report findings and view the extensive local media coverage of the release of this report.

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 Missouri Medicaid, MO HealthNet and Gateway to Better Health.

Screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more than 25,000 individuals in MO HealthNet programs, including:

- 13,435 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids
- 7,874 adults approved for Uninsured Women's Health Services
- 2,063 adults approved for MO HealthNet for the Aged, Blind or Disabled
- 1,741 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 14,500 individuals were enrolled in the Blue Plan and 399 individuals in the Silver Plan 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, 2013, more than 21,000 individuals were enrolled in the Blue Plan and nearly 2,500 in the Silver Plan.

Two of the affiliation partners, 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 it 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**
34.	General Financial Requirements
35.	Reporting Requirements Related to Budget Neutrality
36.	Monthly Calls
37.	Quarterly Progress
38.	Annual Report
39.	Final Report
X.	**General Financial Requirements**
40.	Quarterly Expenditure Reports
41.	Expenditures Subject to the Title XIX Budget Neutrality Expenditure limit
42.	Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit
43.	Standard Medicaid Funding Process
44.	Extent of Federal Financial Participation for the Demonstration
45.	Sources of Non-Federal Share
46.	Monitoring the Demonstration
47.	Program Integrity
48.	Penalty for Failing to Achieve Pilot Plan Milestones Listed in Section XIII
49.	Application of the Penalty
XI.	**Monitoring Budget Neutrality for the Demonstration**
50.	Limit on Title XIX Funding
51.	Risk
52.	Budget Neutrality Expenditure Limit
53.	Future Adjustments to the Budget Neutrality Expenditure Limit
54.	Enforcement of Budget Neutrality
XII.	**Milestones**
55.	Milestones
56.	Additional Milestones
57.	Submission of Draft Evaluation Design
58.	Interim Evaluation Reports
59.	Final Evaluation Design and Implementation
60.	Cooperation with Federal Evaluators
XIV.	**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 participants 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 monthly basis as needed to discuss any outstanding items or 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

It is anticipated the Waiver and Expenditure Authorities would include:

- **Demonstration Population 1:** Effective January 1, 2015, 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, 2015, 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 that differ among the Demonstration population and that differ from the benefits offered to the categorically needy group.

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.

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 Patients Enrolled - Minimum of at least 1 office visit (including a health risk assessment and health and wellness counseling) within the first 6 months following enrollment	80%	20%	Claims Data
Patients with Diabetes, Hypertension, CHF or COPD – 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	80%	20%	Claims Data
Patients with Diabetes - HgbA1c testing performed within the first 4 months following the latter of either: a) initial enrollment, or b) initial diagnosis	85%	20%	Claims Data
Patients with Diabetes – percentage of diabetics who have a HgbA1c <8% within six months following the latter of either: a) initial enrollment, or b) initial diagnosis	60%	20%	Self-Reported by Health Centers
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:

Pay-for-Performance Measures for Distribution of Remaining Funds

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
Emergency Department Utilization among Tier 1/Tier 2 Enrollees (effective through December 31, 2013)	TBD pending final actuarial analysis	30% (7/1/12 – 12/31/13)	Claims data
Rate of Referral to Specialist among Tier 1/Tier 2 Enrollees	TBD pending final actuarial analysis	70% (7/1/12 – 12/31/13) 100% (1/1/14-12/31/14)	Referral 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 for the first two six-month reporting periods of the pilot. 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. 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.

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 quarterly basis. SLRHC also is conducting surveys with participants at least semi-annually.

The most recent results from these surveys are reviewed in the sections below.

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) provides primary, urgent, and specialty care coverage to uninsured[2] 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) provides 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 extension period coverage model will provide primary, urgent and specialty care coverage to 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 will not be eligible for Gateway coverage as of January 1, 2014.

[2] 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.
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.

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, 2013?	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.

Demonstration Objective	Key Questions	Key Measures/Data Sources	Analysis
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.	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 (CRC)? (Through 2013)	Number of primary care patients seen by Gateway providers who are uninsured 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)	Description of trends in connecting 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 MPCA is currently evaluating its ability to provide income, age, gender, and race/ethnicity data for each of the proposed health indicators in Appendix II. Further testing will be 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.	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 smoothly 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, 2013, 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 2014 priorities and budget for the St. Louis Regional Health Commission by its board at its December 2013 meeting.	Explanation of the priorities of the St. Louis Regional Health Commission after December 31, 2013.

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, 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, FQHCs and ConnectCare led organization-wide 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 25,000 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 (submitted to CMS on August 16, 2012 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.

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

The second pay-for-performance reporting period ended on June 30, 2013. 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 payment. 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 of 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;
- 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 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)

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
- 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
- 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 satisfaction will be measured through semi-annual surveys. Referring physician satisfaction will be tracked through quarterly surveys.

Evaluation Activities

Evaluation activities to date include the following:

- Collection and reporting of baseline data for all Demonstration objectives for 2009, 2010, 2011, and 2012 as applicable
- Collection and reporting of proposed health indicator data baselines (see Appendix I)
- Analysis of interim progress in meeting Demonstration objectives comparing 2009, 2010, 2011 and 2012 data, as provided in this report section
- Analysis and reporting of enrollment data for the first fifteen months of the Pilot Program (7/01/12-9/30/13), as provided in this report section.
- Analysis and reporting of financial data for the first fifteen months of the Pilot Program (7/01/12-9/30/13), as provided in this report section.
- Analysis and reporting of claims-based utilization data for the first twelve months of the Pilot Program (7/01/12-6/30/13), as provided in this report section.
- Analysis and reporting of preliminary quality data for the first twelve months of the Pilot Program (7/01/12-6/30/13), 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 2012.

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 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 partner providers 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, 2013?

Findings to Date

The Demonstration has met Objective I, as evidenced by:

A. Access at affiliation partner sites increased during the Demonstration period.

B. Primary and specialty care services were maintained at affiliation partner sites through 2012.

C. Primary and specialty care locations and hours of operation were maintained at affiliation partner sites through 2012.

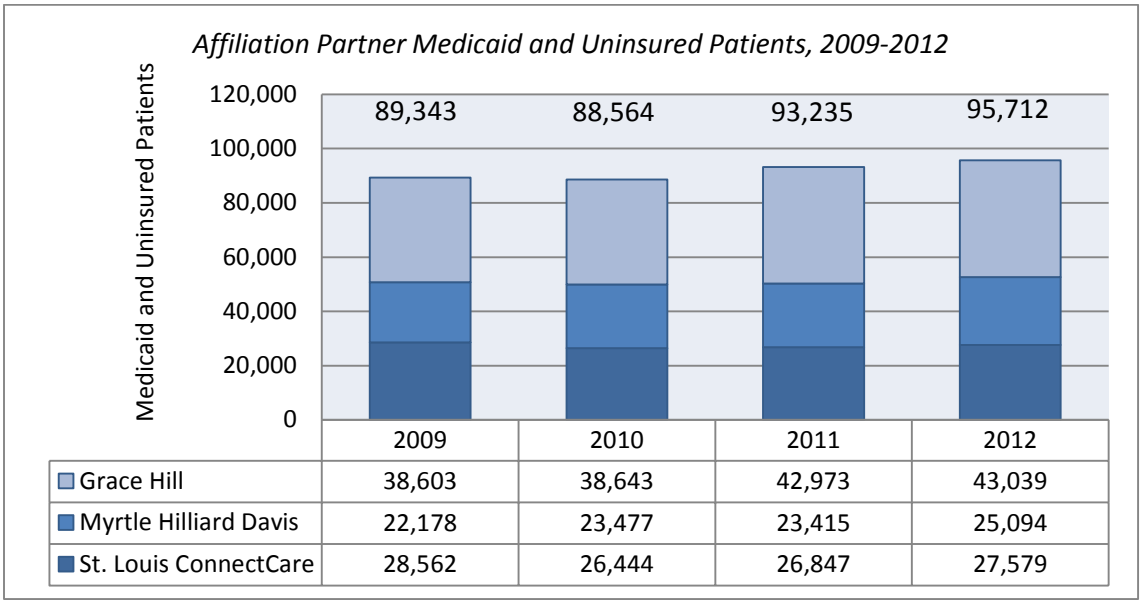
D. The St. Louis safety net providers funded by Gateway were able to increase primary care encounters for all uninsured and Medicaid patients at their locations by 2.2% during the Demonstration.

E. 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 1.9% during the Demonstration.

Each of these findings is reviewed in detail below:

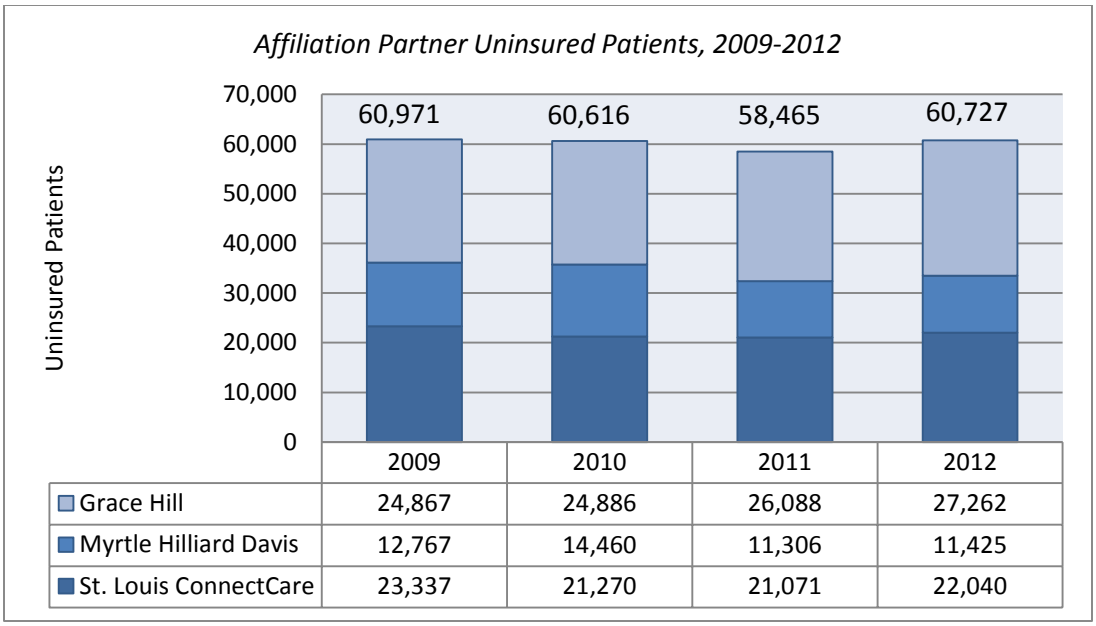
A. Access at affiliation partner sites increased during the Demonstration period.

There was a 7 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
Grace Hill	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.



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 and Gateway to Better Health.

Screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more the 25,000 individuals in MO HealthNet programs, including:

- 13,435 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;
- 7,874 adults approved for Uninsured Women's Health Services;
- 2,063 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 1,741 adults approved for MO HealthNet for Families.

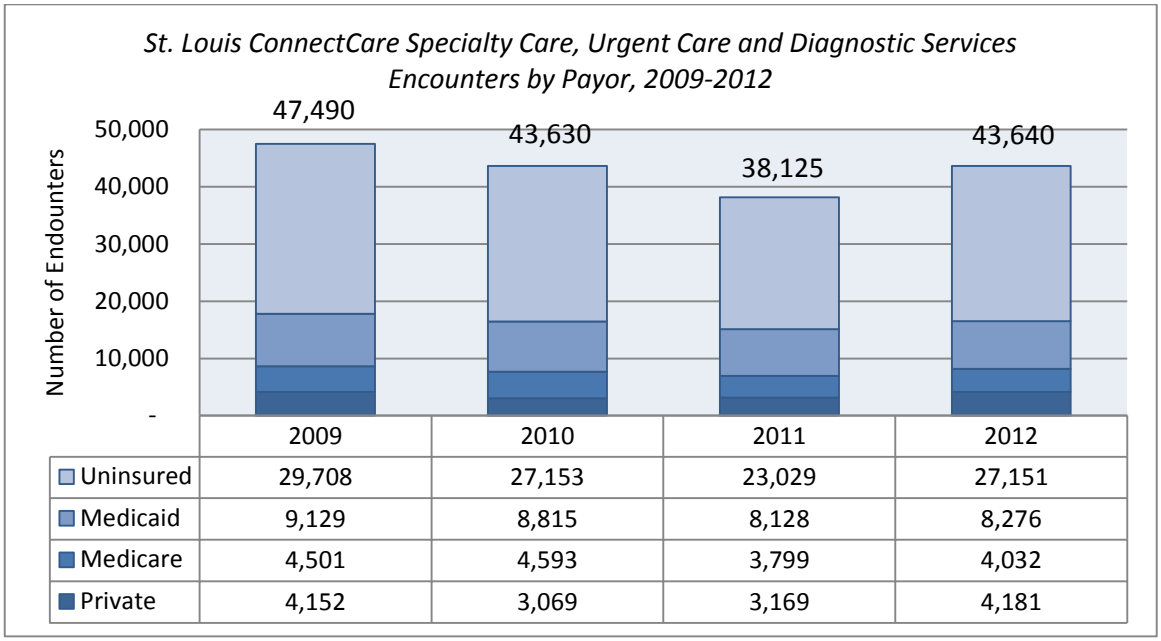
B. Primary and specialty care services were maintained at affiliation partner sites through 2012.

Primary and specialty care services at the Affiliation Partner organizations were maintained from 2009 to 2012, in line with the Demonstration goal of maintaining services available at the Affiliation partner organizations for the first two years of the Demonstration.

Services by Affiliation Partner Providers, 2009-2012

Affiliation Partner	*2012*	*2011*	*2010*	*2009*
Grace Hill Health Centers	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care.	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care.	Primary medical care, dental care, mental health services, substance abuse services, podiatry, optometry, nutrition, and enabling services (case management of pregnant women and patient education), children's behavioral Health services, pharmacy, nutrition, Women Infants and Children (WIC), community health homeless services, prenatal classes/centering pregnancy, chronic disease management, referral to specialty care.
Myrtle Hilliard Davis Comprehensive Health Centers	Primary medical care, podiatry, ophthalmology, dental care, behavioral health, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.	Primary medical care, podiatry, ophthalmology, dental care, behavioral health, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.	Primary medical care, podiatry, ophthalmology, dental care, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.	Primary medical care, podiatry, ophthalmology, dental care, nutrition and enabling services (Community outreach services, community and patient health education (diabetes, cardiovascular, asthma and cancer), case management (for pregnant women), social services, referral for specialty services, eligibility assistance services and HIV counseling. Ancillary services include radiology, pharmacy and CLIA certified clinical laboratory services.
St. Louis ConnectCare	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics, otolaryngology, 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.

Specialty care, urgent care, and diagnostic service encounters at St. Louis ConnectCare increased 14% from 38,125 encounters in 2011 to 43,640 encounters in 2012. Overall, encounters declined eight percent from 2009 to 2012.



	2009	2010	2011	2012
Uninsured	29,708	27,153	23,029	27,151
Medicaid	9,129	8,815	8,128	8,276
Medicare	4,501	4,593	3,799	4,032
Private	4,152	3,069	3,169	4,181

As discussed previously in this document, due to financial constraints, St. Louis ConnectCare ceased all operation is late 2013. Gateway to Better Health has established a network of specialty care providers, including medical schools, hospitals, and some community specialist providers to preserve the safety net of specialty health care services. Data showing the volume of specialty care encounters following the transfer of patients to new specialty care providers will be provided in future reports and the final evaluation.

C. *Primary and specialty care locations and hours of operation were maintained at affiliation partner sites through 2012.*

Primary care and specialty care provider locations and hours of operation were maintained in the neighborhoods where they existed at the beginning of the project from 2009 through 2012.

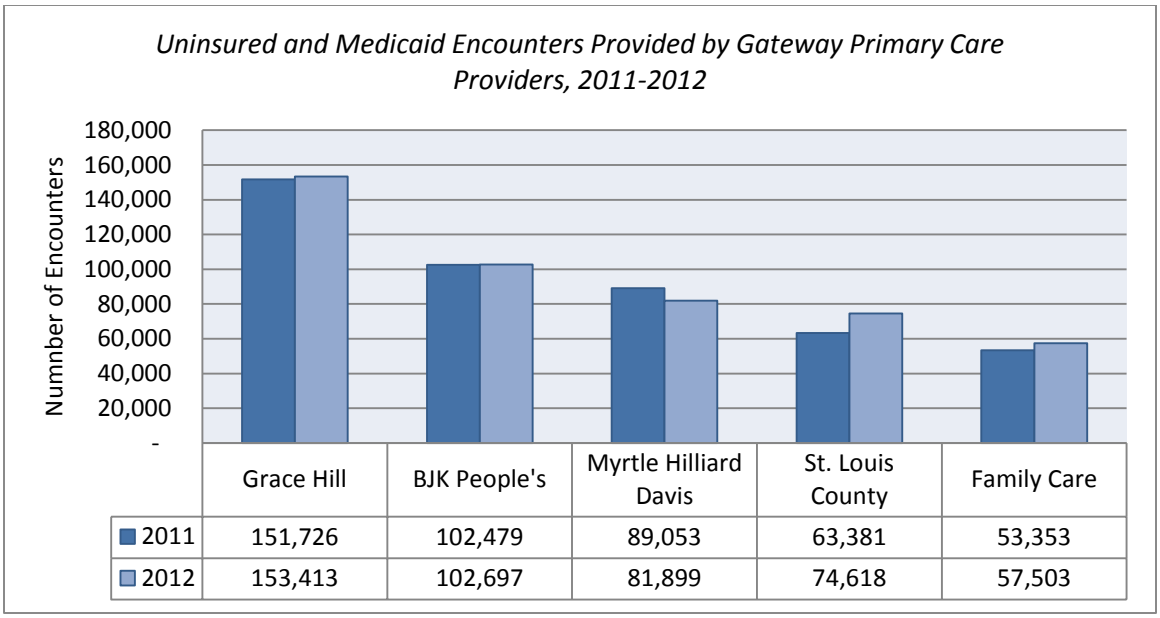
Hours of Operation at Gateway Primary and Specialty Care Provider Locations

Partner Site	***2012***	***2011***	***2010***	***2009***
Grace Hill Health Centers				
Murphy-O'Fallon	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-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	NA	NA

Partner Site	*2012*	*2011*	*2010*	*2009*
Grace Hill 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	NA	NA
BJC Behavioral Health	M-F-8:30am-5pm	M-F-8:30am-5pm	NA	NA
St. Patrick	M-F-8am-4:30pm	M-F-8am-4:30pm	NA	NA
Myrtle Hilliard Davis Comprehensive Health Centers				
Homer G. Phillips	M, T, W, F-8am-5pm; Th-8am-8pm	M, T, W, F-8am-5pm; Th-8am-8pm	M, T, W, F - 8am-5pm; TH- 8am-8pm	M, T, W, F - 8:00am-5:00pm; TH-8am-8pm
Florence Hill	M-8am-8pm; T, W, Th, F-8am-5pm	M-8am-8pm; T, W, Th, F-8am-5pm	M-8am-8pm; T, W, TH, F- 8am-5pm	M-8am-8pm, T, W, TH, F- 8am-5pm
Comp I	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-F-8:30am-5:30pm; Sa (When Scheduled)	M-F-8:30am-5:30pm; Sa (When Scheduled)	NA	NA
North	M, T, Th, F-8:30am-5:30pm; W-11:30am-8:30pm; Sa (When Scheduled)	M, T, Th, F-8:30am-5:30pm; W-11:30am-8:30pm; Sa (When Scheduled)	NA	NA
West	M, T, W, F-8:30am-5:30pm; Th-11:30am-8:30pm; Sa (When Scheduled)	M, T, W, F-8:30am-5:30pm; Th-11:30am-8:30pm; Sa (When Scheduled)	NA	NA
Family Care Health Centers				
Carondelet	M, W, F-8am-4:30pm; T, Th-8am-8pm; Sa-8am-1pm	M, W, F-8am-4:30pm; T, Th-8am-8pm; Sa-8am-1pm	NA	NA
Forest Park	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 Health Centers				
North Central	M, T, F-8am-5pm; W, Th-8am-9pm	M, T, F-8am-5pm; W, Th-8am-9pm	NA	NA
South County	M, T-8am-9pm; W, Th, F-8am-5pm	M, T-8am-9pm; W, Th, F-8am-5pm	NA	NA
St. Louis ConnectCare	M-F-8am-7pm; Sa/Su-8am- 5pm (Urgent Care and General X-ray); M-F- 8am-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)

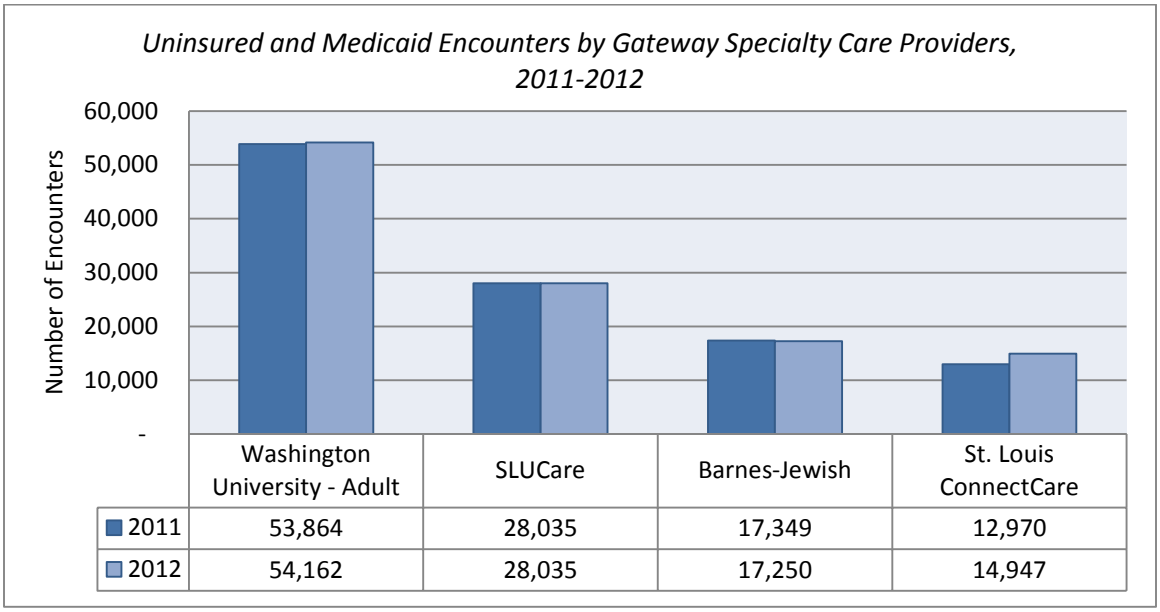
D. The St. Louis safety net providers funded by Gateway were able to increase primary care encounters for all uninsured and Medicaid patients at their locations by 2.2% during the Demonstration.

Uninsured and Medicaid encounters at Gateway primary care providers increased from 459,992 in 2011 to 470,130 in 2012 (+2.2%).


Uninsured and Medicaid Encounters Provided by Gateway Primary Care Providers, 2011-2012
Numnber of Encounters
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
Grace Hill
BJK People's
Myrtle Hilliard Davis
St. Louis County
Family Care
2011
151,726
102,479
89,053
63,381
53,353
2012
153,413
102,697
81,899
74,618
57,503

E. 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 1.9% during the Demonstration.

Gateway specialty care providers provided 114,394 specialty care encounters to uninsured and Medicaid patients in 2012, compared to 112,218 in 2011, an increase of 2,176 encounters.



	Washington University - Adult	SLUCare	Barnes-Jewish	St. Louis ConnectCare
2011	53,864	28,035	17,349	12,970
2012	54,162	28,035	17,250	14,947

Objective II: Connect the uninsured and Medicaid populations to 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, emergency department 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 affiliation partner sites were able to increase the number of uninsured and Medicaid patients served at their locations by 12.1% during the Demonstration.

B. St. Louis safety net providers funded by Gateway were able to maintain the number of uninsured and Medicaid patients served at their location during the Demonstration.

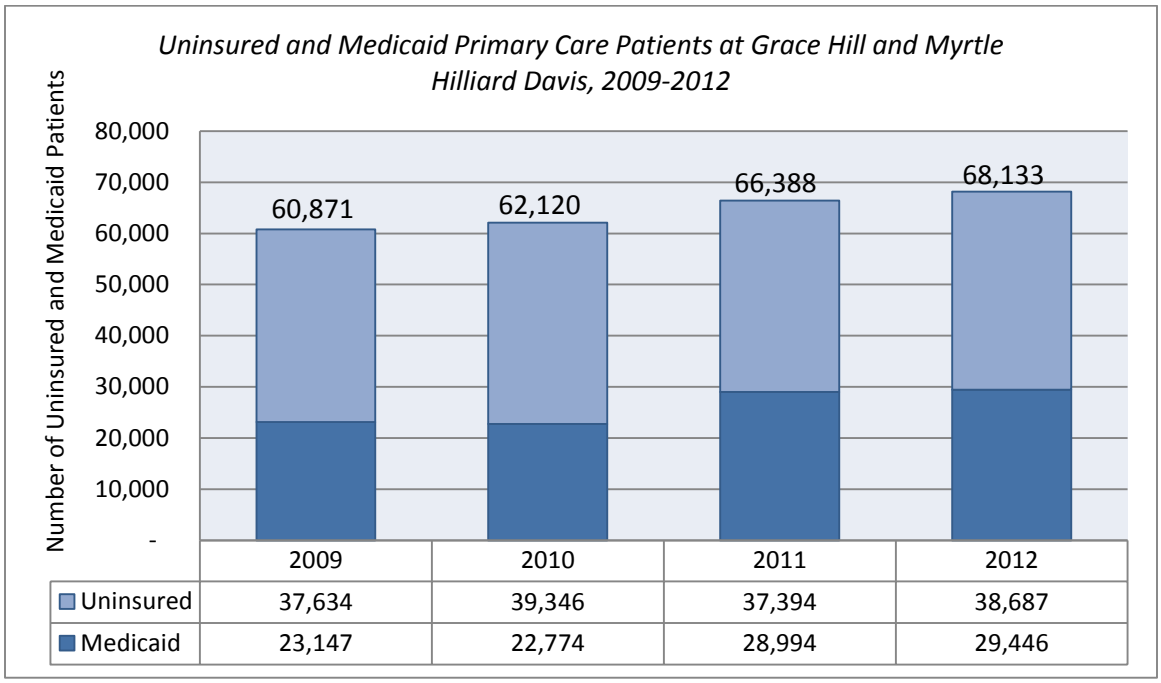
C. The Community Referral Coordinator Program (CRC) consistently reported strong outcomes during the Demonstration, resulting in a total of more than 44,000 patient encounters and 21,000 appointments scheduled from 2009 to 2012.

D. The CRC program improved its “show rate” for primary care appointments from 31 percent in 2009 to 36 percent in 2012.

Each of these findings is reviewed in detail below:

A. Primary care affiliation partner sites were able to increase the number of uninsured and Medicaid patients served at their locations by 12.1% during the Demonstration.

The number of Medicaid and uninsured patients served by Grace Hill Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers, increased by 7,352 individuals from 2009 to 2012.

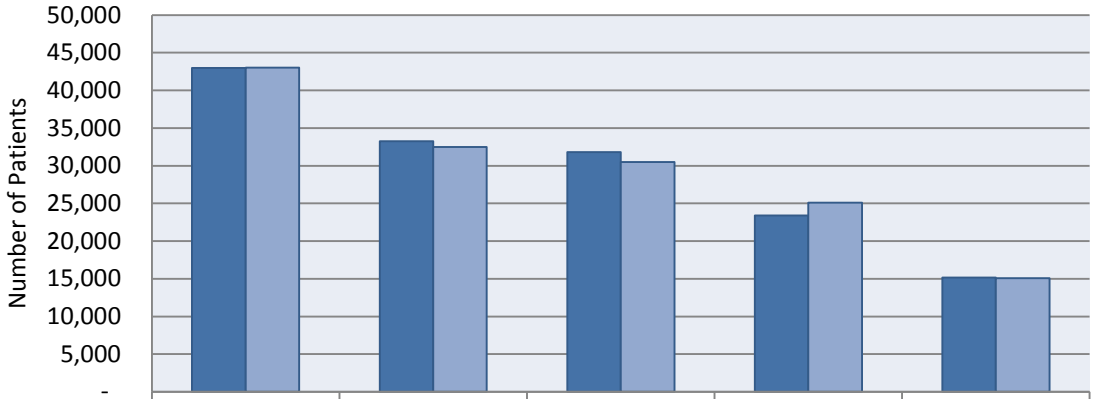


	2009	2010	2011	2012
Uninsured	37,634	39,346	37,394	38,687
Medicaid	23,147	22,774	28,994	29,446

B. St. Louis safety net providers funded by Gateway were able to maintain the number of uninsured and Medicaid patients served at their locations during the Demonstration.

Gateway primary care providers served as a medical home to a total of 146,189 uninsured and Medicaid patients in 2012, compared to 146,635 in 2011, a decline of 0.3% (446 patients).

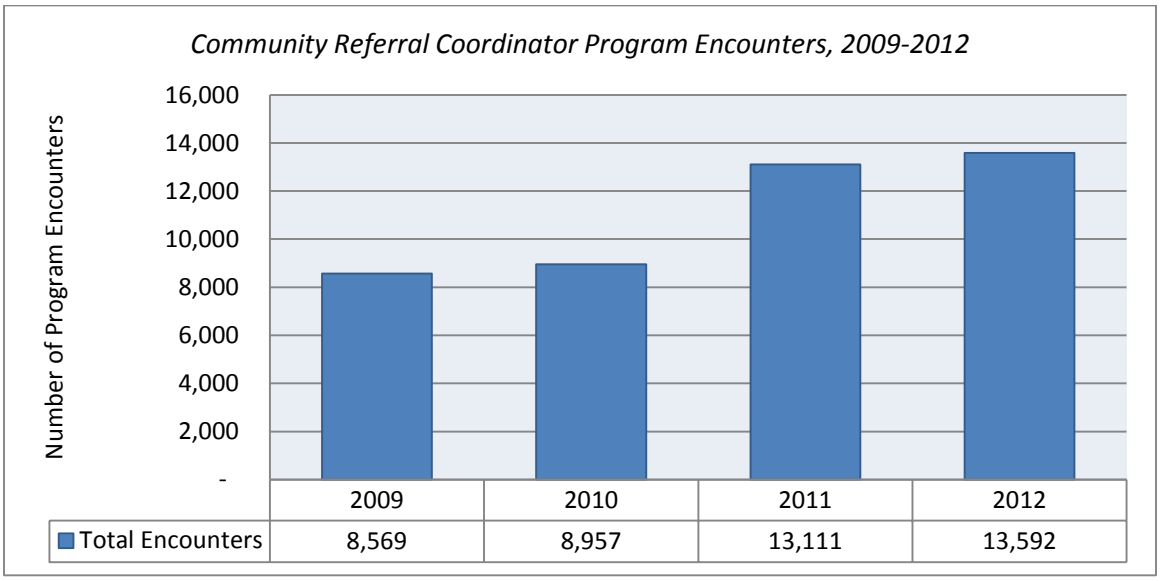
Uninsured and Medicaid Patients Served by Gateway Primary Care Providers, 2011-2012



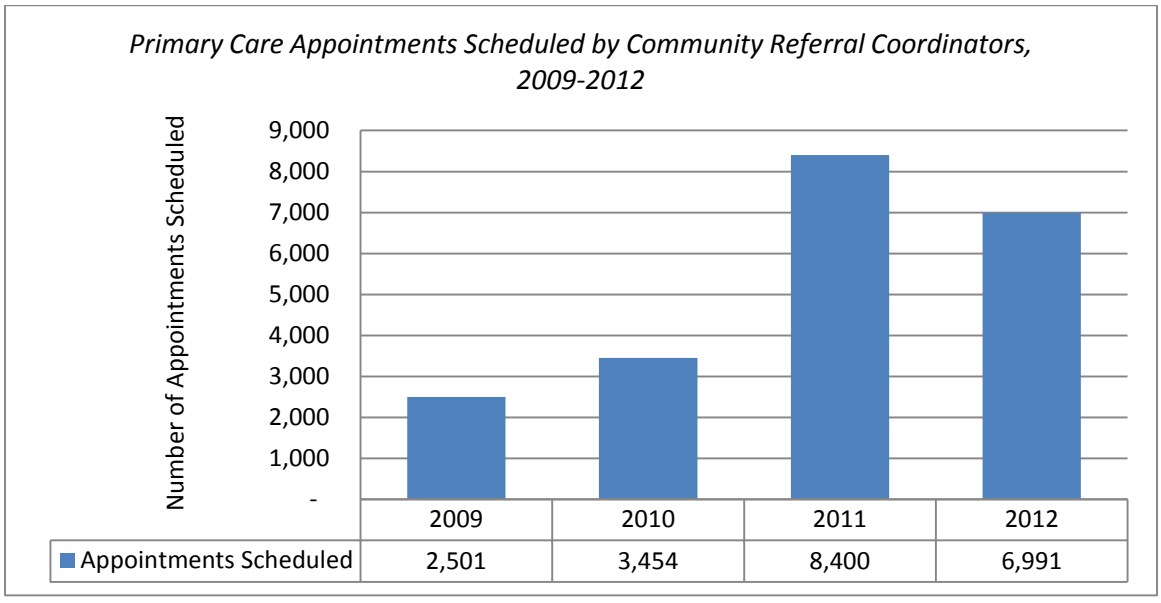
	Grace Hill	BJK People's	St. Louis County	Myrtle Hilliard Davis	Family Care
2011	42,973	33,258	31,822	23,415	15,167
2012	43,039	32,492	30,486	25,094	15,078

C. The Community Referral Coordinator Program consistently reported strong outcomes during the Demonstration, resulting in a total of more than 44,000 patient encounters and 21,000 appointments scheduled from 2009 to 2012.

The CRC program increased annual encounters by 58.6% from 2009 to 2012. In 2012, the program provided 13,592 encounters, exceeding its 2013 Demonstration goal of 9,600 annual encounters.

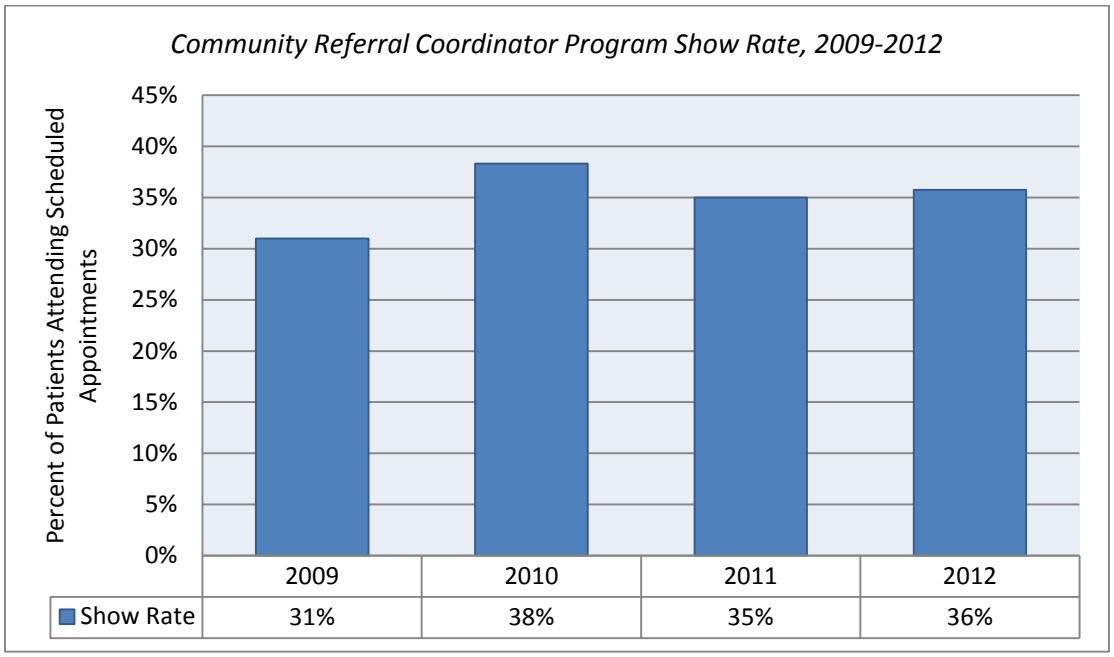


In 2012, the CRC program scheduled 6,991 primary care appointments, exceeding its 2013 Demonstration goal of 4,800 annual referrals.



D. The CRC program improved its "show rate" for primary care appointments from 31 percent in 2009 to 36 percent in 2012.

The 2012 "show rate" for primary care appointments scheduled through a Community Referral Coordinator was 36%, 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 Hba1c < 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. Since implementation of the Gateway coverage model, blood pressure control among patients seen at primary care network providers has increased by 3 percent.

B. Since implementation of the coverage model, diabetes control among patients seen at Gateway primary care network providers has declined slightly by 2 percent.

C. Since implementation of the coverage model, the number of patients seen at Gateway primary care network providers who receive tobacco use intervention has improved by 6 percent.

D. Since implementation of the Gateway coverage model, the number of patients seen at Gateway primary care network providers who receive cervical cancer screenings declined by 10 percent.

E. Since implementation of the coverage model, 73 percent of patients with chronic health conditions had at least two office visits within the first six months following enrollment and/or diagnosis.

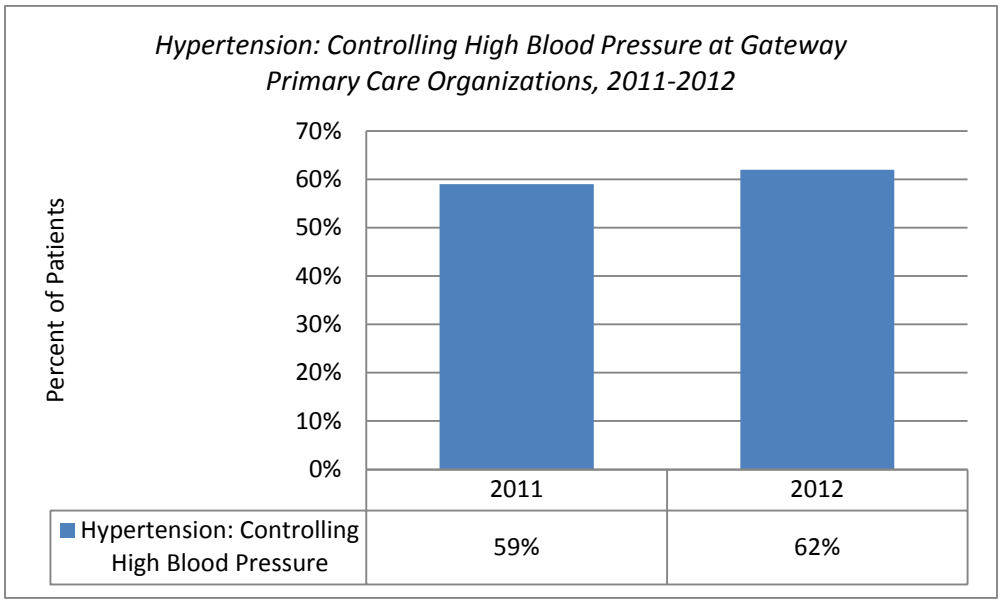
F. Since implementation of the coverage model, 79 percent of hospitalized Gateway patients were contacted by a clinical staff member from their primary care home within seven days of hospital discharge

Each of these findings is reviewed in detail below:

A. Since implementation of the Gateway coverage model, blood pressure control among patients seen at primary care network providers has increased by 3 percent.

The percentage of hypertensive patients whose blood pressure was adequately controlled (less than 140/90) improved at health centers participating in the Gateway Pilot Program from 59% in 2011 to 62% in 2012, approaching the 2013 Demonstration goal of 64%.

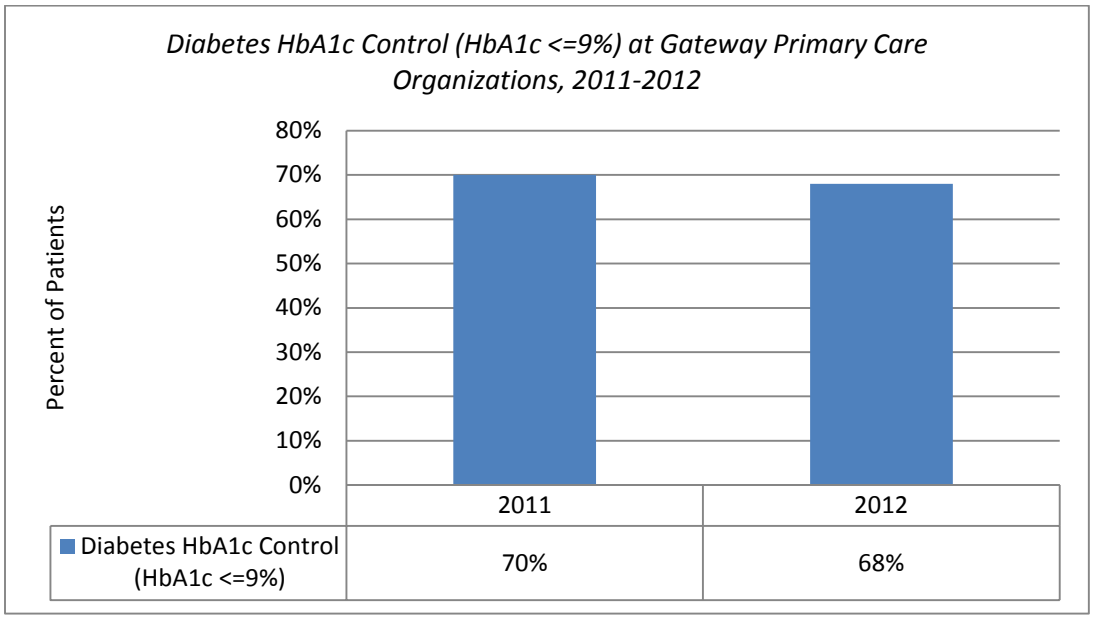
By comparison, the percent of hypertensive patients whose blood pressure was adequately controlled at health centers statewide remained stable at 61% in 2011 and 2012. Gateway providers matched the Missouri health center average for this metric from 2011-2012.



B. Since implementation of the coverage model, diabetes control among patients seen at Gateway primary care network providers has declined slightly by 2 percent.

The percent of adult patients 18 to 75 years of age with Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading at health centers participating in the Gateway Pilot Program decreased slightly from 70% in 2011 to 68% in 2012, lagging behind the 2013 Demonstration goal of 75%.

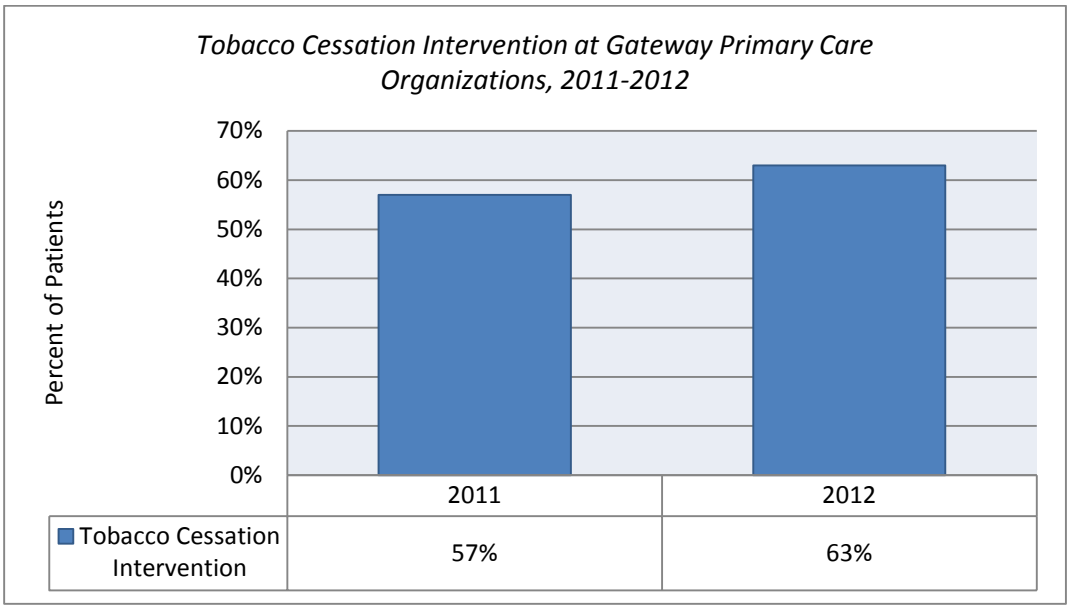
By comparison, the percent of adult diabetes patients with HbA1c readings less than 9% at health centers statewide decreased slightly from 73% in 2011 to 70% in 2012. Gateway providers performed similarly to the Missouri health center average for this metric from 2011-2012.



C. Since implementation of the coverage model, the number of patients seen at Gateway primary care network providers who received tobacco use intervention has improved by 6 percent.

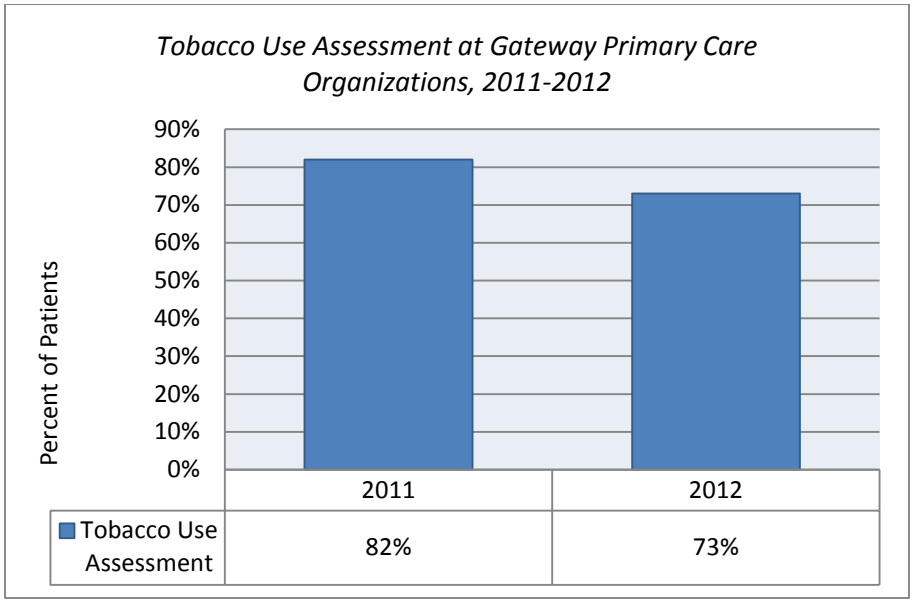
The number of tobacco using patients that received tobacco use intervention at health centers participating in the Gateway Pilot Program increased from 57% in 2011 to 63% in 2012, slightly exceeding the 2013 Demonstration goal of 62%.

By comparison, the number of tobacco using patients that received a tobacco use intervention at health centers statewide increased from 42% in 2011 to 53% in 2012. Gateway providers have consistently outperformed the Missouri health center average for this metric from 2011-2012.



The percentage of patients who were queried about tobacco use at health centers participating in the Gateway Pilot Program declined from 82% in 2011 to 73% in 2012, exceeding the 2013 Demonstration goal of 62%.

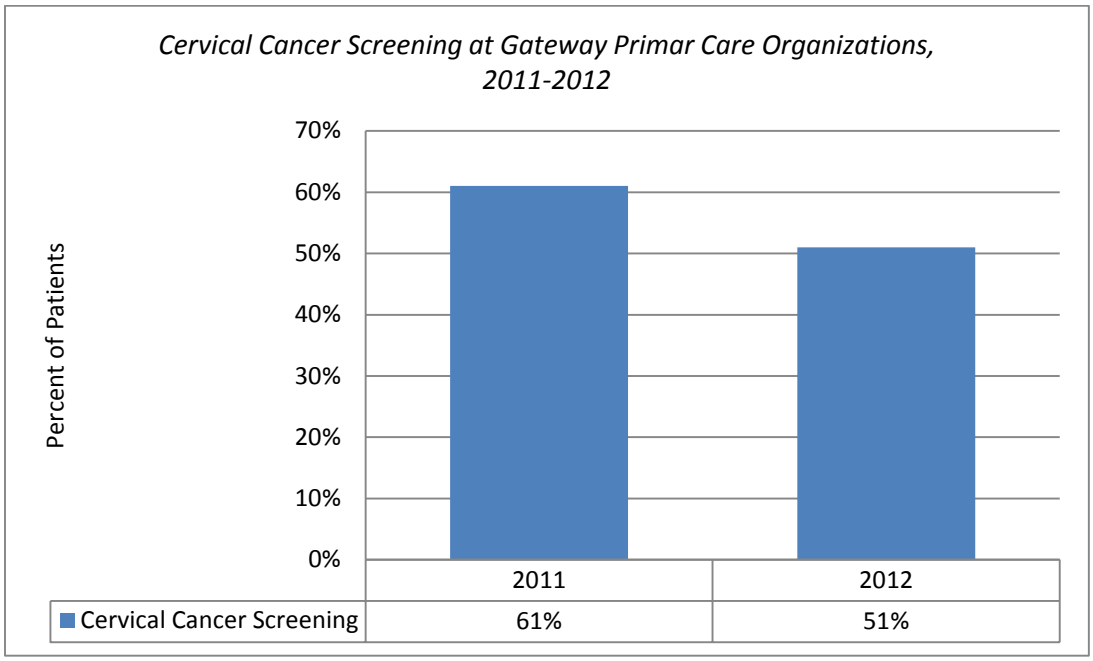
By comparison, the percent of patients queried about tobacco use at health centers statewide increased from 82.3% in 2011 to 83.6% in 2012. After matching the Missouri health center average in 2011, Gateway providers underperformed in comparison to the statewide average for this metric in 2012.



D. Since implementation of the coverage model, the number of patients seen at Gateway primary care network providers who receive cervical cancer screenings declined by 10 percent.

The percentage of women aged 24-64 years of age who received one or more Pap tests to screen for cervical cancer at health centers participating in the Gateway Pilot Program decreased from 61% in 2011 to 51% in 2012, lagging behind the 2013 Demonstration goal of 66%.

By comparison, the percent of women who were screened for cervical cancer at health centers statewide decreased from 52% in 2011 to 48% in 2012. Gateway providers have consistently outperformed the Missouri health center average for this metric from 2011-2012.



E. Since implementation of the coverage model, 73 percent of patients with chronic diseases had at least two office visits within the first 6 months following initial enrollment or diagnosis.

Gateway primary care providers are slightly below the 2013 Demonstration goal of 80%.

F. Since implementation of the coverage model, 79 percent of hospitalized Gateway patients were contacted by a clinical staff member from the primary care home within seven days of hospital discharge.

Gateway primary care providers far exceed the 2013 Demonstration goal of 50%.

Although the health metrics reviewed above are not currently available by racial/ethnic and age group, Gateway to Better Health enrollment data indicated that approximately 73 percent of all coverage

program enrollees are African American and 54 percent are less than 45 years of age. More detailed outcomes will become available in 2014. The Safety Net Pilot Program will evaluate outcomes for patients by age and race across at least 9 indicators, as described in Appendix I.

Objective IV: Have the affiliation partner providers 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:

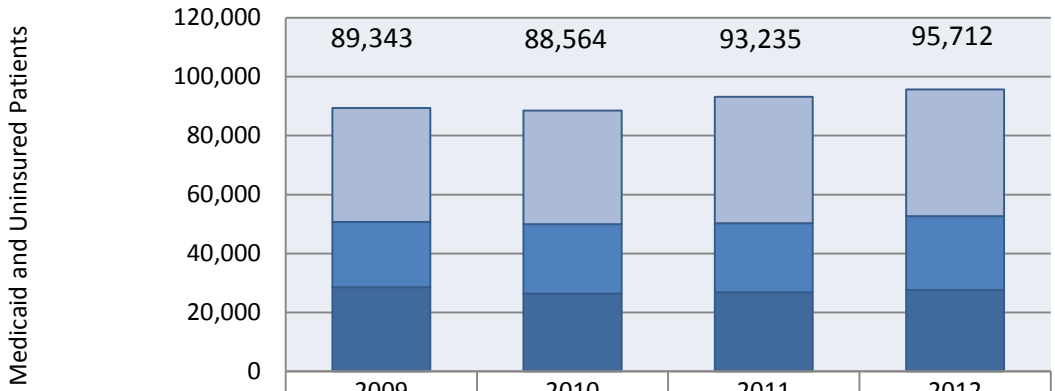
A. Access at affiliation partner sites increased for uninsured and Medicaid patients during the Demonstration period.

This finding is reviewed in detail below:

A. Access at affiliation partner sites increased for uninsured and Medicaid patients during the Demonstration period.

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.

Affiliation Partner Medicaid and Uninsured Patients, 2009-2012



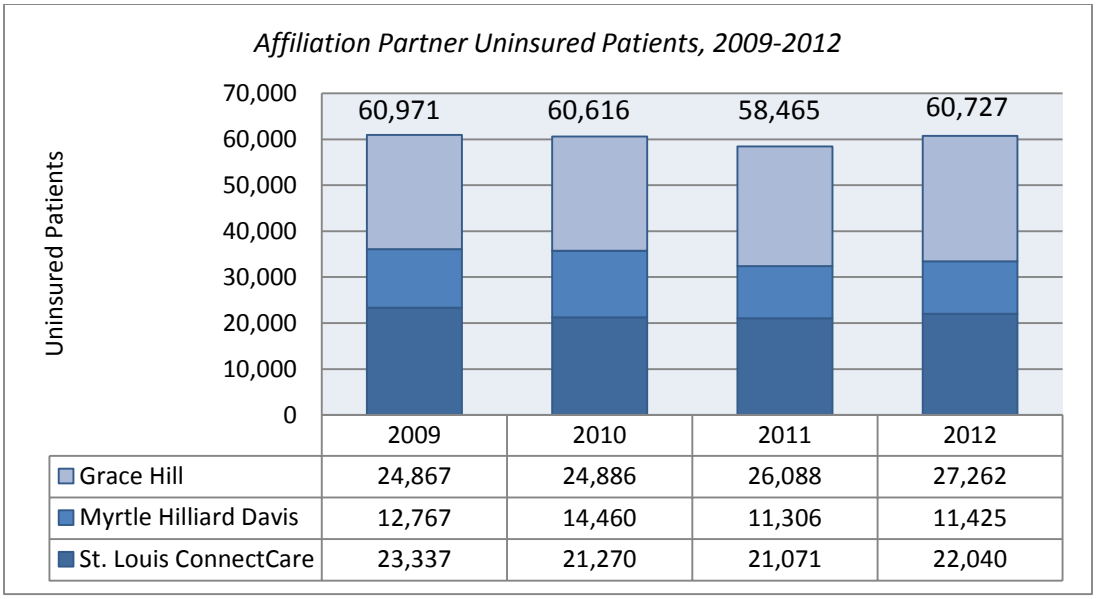
	2009	2010	2011	2012
Grace Hill	38,603	38,643	42,973	43,039
Myrtle Hilliard Davis	22,178	23,477	23,415	25,094
St. Louis ConnectCare	28,562	26,444	26,847	27,579

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

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 25,000 individuals in MO HealthNet programs, including:

- 13,435 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids.
- 7874 adults approved for Uninsured Women's Health Services
- 2063 adults approved for MO HealthNet for the Aged, Blind or Disabled
- 1741 adults approved for MO HealthNet for Families



	2009	2010	2011	2012
Grace Hill	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

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 II 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, 2013, 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 28,000 individuals into coverage over the life of the program to date.
B. The SLRHC, CRC Program, and affiliation partner sites have been engaged in planning for financial sustainability over the course of the Demonstration.

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 28,000 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 Medicaid State 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 currently approved extension period 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.

As of September 30, 2013, more than 23,000 individuals were enrolled into Gateway coverage.

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

Demonstration Populations	Unique Individuals Enrolled as of September 30, 2013	Member Months July 2012 - September 2013
Population 1: Uninsured individuals receiving both Primary and Specialty Care through the Demonstration	21,061	282,303
Population 2: Uninsured individuals receiving only Specialty Care through the Demonstration (0-133% of the Federal Poverty Level)	1134	15,016
Population 3: Uninsured individuals receiving only Specialty Care through the Demonstration (134% - 200% of the Federal Poverty Level)	1326	10,899

**Enrollment numbers are based on MO HealthNet enrollment data as of October 25, 2013*

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. More than 43,000 applications have been collected as of September 30, 2013. Approximately 70% of the applications are converting to approvals for Gateway to Better Health.

Screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more than 25,000 individuals in MO HealthNet programs, including:

- 13435 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids.
- 7874 adults approved for Uninsured Women's Health Services
- 2063 adults approved for MO HealthNet for the Aged, Blind or Disabled
- 1741 adults approved for MO HealthNet for Families

B. The SLRHC, CRC Program, and affiliation partner sites have been engaged in planning for financial sustainability over the course of the Demonstration.

Planning for financial sustainability of the St. Louis Regional Health Commission, the Community Referral Coordinator Program and the Affiliation Partners is underway. The Pilot Program Planning Team developed and approved an outline for the Interim Transition Plan to CMS on June 27, 2012. The State, in partnership with the RHC, will be executing the Interim Transition Plan, which outlines efforts for sustainability, in the months to come.

Key question for this Demonstration topic include:

- As of December 31, 2013, 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?

Updates are provided below:

St. Louis Regional Health Commission

At the current time, 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 more than 12,000 individuals annually, with 45% 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 43% 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, annual commitments of over $500,000 from SSM Health Care, St. Louis County Department of Health, St. Louis University Hospital, BJC Healthcare and Mercy to continue the CRC model in at least six area hospitals in St. Louis' urban core. With the funding that has been already secured, the successful CRC model will be sustainable in St. Louis' areas of high need beyond 2014.

Affiliation Partner Primary Care Providers

The primary care Affiliation Partner organization 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 costs 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 will be submitted to CMS in the form of a transition plan on June 30, 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 and have maintained access levels and continuity of care for these patients 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), Section XIV	6/27/2012
8/01/2012	Submit MOU between the State and SLRHC for CMS review	Section XIV	7/30/2012
9/01/2012	Incentive protocol	Section V (#21)	8/16/2012
10/31/2012	Submit revised evaluation design	Section XIII, (#57)	10/31/2012
1/28/2013	Submit draft annual report for DY 3 (October 2011 – September 2012)	Section IX, (#38)	01/28/2013
12/31/2013	ConnectCare, Grace Hill, and Myrtle Davis attain financial sustainability	Section XII (#56b)	See pages 57-58
12/31/2013	SLRHC and CRC must attain financial sustainability	Section XII (#56d)	See page 57
01/28/2014	Submit draft annual report for DY 4 (October 2012 – September 2013)	Section IX (#38)	
07/01/2014	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 page 61
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)	

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 status of the FQHC's financial position for fiscal year 2014 (July 2013-June 2014) is not currently available. This evaluation metrics will be reviewed in future reports submitted to CMS when additional information becomes available.

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.

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

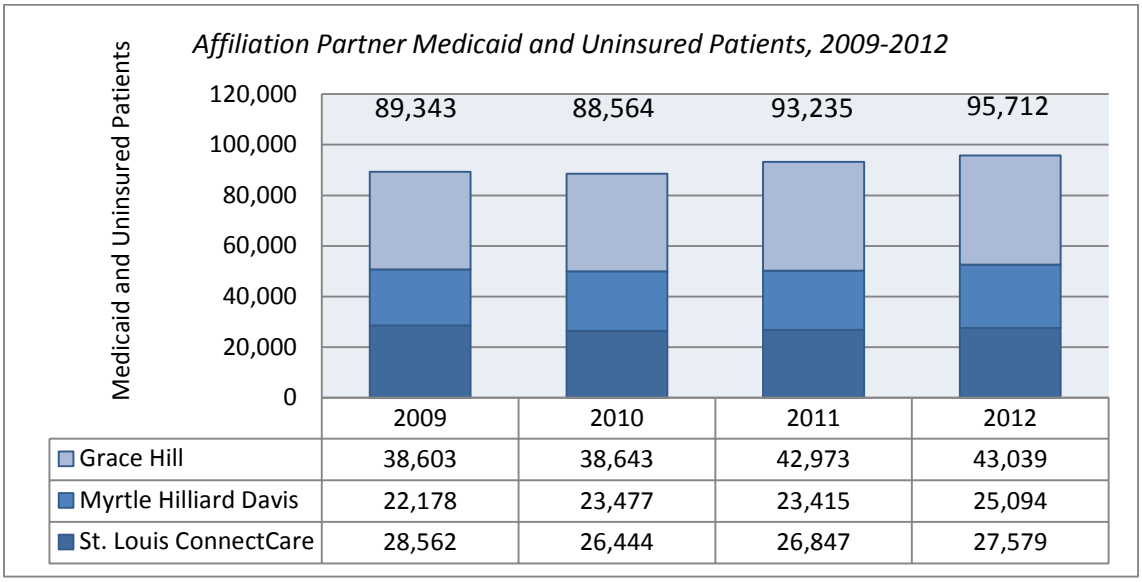
The Gateway to Better Health Demonstration has improved access to care for low-income individuals, as discussed in the description of interim evaluation findings for Objective I. Key findings to date include the following:

- Initial data indicate the Gateway to Better Health Demonstration will provide about 80,000 annual medical visits, as well as access to generic medications and non-emergency transportation, in an effort to improve the health of the more than 28,000 individuals enrolled over the life of the program.
    - Primary care physicians see about 2,300 patients in their offices each month, providing everything from routine medical care to managing complicated chronic conditions.
    - Dentists see about 950 patients in their offices each month, providing basic preventative care, giving patients the opportunity to achieve better overall health.
    - For patients with more advanced medical needs, primary care physicians are able to refer their patients for diagnostic and specialty care services as well as outpatient surgeries. Doctors make about 2,400 of these referrals for advanced care each month.
- Gateway patients are accessing emergency care appropriately. Less than 5% of all Gateway patients who have accessed emergency room care have done so for low-severity medical concerns. In comparison, St. Louis hospitals reported last year that of all emergency room visits 22 percent were for non-emergent reasons.
- Approximately 45 percent of all Gateway patients live with a chronic condition, such as diabetes or hypertension. These patients now have greater access to outpatient care and medications as well as care coordination and management programs that will keep them healthier and reduce preventable ED visits and hospitalizations. Medical outcomes related to this population will be measured over the life of the 18-month program.

- As the pilot program is just completing its first full year of operations, health outcomes are not completely available for analysis (per the pilot program evaluation design). However, limited preliminary outcomes are available. For example, one physician at Grace Hill studied a group of uninsured patients who had uncontrolled hypertension. Despite many attempts at intervention prior to the launch of the Safety Net Pilot Program, most patients continued to experience uncontrolled hypertension. Since the inception of the Safety Net Pilot Program, 75 percent of those patients in the cohort who enrolled now have blood pressure less than 140/90. The physicians credit access to low-cost appointments and medications for the success rate.
    - Similarly, across all Gateway primary care organizations, the percent of hypertensive patients with blood pressure less than 140/90 improved from 59% in 2011 to 62% in 2012, after implementation of Pilot Program.

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

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.

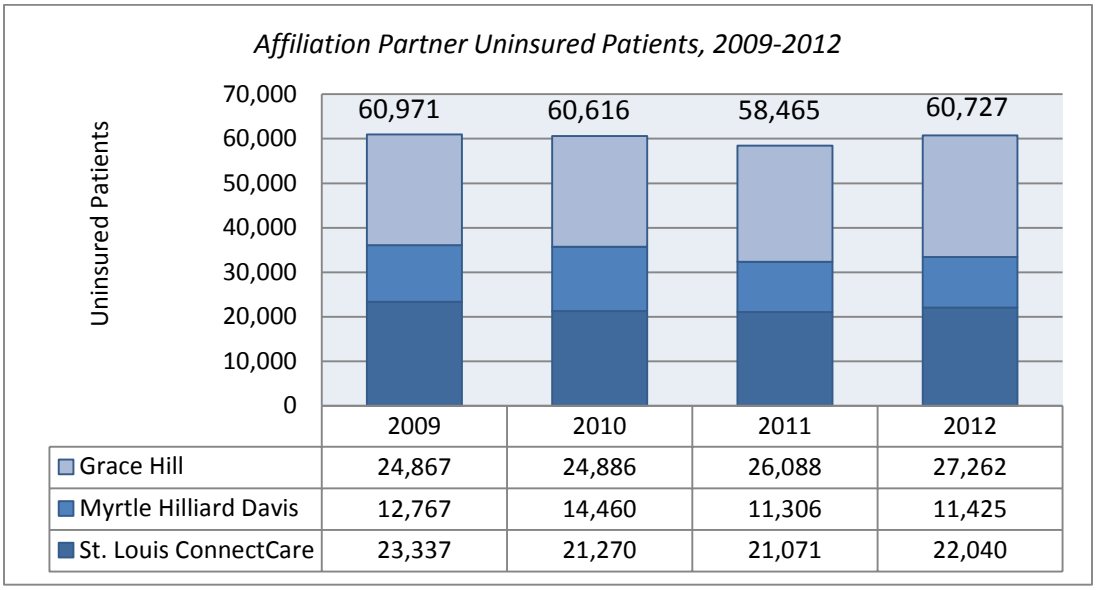


	2009	2010	2011	2012
Grace Hill	38,603	38,643	42,973	43,039
Myrtle Hilliard Davis	22,178	23,477	23,415	25,094
St. Louis ConnectCare	28,562	26,444	26,847	27,579

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

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 25,000 individuals in MO HealthNet programs.



	2009	2010	2011	2012
Grace Hill	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

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

The Pilot Program began on July 1, 2012. Limited preliminary health indicator data are available for Gateway primary care providers. Initial key findings include the following:

- ***Tobacco use intervention improved at Gateway primary care providers by six percentage points from 2011 to 2012.***

  The number of tobacco using patients that received tobacco use intervention at health centers participating in the Gateway Pilot Program increased from 57% in 2011 to 63% in 2012, slightly exceeding the 2013 Demonstration goal of 62%.

- ***Blood pressure control remained stable at Gateway primary care providers from 2011 to 2012.***

  The percentage of hypertensive patients whose blood pressure was adequately controlled (less than 140/90) improved at health centers participating in the Gateway Pilot Program from 59% in 2011 to 62% in 2012, approaching the 2013 Demonstration goal of 64%.

- ***Diabetes HbA1c control, use of tobacco assessment, and cervical cancer screenings declined from 2011 to 2012.***

  The percent of adult patients 18 to 75 years of age with Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading at health centers participating in the Gateway Pilot Program decreased slightly from 70% in 2011 to 68% in 2012, lagging behind the 2013 Demonstration goal of 75%.

  The percentage of patients who were queried about tobacco use at health centers participating in the Gateway Pilot Program declined from 82% in 2011 to 73% in 2012, lagging behind the 2013 Demonstration goal of 62%.

The percentage of women aged 24-64 years of age who received one or more Pap tests to screen for cervical cancer at health centers participating in the Gateway Pilot Program decreased from 61% in 2011 to 51% in 2012, lagging behind the 2013 Demonstration goal of 66%.

Although the health metrics reviewed above are not currently available by racial/ethnic and age group, Gateway to Better Health enrollment data indicated that approximately 73 percent of all coverage program enrollees are African American and 54 percent are less than 45 years of age. More detailed outcomes will become available in 2014. The Safety Net Pilot Program will evaluate outcomes for patients by age and race across at least 9 indicators as described in Appendix I.

In addition, data from the SLRHC's 2012 health status report, *Decade Review of Health*, indicate there have been many improvements in health indicators across all race- and gender-based groups in St. Louis City and County over the past ten years (2000 to 2010). Key data from this report are provided below:

- Rate of heart disease mortality decreased 27%.
- Rate of stroke mortality decreased 32%.
- Rate of diabetes mortality decreased 23%.
- New cases of lung, prostate, and colon cancer fell 5%, 9% and 13%, respectively.
- Births by teenage mothers, ages 15-17, fell 30%.
- Incidence of Gonorrhea cases decreased 40%.

VI. Describe provider incentives and activities.

The primary care organizations and St. Louis ConnectCare 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 these performance metrics.

The second pay-for-performance reporting period ended on June 30, 2013. 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, they pay-for-performance measures will only apply to the participating primary care providers.

In the second reporting period, individually, primary care providers achieved 3 or 4 out of 7 of the clinical quality measures. St. Louis ConnectCare achieved all of its measures with the exception of wait times in one specialty – dermatology. Across all primary providers, 62% of patients enrolled for six months had a primary care visit during that time, with a threshold of 80%. This is a slight decrease from 65% reported in the first period. 73% of patients with chronic conditions enrolled six months had two primary care visits during that time, with a threshold of

80%. This is a slight decrease from 74% reported in the first period. In addition, 53% of the patients with diabetes had HgbA1c measures <8%, with a threshold of 60% (a slight decrease from 54% in the first period). Of these diabetic patients, 77% had their HgbA1c drawn within four months, with a threshold of 85% (a sizable improvement from 66% reported in the first period).

In the second pay-for-performance period, the providers successfully attained the measures related to emergency department utilization; follow up post hospitalization and rates 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**: the percentage of patients aged 18 and over who were queried about tobacco use at health centers participating in the Gateway Pilot Program declined from 82% in 2011 to 73% in 2012. By comparison, the percent of patients queried about tobacco use at health centers statewide increased from 82% to 84% in 2012. After matching the Missouri health center average in 2011, Gateway providers underperformed in comparison to the statewide average for this metric in 2012.
- **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 improved at health centers participating in the Gateway Pilot Program from 59% in 2001 to 62% in 2012. By comparison, the percent of hypertensive patients whose BP was adequately controlled at health centers statewide remained stable at 61% in 2011 and 2012. Gateway providers matched the Missouri health center average for this metric from 2011-2012.
- **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 decreased slightly from 70% in 2011 to 68% in 2012. By comparison, the percent of adult diabetes patients with HbA1c readings less than 9% at health centers statewide decreased slightly from 73% in 2011 to 70% in 2012. Gateway providers performed similarly to the Missouri health center average for this metric from 2011-2012.

The Safety Net Pilot Program will continue to evaluate the impact of performance incentives on population metrics as additional information becomes available. Outcomes among Gateway providers will be compared to other community health centers in the State.

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

The status of the FQHC's financial position for fiscal year 2014 (July 2013-June 2014) is not currently available and will be reviewed in future reports submitted to CMS.

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 the last 18 months of the Demonstration when the providers were paid on a capitated basis with incentive payments.

While the cost of care at Grace Hill Health Centers remained flat from 2011 to 2012, after implementation of the Gateway coverage model, costs decreased by 32% at Myrtle Hilliard Davis during this period. Performance data for this evaluation topic will be provided in future reports submitted to CMS as additional information becomes available.

Cost Per Medical Encounter at Grace Hill and Myrtle Hilliard Davis, 2011 and 2012*

Legacy FQHC Provider	Cost per Encounter, 2011	Cost per Encounter, 2012
Grace Hill Health Centers	$152	$161
Myrtle Hilliard Davis Health Centers	$139	$136

*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 first fifteen months of the Pilot Program (7/01/12-9/30/13), as provided in this report section.
- Financial data for the first fifteen months of the Pilot Program (7/01/12-9/30/13), as provided in this report section.
- Claims-based utilization data for the first twelve months of the Pilot Program (7/01/12-6/30/13), as provided in this report section.
- Quality data for the first twelve months of the Pilot Program (7/01/12-6/30/13), 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 is raising 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 September 30, 2013, over 21,000 individuals were enrolled in the Blue Plan and nearly 2,500 enrolled in the Silver Plan.

Outlined below are the key statistics related to enrollment in the Pilot Program as of September 30, 2013.

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

Demonstration Populations	Unique Individuals Enrolled as of September 30, 2013	Member Months July 2012 – September, 2013
Population 1: Uninsured individuals receiving both Primary and Specialty Care through the Demonstration	21,061	282,303
Population 2: Uninsured individuals receiving only Specialty Care through the Demonstration	1134	15,016
Population 3: Uninsured individuals receiving only Specialty Care through the Demonstration	1326	10,899
Total	23,521	308,218

**Enrollment numbers are based on Mo HealthNet enrollment data as of October 25, 2013.*

Gateway to Better Health "Blue Plan" Enrollment by Health Center, as of September 30, 2013

Health Center	Unique Individuals Enrolled as of September 30, 2013	Member Months July 2012 - September 2013
BJK People's Health Centers	2767	35,323
Family Care Health Centers	1459	19,672
Grace Hill Health Centers	9759	128,930
Myrtle Hilliard Davis Comp. Health Centers	3759	55,158
St. Louis County Dept. of Health	3317	43,218
Total	21,061	282,303

**Enrollment numbers are based on MO HealthNet enrollment data as of October 25, 2013.*

Gateway to Better Health Enrollment by Gender, as of September 30, 2013

Gender	Count	Percentage
Female	13,760	58.5%
Male	9,761	41.5%
Total	23,521	100.0%

*Top 15 Zip Codes by Member Count as of September 30, 2013**

ZIP	Member Count	City or County
63136	1940	St. Louis County
63115	1546	St. Louis City
63118	1141	St. Louis City
63116	1113	St. Louis City
63121	964	St. Louis City
63112	913	St. Louis City
63107	902	St. Louis City
63106	834	St. Louis City
63111	821	St. Louis City
63113	811	St. Louis City
63137	664	St. Louis County
63104	637	St. Louis City
63120	637	St. Louis City
63033	613	St. Louis City
63103	586	St. Louis City
All Others	9339	St. Louis City and St. Louis County
Total	*23,521*	-

**These 15 zip codes account for 60.3% of the total Gateway population. As a whole, approximately 52.4% (12,325 members) reside in St. Louis City and 45.6% (10,726 members) reside in St. Louis County.*

Members by Age Group as of September 30, 2013

Age Groups	Members	% of Total
19-20	776	3.3%
21-44	11,925	50.7%
45-64	10,820	46.0%
Total	23,521	100.0%

Members by Race as of September 30, 2013

Race	Members	% of Total
Caucasian	4422	18.8%
African American	17,311	73.6%
Other	24	<1%
Unknown	1764	7.5%
Total	23,114	100.0%

II. **Financial**

Outlined below are the financial results from the first fifteen months of the pilot program.

Provider Payments through September 31, 2013 for Enrollment and Dates of Service, July 2012 – September 2013

Providers	*Provider Payments Earned***	*Incentive Payments Withheld*
	July 2012 – September 2013	*July 2012 – September 2013*
BJK People's Health Centers	*$ 1,833,754*	*$ 128,540*
Family Care Health Centers	*$ 1,029,014*	*$ 72,098*
Grace Hill Health Centers	*$ 6,694,217*	*$ 469,154*
Myrtle Hilliard Davis Comp. Health Centers	*$ 2,852,151*	*$ 199,923*
St. Louis County Dept. of Health	*$ 2,245,999*	*$ 157,502*
St. Louis ConnectCare (Including Infrastructure Payments)	*$ 7,131,363*	*$ 296,329*
Voucher Providers	*$ 5,918,234*	*-*
Total	*$ 27,704,732*	*$ 1,323,546*

**Payments in the table above are subject to change as additional claims are submitted by providers.*
*** Amount represents gross earnings net of incentive withholds*

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*
Total	*$ 2,900,000*

III. Utilization

Outlined below are key findings from an initial review of claims for the first twelve months of the pilot program (July 2012 – June, 2013).

As of June 30, 2013, 45% of all visits were for patients with at least one chronic condition.

*Percentage of Visits for Patients with Certain Diagnosis**

Medical Condition	Percentage of Visits
Diabetes (Type 1 & 2)	12.1%
Hypertension	27.9%
Asthma	3.4%
COPD	1.2%
Congestive Heart Failure	0.4%

**Percentage of visits is based on the current Gateway population as represented in claims data.*

As of June 30, 2013, 96% of all ED visits for Blue Plan participants and 96% of ED visits for Silver Plan participants were for moderate to high or critical severity, indicating very few visits are for non-emergent issues.

*Percentage of ED Visits by Acuity**

Level of severity	Number of Visits	Percent of Total Visits
Blue Plan:		
Minor to low severity[1]	127	4%
Moderate severity[2]	1142	32%
High severity and critical care[3]	2352	65%
Total	3621	–
Silver Plan:		
Minor to low severity[1]	17	4%
Moderate severity[2]	76	31%
High severity and critical care[3]	155	64%
Total	248	–

[1] CPT codes: 99281 and 99282
[2] CPT code: 99283
[3] CPT codes: 99284, 99285, 99291, and 99292
**Percentage of visits is based on the current Gateway population as represented in claims data.*

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.

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 quarterly basis. Survey outcomes from the first twelve months of the pilot program (July 2012 – June, 2013) 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 first two quarters of the program. In the July-September 2012 quarter, a total of 17 surveys were returned; in the October-December 2012 quarter, a total of 44 surveys were returned; in January-March 2013 quarter, a total of 37 surveys were returned; and in the April-June 2013 quarter, a total of 34 surveys were returned. Overall, in the first complete year of the pilot program, providers tended to have a good experience when referring for Gateway patients.

In the July-September 2012 quarter, specialty care providers in the Gateway to Better Health Network provided feedback on the following criteria:

- Overall ease of scheduling a consultation
- Ease of contacting the provider's call center
- Helpfulness and courtesy of staff when scheduling
- Timeliness of available appointments
- Appropriateness of the information needed for scheduling
- Receipt and usefulness of report from consultation provider
- Availability of rendering specialist to speak with you

The lowest scores for most providers during this program quarter were related to the information needed for scheduling and the availability of the rendering specialist to speak with the health center. Results from July-September 2012 surveys are outlined below:

*Provider Satisfaction Survey Results, July – September, 2012**

Survey Item	Provider Response
Overall ease of scheduling a consultation	2.5
Ease of contacting the Call Center	2.7
Helpfulness and courtesy of staff when scheduling	2.9
Timeliness of available appointments	2.8
Information needed for scheduling, is it appropriate?	2.1
Report from consultation provider, did you receive it?	2.1
Report from consultation provider, was it meaningful?	2.5
Rendering specialist, available to speak with you?	1.5
Overall Satisfaction	2.4

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

In the October 2012, the Provider Survey tool was updated to capture information from both support staff and referring providers. For the October-December 2012, January-March 2013, and April-June 2013 program quarters, specialty providers and support staff in the Gateway to Better Health Network provided feedback on the following criteria (criteria varied depending on job role):

- Overall ease of scheduling a consultation

- Ease of contacting the rendering provider
- Helpfulness and courtesy of staff when scheduling
- Timeliness of available appointments
- Receipt and usefulness of report from consultation provider
- Availability of rendering specialist to speak with you

Overall, the lowest scores for most support staff were related to the timeliness of available appointments. Results from October 2012 - June 2013 for support staff respondents are outlined below:

*Provider Satisfaction Survey Results (Support Staff), October 2012 – June 2013**

Survey Item	Oct-Dec 2012	Jan-March 2013	April-June 2013
Helpfulness and courtesy of staff when scheduling	3.5	3.1	2.8
Timeliness of available appointments	3.2	2.7	2.6
Ease of contacting the rendering provider	3.4	2.9	2.6
Overall ease of scheduling a consultation	3.4	2.8	2.7
Overall satisfaction	3.4	2.9	2.7

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

Overall, the lowest scores for most rendering providers were related to the timeliness of available appointments. Results from October 2012 - June 2013 for provider respondents are outlined below:

*Provider Satisfaction Survey Results (Referring Providers), October 2012 – June 2013**

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

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

Patient Satisfaction surveys were conducted three times from July 2012 – March 2013 with Gateway to Better Health patients. In the July-September 2012 quarter, a total of 66 patients participated in the survey; in the October-December 2012 quarter, a total of 40 patients participated; and in the January-March 2013 quarter, a total of 98 patients participated.

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

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

Table 16. Results of Gateway to Better Health Patient Experience Survey, July 2012 – March, 2013

Survey Item	Patient Agreement (%)		
	July – Sep 2012	Oct – Dec 2012	Jan – March 2013
More likely to see doctor	100%	97%	100%
Would recommend health center to family and friends	98%	86%	92%
Understand services covered by Gateway	85%	87%	78%
Time without insurance before Gateway*:	1 month: 0% 6 months: 4% 12 months: 6% > 1 year: 19% 2 to 4 years: 30% > four years: 42%	< 1 year: 27% 1 to 2 years: 31% ≥ 3 years: 60%	< 1 year: 11% 1 to 2 years: 25% ≥ 3 years: 64%

**Response choices in the second quarter survey related to the "time without insurance before Gateway" were simplified into three categories for ease of patient completion.*

Provider and participant survey outcomes for remaining Demonstration reporting periods will be provided in future reports.

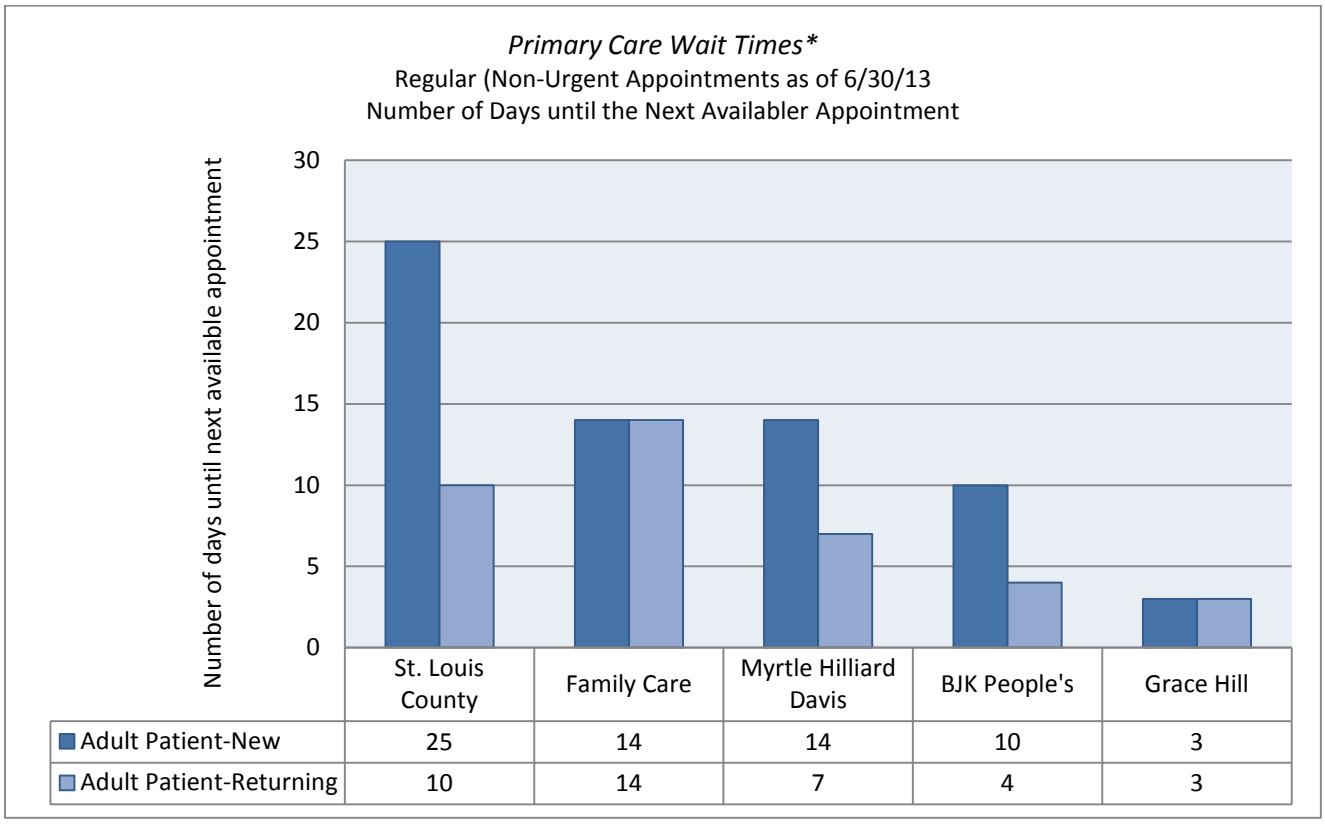
In addition to the financial oversight and reporting provided by the State to CMS, the State and SLRHC also monitor call center performance, access to specialty care, and wait times for medical appointments.

Call Center Performance, July 2012 – June 2013

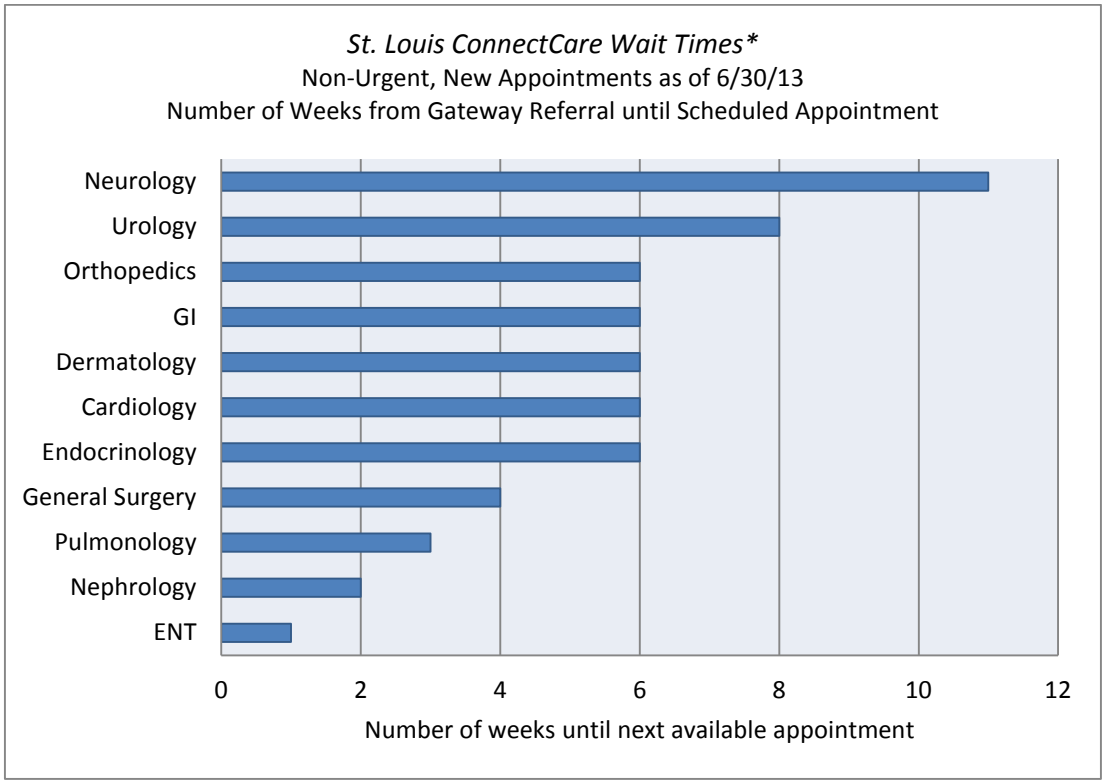
Key Performance Measure	Outcome
Calls Received	21,349
Calls Answered	20,394
Average Abandonment Rate	4.5%
Average Answer Speed (*seconds*)	39 sec.
Length of Time per Call (*minutes: seconds*)	3:22

Access to Specialty and Diagnostic Care, July 2012 – June 2013

Month	Referrals to St. Louis ConnectCare	Referrals to Voucher 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



**All data self-reported by individual health centers*



**Data self-reported by St. Louis ConnectCare.*

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; and

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. If upon actuarial analysis, there is additional budget to provide a new benefit, the evaluation will include metrics to evaluate the impact of adding the benefit.

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 December 2, 2013, and ran for 30 days, until December 31, 2013. On December 2, 2013, the State published the full public notice document (See Appendix VI) in a prominent location on its website at http://dss.mo.gov/mhd/ and on December 2, 2013 published the abbreviated public notice (see Appendix V) 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 December 2, 2013 to December 31, 2013. 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

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 3, 2013, 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 3 public hearing via conference call may dial 888-808-6929, access code: 9158702.

Wednesday, December 4, 2013, 5:30-6:30PM
Metropolitan Psychiatric Center
5351 Delmar Blvd.
St. Louis, MO 63112

The State and the St. Louis Regional Health Commission accepted verbal and written comments at the public hearings. Twenty-five people attended the first public hearing, and approximately 50 people attended the second one. A presentation 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. Comments included:

> *"I firmly believe that without this Gateway program continuing, the entire State of Missouri will suffer in that the hospitals will be overrun by emergency visits. Many poor people will become ill that could have been prevented. The St. Louis model has worked and could continue to serve as a model for health for the nation as a whole."*
>
> *"An extension of the GBH "bridge" is absolutely essential until such time that the State of MO finally decides to expand Medicaid as a part of the foundation of the safety net."*
>
> *"Gateway is a prudent program that shows the value of aligning clinical, moral, and economic goals. As a fiscal conservative, I see the value of this program as vital and well worth the investment. Without Medicaid expansion, any jeopardy to the Gateway program would be a disaster. Thanks to all who have supported this precious gem for our community."*
>
> *"In the absence of Missouri's adoption of the ACA this is an essential support for the safety net care in St. Louis. I am in full support of the continuation of the Gateway program."*

The State received no additional comments about the extension of the Demonstration via U.S. mail or email, and have no requests to view the documents in person.

In addition to these activities, the SLRHC engaged its boards, advisory boards, workgroups, and community members on discussions about extending the Demonstration until such time as Missouri's Medicaid eligibility is expanded to include the waiver population, or up to two years. The community feedback indicated that without an expansion of Medicaid eligibility, it was critical to maintain access to health care services for the community's most vulnerable. Providers and community members had input into the Extension Application. The SLRHC's advisory boards and sub-committees of the Pilot Program Planning Team provided recommendations and feedback to the Pilot Program Planning Team. This team approved the final draft application for public comment. The board of the SLRHC also approved the final draft application.

In addition, on March 18, 2014, the community was invited to a "Post-Award Public Input Forum" in order to learn about and provide input into the Demonstration and its progress, in compliance with 42 C.F.R. § 431.420(c). Notice of the forum, including its date and time, was posted on the State's web site more than 30 days before the event. *See* Appendix VII. The event was held as part of the monthly Community Advisory Board meeting of the St. Louis Regional Health Commission.

Approximately 25 people attended the forum. After hearing a summary of the program's progress and the changes implemented effective January 1, 2014, participants were encouraged to submit written or verbal comments. No written comments were submitted. Participants expressed strong support for the program in the absence of Medicaid expansion in Missouri. Some participants discussed individuals they know who are members of the program who have had a positive experience with the program and report receiving health care services that had been delayed prior to receiving the coverage.

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	Goal	Data Source
1. Tobacco Use Assessment 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%	73%	87%	UDS
2. Tobacco Cessation Intervention 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%	63%	62%	UDS
3. 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%	62%	64%	UDS

Metric	Numerator	Denominator	2011	2012	Goal	Data Source
4. 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%	TBD	59%	HITECH Meaningful Use
5. 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%	51%	66%	UDS
6. 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%	68%	75%	UDS
7. 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%	47%	24%	UDS

Metric	Numerator	Denominator	2011	2012	Goal	Data Source
8. 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	73%	80%	Claims data
9. Primary Care Follow-Up After Hospitalization Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days of hospital discharge	Number of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days of hospital discharge.	Number of enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center during the measurement year.	NA	79%	50%	Claims data

APPENDIX II
Incentive Payment Protocol

Incentive Payments

The state will withhold 7% from payments made to the primary care health centers (PCHC) through December 31, 2014, and St. Louis ConnectCare (SLCC) through December 31, 2013. The amount withheld will be tracked on a monthly basis as two separate incentive pools - one for primary care health centers and one for specialty care. The SLRHC will be responsible for monitoring the PCHC and SLCC 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, 2014

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. PCHC and SLCC 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 Patients Enrolled - Minimum of at least 1 office visit (including a health risk assessment and health and wellness counseling) within the first 6 months following enrollment	80%	20%	Claims Data
Patients with Diabetes, Hypertension, CHF or COPD – 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	80%	20%	Claims Data
Patients with Diabetes - HgbA1c testing performed within the first 4 months following the latter of either: a) initial enrollment, or b) initial diagnosis	85%	20%	Claims Data
Patients with Diabetes – percentage of diabetics who have a HgbA1c <8% within six months following the latter of either: a) initial enrollment, or b) initial diagnosis	60%	20%	Self-Reported by Health Centers
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
Emergency Department Utilization among Tier 1/Tier 2 Enrollees (effective through December 31, 2013)	TBD pending final actuarial analysis	30% (7/1/12 – 12/31/13)	Claims data
Rate of Referral to Specialist among Tier 1/Tier 2 Enrollees	TBD pending final actuarial analysis	70% (7/1/12 – 12/31/13) 100% (1/1/14-12/31/14)	Referral data

The primary care providers will be eligible for the remaining funds based on the percentage of Tier 1 and Tier 2 patients (Blue Plan) enrolled at their health centers. For example, if Grace Hill has 60% of the primary care patients and Myrtle Hilliard Davis 40%, they would each qualify up to that percentage of the remaining funds. Funds not distributed will be used to create additional enrollment slots where demand and capacity exist. Payments will not be redirected for administrative or infrastructure payments.

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

Primary Care Health Center (PCHC) Calculations

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

- IP = PCHC Payments Earned x 7%

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

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

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

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

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

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

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

- PS = RPCIF x (CMM/TMM)

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

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

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

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

- RPCIFP = PS x IPW

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

SCENARIO 1

Key assumptions:

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

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

STEP 3

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

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

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

Step 6

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

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

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

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

SCENARIO 2

Key assumptions:

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

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

STEP 3

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

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

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

Step 6

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

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

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

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

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

St. Louis ConnectCare Pay-for-Performance Eligibility (Effective July 1, 2012 - December 31, 2013)

For those patients with Tier 1 and Tier 2 benefits (Blue Plan), St. Louis ConnectCare will receive an alternative payment for medical and pharmaceutical expenses. The payment to St. Louis ConnectCare will be subject to a 7% withhold, which will be paid out in whole or part within the first quarter following the attainment of certain quality measures.

For those patients with Tier 2 only benefits (Silver Plan), reimbursement to St. Louis ConnectCare will be based on a fee-for-service methodology at 120% of Medicare with a withhold of 7%, which will be paid out in whole or part within the first quarter following the attainment of certain quality measures.

The pay-for-performance incentive payment will be based on achieving specified goals for the following:

TABLE 3: St. Louis ConnectCare Pay-for-Performance Metrics

<table>
<tr><th>Pay-for-Performance Incentive Criteria</th><th>Threshold</th><th>Weighting</th><th>Source</th></tr>
<tr><td><u>Timely Patient Access as Measured by Appointment Wait Times</u> -
<table>
<tr><th>Specialty</th><th>Benchmark (weeks)</th><th></th><th>Specialty</th><th>Benchmark (weeks)</th></tr>
<tr><td>Cardiology</td><td>5</td><td></td><td>Neurology</td><td>9</td></tr>
<tr><td>Dermatology</td><td>4</td><td></td><td>Orthopedics</td><td>6</td></tr>
<tr><td>Endocrinology</td><td>7</td><td></td><td>Pulmonology</td><td>8</td></tr>
<tr><td>ENT</td><td>4</td><td></td><td>General Surgery</td><td>3</td></tr>
<tr><td>GI</td><td>6</td><td></td><td>Urology</td><td>8</td></tr>
<tr><td>Nephrology</td><td>5</td><td></td><td></td><td></td></tr>
</table></td><td>80%</td><td>50%</td><td>Semi-Annual Self Reporting/AHS</td></tr>
<tr><td><u>Coordination of Care</u> – (a) Receipt of consultation documentation within 10 business days; (b) Completion of a primary care – specialist physician compact of collaborative guidelines *</td><td>(a) 80%
(b) 100%</td><td>(a) 15%
(b) 10%</td><td>AHS/RHC</td></tr>
<tr><td><u>Timely, Accurate Filing of Patient Encounters and Claims Data</u>– Utilization data for patients covered by cap payments and claims data all submitted within 60 days of date of service</td><td>90%</td><td>25%</td><td>Claims Processing Vendor</td></tr>
<tr><td>TOTAL POSSIBLE SCORE</td><td></td><td>100%</td><td></td></tr>
</table>

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: SLCC and state are represented on the Pilot Program Planning Team.)

Remaining funding in the specialty care incentive pool will be used to create additional enrollment slots where demand and capacity exist. Payments will not be redirected for administrative or infrastructure payments. Incentive payments will be calculated based on the data received and the methodology described below.

St. Louis ConnectCare (SLCC) Calculations

Step 1: Calculate the SLCC Incentive Pool (SIP).

- SIP = SLCC Payments Received x 7%

Step 2: Calculate the SLCC Incentive Pool Earned Payment (SIPEP) to be paid to SLCC.

- Identify which performance metrics were achieved
- Determine the SLCC Incentive Pool Weight (SIPW) by adding the weights of each performance metric achieved

Example: If SLCC achieves 2 of the 3 performance metrics - timely patient access and coordination of care, then:

SIPW = 50% + 25% = 75%

- SIPEP = SIP x SIPW

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 any remaining funds. Payments will not be redirected for administrative or infrastructure payments.

Appendix III

Pay-for-Performance Incentive Payment Results
Reporting Period: January – June 2013

Background

The State withholds 7% from payments made to the primary care health centers (PCHC) and St. Louis ConnectCare (SLCC). The amount withheld is tracked on a monthly basis as two separate incentive pools - one for primary care health centers and one for specialty care. To calculate the pay-for-performance incentive payments, the St. Louis Regional Health Commission (SLRHC) monitored the PCHC and SLCC performance against the pay-for-performance metrics outlined in the Incentive Payment Protocol (Protocol) dated December 20, 2012. According to the protocol, pay-for-performance incentive payments will be paid out at six-month intervals of the Pilot Program based on performance during the reporting period.

PCHC and SLCC 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 Protocol. The results are summarized below.

Primary Care Health Center Pay-for-Performance Results

The following table outlines the pay-for-performance thresholds in comparison to the actual results of each metric for the PCHC.

Table 1 **Pay-for-Performance Criteria**	**Threshold**	*Actual Outcomes Achieved*					
		GH	**MHD**	**FC**	**BJKP**	**County**	**Total**
1 - All Patients (1 visit)	80%	52%	58%	73%	61%	75%	62%
2 - Patients with Chronic Disease (2 visits)	80%	81%	87%	18%	68%	95%	73%
3 - Patients with Diabetes HgbA1c Tested	85%	91%	78%	70%	57%	83%	77%
4 - Patients with Diabetes HgbA1c < 8%	60%	60%	48%	53%	37%	64%	53%
5 - Hospitalized Patients	50%	83%	59%	100%	77%	100%	78%

The number of metrics met by each PCHC is depicted by the green highlighted fields in the table above. The following table summarizes the incentive earnings for each PCHC in light of the metrics that were achieved.

Table 1A Description		GH	MHD	FC	BJKP	County
Number of Criteria Met	*a*	4	2	1	1	3
Criteria Weight	*b*	20%	20%	20%	20%	20%
Incentive Pool Percentage Earned	*c = a x b*	80%	40%	20%	20%	60%
Incentive Amount Withheld	*d*	$ 198,323.89	$ 83,691.07	$ 30,665.84	$ 54,425.98	$68,642.08
Incentive Amount Earned	*e = c x d*	$ 158,659.11	$ 33,476.43	$ 6,133.17	$ 10,885.20	$41,185.25
Remaining Balance in PCHC Pool	*f = d - e*	$ 39,664.78	$ 50,214.64	$ 24,532.67	$ 43,540.78	$27,456.83

The PCHC earned $250,339.16 of the PCHC Incentive Pool (PIP) valued at $435,748.86, leaving a remaining balance of $185,409.65 in the PIP. According to the Protocol, each PCHC is eligible for the remaining funds based on the percentage of Blue Plan patients enrolled at the PCHC provided that the emergency department utilization and the specialist referral rate criteria are met. The following tables illustrate how the remaining PIP was allocated to each PCHC.

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

STEP 1

	7% Withheld	Earned	Remaining (Unearned)
GH	$ 198,323.89	$ 158,659.11	$ 39,664.78
MHD	$ 83,691.07	$ 33,476.43	$ 50,214.64
FC	$ 30,665.84	$ 6,133.17	$ 24,532.67
BJKP	$ 54,425.98	$ 10,885.20	$ 43,540.78
County	$ 68,642.08	$ 41,185.25	$ 27,456.83
Total	$ 435,748.86	$ 250,339.16	**$185,409.70**

Remaining Primary Care

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

STEP 2 ***STEP 3***

	Gross Earnings	# of Member Months	% of Member Months	PCHC Proportionate Share
GH	$ 2,832,108.68	54,485	46%	$ 85,288.47
MHD	$ 1,195,126.82	22,992	19%	$ 35,227.84
FC	$ 437,914.87	8,425	7%	$ 12,978.68
BJKP	$ 777,214.97	14,952	12%	$ 22,249.16
County	$ 980,224.04	18,858	16%	$ 29,665.55
Total	**$ 6,222,589.38**	**119,711**	100%	**$ 185,409.70**

Each PCHC actual outcome for emergency department utilization and referral rate to specialty care was compared to the thresholds established by the actuary. The results are summarized as follows:

Table 2C Pay-for-Performance Criteria	Weigh t	Threshold	*Actual Outcomes Achieved*					
			GH	MHD	FC	BJKP	County	Total
1 - Emergency Department Utilization	30%	36/1000	13	10	11	16	7	12
2 - Referral Rate to Specialty Care	70%	680/1000	427	353	647	440	510	443
Incentive Pool Percentage Earned	**100%**		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

All PCHC met both pay-for-performance criteria for the emergency department utilization and the rate of referrals to specialty care as indicated by the green highlights. Therefore, each PCHC has earned 100% of its proportionate share of the remaining PIP as calculated in the tables below.

Table 2D - Computes the remaining primary care incentive fund payment (RPCIFP) for each PCHC given that the performance metrics for both emergency department utilization and specialty referral metrics were met.

Step 4

	PCHC Proportionate Share	IPW	RPCIFP
GH	$ 85,288.47	100%	$ 85,288.47
MHD	$ 35,227.84	100%	$ 35,227.84
FC	$ 12,978.68	100%	$ 12,978.68
BJKP	$ 22,249.16	100%	$ 22,249.16
County	$ 29,665.55	100%	$ 29,665.55
Total	**$185,409.70**		**$185,409.70**

The total amount due to each PCHC for the January through June 2013 reporting period is summarized as follows:

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

	7% Withheld	Earned	RPCIFP	Total Due to Providers	State/Fed Portion	Local Portion
GH	$ 198,323.89	$ 158,659.11	$ 85,288.47	$ 243,947.58	201,891.02	42,056.56
MHD	$ 83,691.07	$ 33,476.43	$ 35,227.84	$ 68,704.27	56,859.65	11,844.62
FC	$ 30,665.84	$ 6,133.17	$ 12,978.68	$ 19,111.85	15,816.97	3,294.88
BJKP	$ 54,425.98	$ 10,885.20	$ 22,249.16	$ 33,134.36	27,422.00	5,712.36
County	$ 68,642.08	$ 41,185.25	$ 29,665.55	$ 70,850.80	58,636.12	12,214.68
Total	$ 435,748.86	$ 250,339.16	$185,409.70	**$435,748.86**	360,625.76	75,123.10

St. Louis ConnectCare Pay-for-Performance Results

In accordance with the Protocol, SLCC was evaluated based on three pay-for-performance criteria: timely patient access (measured by appointment wait times), coordination of care and timely, accurate filing of patient encounter and fee-for-service claims. The following tables summarize the pay-for-performance thresholds in comparison to the actual results of each SLCC metric.

	Appointment Wait Time in Weeks			*Appointments*	
Specialty	**Benchmark**	**Actual @ 80% Threshold**	**Favorable / (Unfavorable) Variance**	**#**	**%**
Cardiology	5	5	0	326	14%
Dermatology	4	5	(1)	246	11%
Endocrinology	7	5	2	94	4%
ENT	4	1	3	195	9%
GI	6	5	1	314	14%
Nephrology	5	2	3	55	2%
Neurology	9	9	0	194	9%
Orthopedics	6	5	1	236	10%
Pulmonary	8	2	6	191	8%
Surgery	3	3	0	260	11%
Urology	8	6	2	159	7%
			Total Appointments	**1,582**	**100%**

SLCC met the benchmarks for patient access as measured by appointment wait times 80% of the time with the exception of the Dermatology specialty. Utilizing a weighted average of the number of appointments by specialty, SLCC earned 89% of the funds withheld for this metric. Overall, SLCC earned $115,695.64 (or 94.6%) of its incentive pool. This calculation along with the results and earnings for the remaining metrics is summarized in Table 5 as follows.

Table 5 - Amount Due to SLCC	**Threshold**	**Outcome**	**Weighting**	**Incentive Pool % Earned**	**SLCC Pool Amount**	**Total Due to SLCC**	**State Portion**	**Local Match**
1 - Timely patient access	80%	89%	50.0%	44.6%	$122,323.75	$ 54,533.76	$ 45,132.14	$ 9,401.62
2 - Coordination of care - consultation notes uploaded within 10 business days	80%	82%	15.0%	15.0%	$122,323.75	$ 18,348.56	$ 15,185.27	$ 3,163.29
3 - Coordination of care - collaborative guidelines compact completed	100%	100%	10.0%	10.0%	$122,323.75	$ 12,232.38	$ 10,123.51	$ 2,108.87
4 - Timely, accurate claim filings - within 60 days of DOS	90%	92%	25.0%	25.0%	$122,323.75	$ 30,580.94	$ 25,308.78	$ 5,272.16
Total Percentage of Pool Earned			100.0%	94.6%		**$ 115,695.64**		

Conclusion

The pay-for-performance metrics were evaluated and payments to PCHC and SLCC were calculated based on the methodology described in the Protocol. Per the Protocol, the incentive payments summarized Table 3 and Table 5 for PCHC and SLCC, respectively, will be issued to the health centers no later than September 30, 2013. All of the incentive funds will be paid to the health centers and none will be redirected for administrative or infrastructure payments. The State will determine with the SLRHC where to apply the remaining budgeted funds based on the demand between primary and specialty care within in the Pilot Program.

Appendix IV
Projected Budget Neutrality Impact Through 2016

Budget Neutrality

Gateway to Better Health (Total Computable)

	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- 09/30/2014	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- 12/31/2016	Total -
No. of months in DY	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**3 months**	
No. of months of direct payments to facilities	**9 months**	**0 months**	**0 months**	**0 months**	**0 months**	**0 months**	
No. of months of Coverage Model (will be implemented on 07/01/2012)	**3 months**	**12 months**	**12 months**	**12 months**	**12 months**	**3 months**	
Without Waiver Projections							
Estimated DSH Allotment**	*$764,632,976*	*$764,632,976*	*$764,632,976*	*$764,632,976*	*$764,632,976*	*$191,158,244*	**$4,014,323,124**
Without Waiver Total	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$191,158,244**	**$4,014,323,124**
With Waiver Projections							
Residual DSH	*$738,644,994*	*$735,638,937*	*$732,800,091*	*$734,633,145*	*$734,633,145*	*$183,658,286*	$3,860,008,596
St. Louis ConnectCare	$14,879,909	*$3,148,648*	*$123,000*	$0	$0	$0	$18,151,557
Grace Hill Neighborhood Health Centers	*$5,071,706*	*$5,016,507*	*$6,778,731*	*$7,994,760*	*$7,994,760*	*$1,998,690*	*$34,855,154*
Myrtle Davis Comprehensive Health Centers	*$3,097,841*	*$2,108,161*	*$2,799,911*	*$3,302,183*	*$3,302,183*	*$825,546*	*$15,435,825*
Contingency Provider Network	*$379,372*	*$4,254,902*	*$5,157,730*	*$6,082,969*	*$6,082,969*	*$1,520,742*	*$23,478,686*
NEMT			*$352,560*	*$352,560*	*$352,560*	*$88,140*	*$1,145,820*
Voucher	$0	*$4,541,262*	*$9,519,792*	$7,767,359	$7,767,359	$1,941,840	*$31,537,613*
Infrastructure	$975,000	*$1,925,000*	*$0*	*$0*	*$0*	*$0*	$2,900,000
SLRHC Administrative Costs	$300,000	*$300,000*	*$75,000*	*$0*	*$0*	*$0*	$675,000
SLRHC Administrative Costs Coverage Model	$584,155	*$4,328,950*	*$4,080,776*	*$4,500,000*	*$4,500,000*	*$1,125,000*	$19,118,882
CRC Program Administrative Costs	$700,000	*$700,000*	*$175,000*	*$0*	*$0*	*$0*	$1,575,000
Projected expenditures for DY3 DOS*	*$0*	*$0*	*$29,832*	*$0*	*$0*	*$0*	$29,832
Actual expenditures for DY3 DOS		$2,670,607	*$0*	*$0*	*$0*	*$0*	$2,670,607
Projected expenditures for DY4 DOS*		$0	*$2,740,553*	*$0*	*$0*	*$0*	$2,740,553
Actual expenditures for DY4 DOS		$0	*$0*	*$0*	*$0*	*$0*	$0
Total With Waiver Expenditures	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$191,158,244**	**$4,014,323,124**
Amount under (over) the annual waiver cap	$0	$0		$0	$0	$0	$0
Annual expenditure by DY Payment Date as reported on CMS 64s (Demo expenses NOT including residual DSH)	$25,987,982	$28,994,039	$29,092,333	$29,999,831	$29,999,831	$7,499,958	
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$28,658,589	$26,353,265	$29,062,500				

Note: These are preliminary projections that are subject to change pending the final actuarial certification.

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 that it is considering giving notice to the Centers of Medicare and Medicaid Services (CMS) of its intent to request a two-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2014. 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. In providing this timely notice in accordance with federal regulation, the State of Missouri reserves the option to not file a notice of extension by December 31, 2013.

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. At this time 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); any future changes to the program submitted as amendments to CMS will be evaluated through the St. Louis Regional Health Commission's (SLRHC) community planning process. The benefit package is detailed in the full public notice document (link provided below). 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 31, 2013. Comments may be sent to:

Department of Social Services, MO HealthNet Division
Attention: Gateway Comments
P.O. Box 6500
Jefferson City, MO 65102-6500

Public hearings are scheduled for:

Tuesday, December 3, 2013, 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 3 public hearing via conference call may dial 888-808-6929, access code: 9158702.

Wednesday, December 4, 2013, 5:30-6:30PM
Metropolitan Psychiatric Center
5351 Delmar Blvd.
St. Louis, MO 63112

The State and the SLRHC will take 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 final application for Demonstration extension.

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)

December 2, 2013

The State of Missouri, Department of Social Services (DSS), hereby notifies the public that it is considering giving notice to the Centers of Medicare and Medicaid Services (CMS) of its intent to request a two-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2014. 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. In providing this timely notice in accordance with federal regulation, the State of Missouri reserves the option to not file a notice of extension by December 31, 2013.

DSS proposes that Gateway's "Safety Net Pilot Program" be extended for a period up to two years. 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 the ACA Medicaid expansion. 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, Grace Hill Health Centers, 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, Grace Hill Health Centers, and Myrtle Hilliard Davis Comprehensive Health Centers. As of July 1, 2012, the program transitioned to a coverage model.

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

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

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

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

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.

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

II. Beneficiaries and Eligibility Criteria

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

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

III. Delivery System

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

- BJK People's Health Centers
- Family Care Health Centers
- Grace Hill Health Centers
- Myrtle Hilliard Davis Comprehensive Health Centers
- St. Louis County Department of 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 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; gynecology; podiatry, generic prescriptions dispensed at primary care clinics; 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; urgent care (up to a maximum of 5 visits during each 18-month period of the Demonstration); non-emergency medical transportation.

The State seeks to continue to provide all benefits currently approved for the Gateway to Better Health Demonstration.

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 22,600 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 2014.

VIII. Waiver and Expenditure Authorities

It is anticipated the Waiver and Expenditure Authorities would include:

- **Demonstration Population 1:** Effective January 1, 2015, 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, 2015, 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 Demonstration populations.

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 populations and that differ from the benefits offered to the categorically needy group.

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

To the extent necessary, to permit the State to extend eligibility for Demonstration populations 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 all Demonstration populations 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 Demonstration populations 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 1 using reimbursement methodologies other than those required by section 1902(bb) of the Act.

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.

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 31, 2013, 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

Public hearings are scheduled for:

Tuesday, December 3, 2013, 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 3 public hearing via conference call may dial 888-808-6929, access code: 9158702.

Wednesday, December 4, 2013, 5:30-6:30PM
Metropolitan Psychiatric Center
5351 Delmar Blvd.
St., Louis, MO 63112

The State and the St. Louis Regional Health Commission will take 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.

Appendix VII

Post-Award Public Input Forum Notice

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

On September 27, 2013, 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 is designed to provide 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, 2014.

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

Tuesday, March 18, 2014
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.