State of Missouri
Gateway to Better Health Demonstration 11-W-00250/7
Section 1115 Quarterly Report

Demonstration Year: 6 (October 1, 2014 – September 30, 2015)
Federal Fiscal Quarter: 2/2015 (January 1, 2015 – March 31, 2015)

Introduction:

On July 28, 2010, CMS approved the State of Missouri's "Gateway to Better Health" Demonstration, which preserved access to ambulatory care for low-income, uninsured individuals in St. Louis City and County. The Demonstration was amended in June 2012, to enable the Safety Net Pilot Program to be implemented by July 1, 2012. The July 1, 2012, implementation of the Pilot Program ensured patients of the St. Louis safety net maintained access to primary care and specialty care. The Centers for Medicare and Medicaid Services (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:

- 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);
- 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;
- Maintain and enhance quality service delivery strategies to reduce health disparities;
- 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
- 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 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, when the covered patients were expected to be able to enroll in Medicaid or other coverage available through health care reform.

The Missouri legislature did not expand Medicaid eligibility during its 2013, 2014 or 2015 legislative sessions. On September 27, 2013, and again in July 2014, CMS approved a one-year extension of the Gateway Demonstration program for patients up to 100% FPL until December 31, 2015, or until Missouri's Medicaid eligibility is expanded to include the waiver population.

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 (MOU) with the St. Louis Regional Health Commission (SLRHC). The SLRHC, formed in 2001, is a non-profit, non-governmental organization whose mission is to increase access to health care for people who are medically uninsured and underinsured; reduce health disparities among populations in St. Louis City and County; and improve health outcomes among populations in St. Louis City and County, especially among those most at risk.

In order to meet the requirements for the Demonstration project, the State of Missouri Department of Social Services asked the SLRHC to lead planning efforts to determine the Pilot Program design, subject to CMS review and approval, and to incorporate community input into the planning process. Accordingly, on July 21, 2010, the SLRHC approved the creation of a "Pilot Program Planning Team." (A full roster of the Pilot Program Planning Team can be found in Attachment I). The MO HealthNet Division of the Missouri Department of Social Services is represented on the Planning Team to ensure the SLRHC and MO HealthNet are working closely to fulfill the milestones of the Demonstration project and develop deliverables.

The information provided below details Pilot Program process outcomes and key developments for the second quarter of Demonstration Year 6 (January 1, 2015 – March 31, 2015).

Enrollment Information:

As of March 31, 2015, 22,022 unique individuals were enrolled in the Gateway to Better Health. There were no program wait lists during this quarter of the Pilot Program.

Table 1. Gateway to Better Health Pilot Program Enrollment by Health Center*

Health Center (Tier 1 and Tier 2)	Unique Individuals Enrolled as of March 2015	Enrollment Months January - March 2015
BJK People's Health Centers	3,531	10,408
Family Care Health Centers	1,621	4,786
Grace Hill Health Centers	9,871	29,520
Myrtle Hilliard Davis Comprehensive Health Centers	3,784	11,227
St. Louis County Department of Health	3,215	9,337
Total for All Health Centers	**22,022**	65,278

**Enrollment numbers are based on MO HealthNet enrollment data as of April 1, 2015.*

The Gateway enrollment cap remains at 22,600, leaving room for approximately 578 new members under 100% FPL as of March 31, 2015.

Outreach/Innovation Activities:

Each month the SLRHC shares information and gathers input about the Demonstration from its 20-member board, and its 30-member Community and Provider Services Advisory boards. Full rosters of these boards may be found at www.stlrhc.org.

The SLRHC shares monthly financial, enrollment, and customer service reports about the pilot program with these advisory boards in addition to the Pilot Program Planning Team and the committees that report to this team; these committees include Medical/Referral, Outreach and Finance workgroups. Members of the community, health center leadership, health center medical staff and representatives from other medical providers in the St. Louis region are represented on these committees. (Full rosters can be found in Attachment I of this report).

Starting March 2015, the SLRHC implemented member orientations. The sessions were open to all members but targeted towards those members who joined the program in the last 6 months. Since this initiative began, 13 sessions have been conducted with more than 300 members in attendance overall. The member orientations have provided an avenue for the SLRHC to explain the program to new Gateway members and to gather feedback from patients on a regular basis.

The SLRHC regularly uses the infrastructure of its public Advisory Board and Gateway Team meetings to gather input about the Demonstration. In addition, the SLRHC and State will host a public hearing in June for the general public to comment on the progress of the demonstration project. The SLRHC and the State will take written and verbal comments during this public hearing. Community input will be summarized and submitted for review to CMS.

Public meetings held during the second quarter are listed below:

Team	Meeting Date
Provider Services Advisory Board Meeting	January 6, 2015
Gateway to Better Health Pilot Program Planning Team	January 13, 2015
Gateway to Better Health Medical Referral Team Meeting	January 15, 2015
Community Advisory Board Meeting	January 20, 2015
Commission Monthly Board Meeting	January 21, 2015
Gateway to Better Health Outreach Subcommittee Meeting	January 22, 2015
Provider Services Advisory Board Meeting	February 3, 2015
Community Advisory Board Meeting	February 17, 2015
Gateway to Better Health Finance Team Meeting	February 17, 2015
Commission Monthly Board Meeting	February 18, 2015
Provider Services Advisory Board Meeting	March 3, 2015
Community Advisory Board Meeting	March 17, 2015
Commission Monthly Board Meeting	March 18, 2015

In addition, screening for Gateway eligibility over the life of the Pilot Program has resulted in the enrollment of more than 30,000 individuals in MO HealthNet programs, including:

- 16,481 children (18 years or under) approved for MO HealthNet for Families or MO HealthNet for Kids;

- 9,184 adults approved for Uninsured Women's Health Services;
- 2,941 adults approved for MO HealthNet for the Aged, Blind, or Disabled; and
- 2,746 adults approved for MO HealthNet for Families.

Through ongoing outreach initiatives by the community health centers to enroll patients into coverage, the Gateway program continues to accept approximately 1,000 applications a month. With the eligibility review process for Gateway members and other factors, the program experiences a net loss of 700-800 members each month. These numbers are projected to be higher in coming months as higher numbers of individuals are scheduled for reviews. The SLRHC and community health centers are conducting significant outreach to ensure members retain their benefits. This outreach includes multiple attempts to reach patients by phone, mail, and during appointments at the community health centers.

Operational/Policy Development/Issues:

On March 25, 2015, the RHC was notified that Grace Hill Health Centers will change its name to Affinia Healthcare. To accommodate the name change, SLRHC is working with the State to update Gateway contracts, marketing and communication materials and eligibility, referral and payment systems. Letters were mailed to Affinia Healthcare's Gateway members to notify them of the name change.

Financial/Budget Neutrality Development/Issues:

The State continues to monitor budget neutrality for this quarter as claims are processed. At this time, the program is projected to be budget neutral for the federal fiscal year.

Consumer Issues:

Individuals enrolled in the Gateway to Better Health Pilot Program have access to a call center, available Monday through Friday, 8:00AM to 5:00PM central standard time. When the call center is not open, callers may leave messages that are returned the next business day.

From January – March 2015, the call center answered 5,706 calls, averaging approximately 85 calls per day. Of calls answered during this time, 25 (<1%) resulted in a consumer complaint. The 25 consumer issues were resolved directly with the patient and associated provider(s). The most common source of complaints for this quarter was related to patient access to care including, prescription medication, appointment scheduling and transportation. The type and number of complaints received during this period of time are outlined below:

Table 2. Summary of Consumer Complaints, January 1, 2015 – March 31, 2015*

Type of Complaint	Number of Complaints	Nature of Complaints/Resolution
Access to Care	8	Patient (1) reported difficulty coordinating care and having prescriptions filled. The patient's prescriptions were filled and an earlier follow-up appointment was offered. Patients (2) reported difficulty scheduling a follow-up appointment after hospital discharge. The patients were contacted and received an appointment.

		Patient (1) reported difficulty scheduling a dental appointment. The dental manager followed up with the patient and a timely appointment was scheduled. Patient (2) reported difficulty getting prescriptions filled. The nurse manager followed up with the patient. Patient (1) reported difficulty getting prescriptions filled. The patient was determined eligible for MO HealthNet and was able to access the prescriptions through the Mo HealthNet benefits package. Patient (1) is dissatisfied with wait times for a pain management appointment. RHC staff explained wait times to the patient and advised them to follow-up with their PCP in the interim if needed.
Transportation	9	Patients (4) reported transportation was late for scheduled pick-ups. The patients were contacted and offered an apology. A preferred provider for future appointments was assigned and/or transportation was scheduled for the new appointment. Patient (2) reported transportation did not show for a scheduled pick-up. LogistiCare followed up with the patients and provided direct contact information for any future problems. The patients were offered an apology. Patient (1) reported dissatisfaction with treatment received from the transportation provider. Logisticare contacted the patient and offered an apology. The patient was advised that Logisticare will attempt to assign a preferred provider to all future reservations. Patients (2) reported difficulty scheduling transportation at the health center. The transportation appointment was scheduled and the patients were notified of the pick-up time.
Co-Payment	4	Patient (1) reported a co-pay that was not consistent with Gateway standards. The patient was reimbursed. Patients (3) reported dental co-pays that were not consistent with Gateway standards. The patients were either provided appropriate co-pay standards or reimbursed for the difference.
Member Services	2	Patient (1) reported receiving a constant busy signal when trying to reach the health center. The technical problem was resolved the same day. Patient (1) reported difficulty getting a copy of their medical records. The patient was able to get a copy of the medical records without charge.
Quality of Care	2	Patient (1) reported dissatisfaction with treatment received at the health center. The health center contacted the patient and clarification was provided on covered services and on the Gateway application process. Patient (1) reported dissatisfaction with treatment received at the dental clinic. The Appointment Manager contacted the patient and a new appointment was scheduled.

**Reported consumer complaints are based on Automated Health Systems data as of April 6, 2015*

Action Plans for Addressing Any Policy, Administration, or Budget Issues Identified:

No policy, administrative, or budget issues have been identified this quarter.

Quality Assurance/Monitoring Activity:

The State and SLRHC are continually monitoring the performance of the program to ensure it is providing access to quality health care for the populations it serves. Representatives from the provider organizations meet regularly to evaluate clinical, consumer and financial issues related to the program.

The SLRHC conducts satisfaction surveys with referring physicians (including support staff) and Gateway to Better Health enrollees on a regular basis. The next patient and provider satisfaction evaluation is scheduled to be conducted in July. Evaluations of the newly implemented member orientations were also conducted during this quarter.

In addition, the State and SLRHC continually monitors call center performance, access to medical referrals (including referrals for diagnostic care, specialty care and surgical procedures), and wait times for medical appointments. Most recently available outcomes for these measures are detailed in the sections below:

Member Orientation Evaluation Surveys

Thirteen member orientation sessions were conducted in March and April 2015. A total of 336 members attended the sessions. After the sessions, member evaluations provided the following feedback:

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

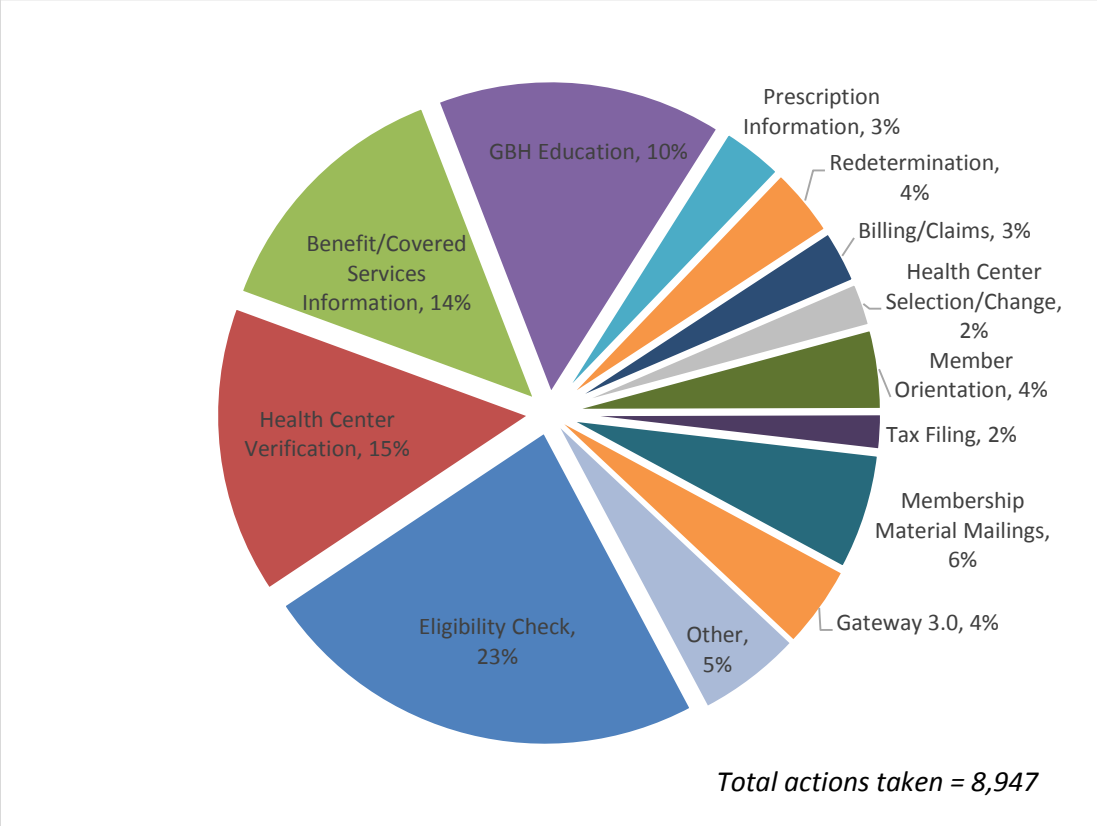
Call Center Performance

Table 3. Call Center Performance, January – March 2015*

Performance Measure	**Outcome**
Calls received	5,706
Calls answered	5,525
Abandonment rate	3.2%
Average answer speed (*seconds*)	22
Average length of time per call (*minutes: seconds*)	3:21

**Call center performance metrics are based on Automated Health Systems data as of April 6, 2015*

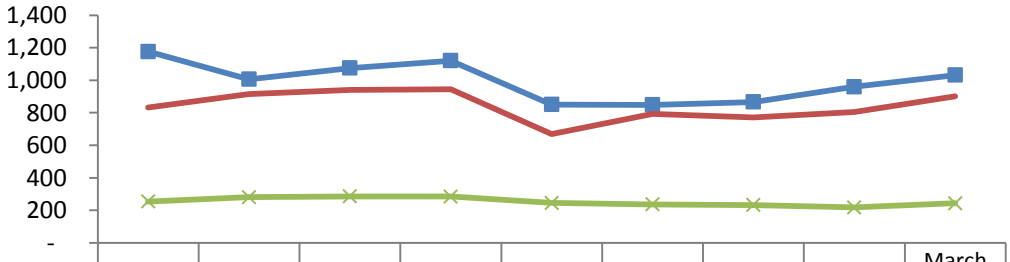
Figure 1. Call Center Actions, January – March 2015*



**Reported call center actions are based on Automated Health Systems data as of March 6, 2015*

Access to Medical Referrals

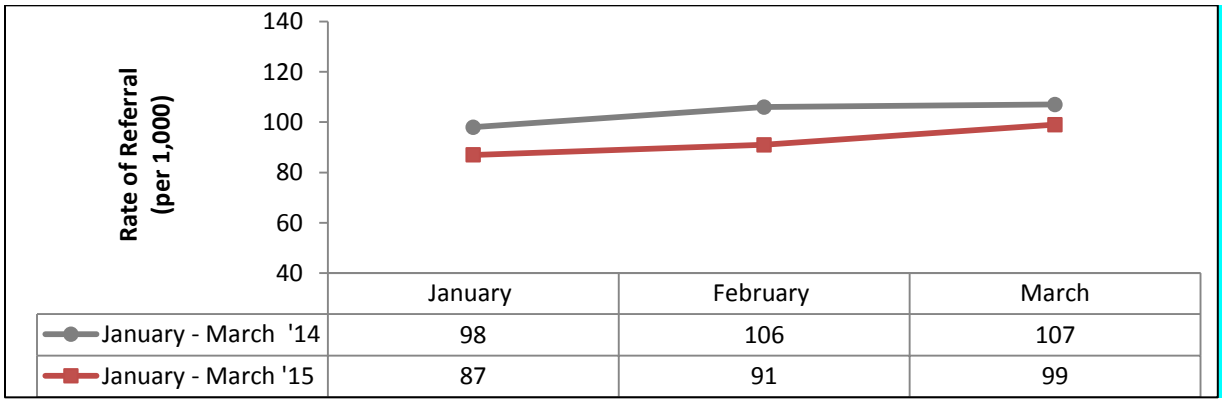
Figure 2. Medical Referrals by Type and Pilot Program Month, July 2014 – March 2015*



	July '14	Aug '14	Sep '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	March '15
Diagnostic	1,176	1,006	1,075	1,120	851	849	866	960	1,032
Specialty	833	915	940	944	670	793	772	805	902
Surgical	254	281	286	285	246	237	233	218	244
Total	2,263	2,202	2,301	2,349	1,767	1,879	1,871	1,983	2,178

**Reported medical referrals are based on Automated Health Systems data as of April 6, 2015.*

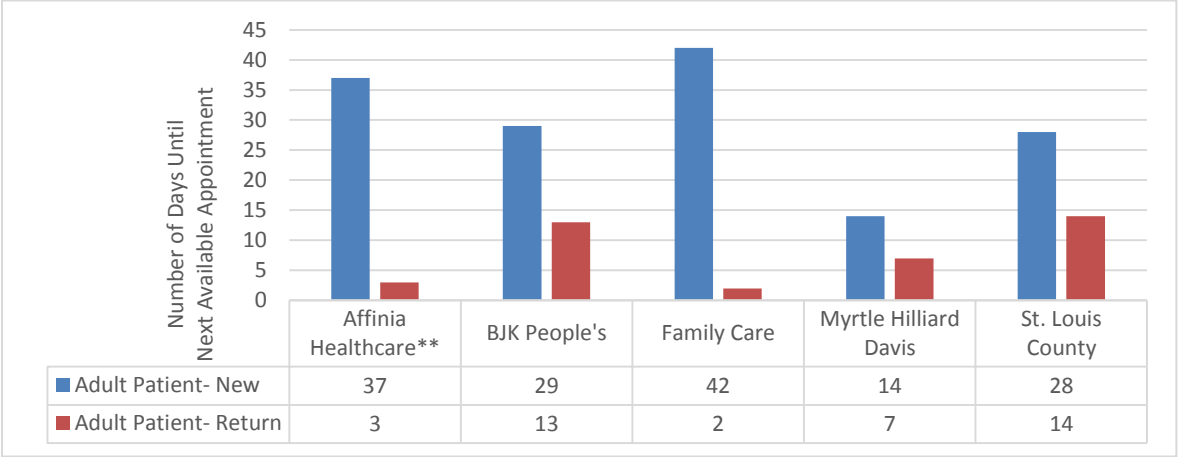
Figure 3. Comparison of Rate of Referral to Specialist by Pilot Program Month (per 1,000 Members Enrolled), January – March 2014 vs. January – March 2015*



**Reported rates of medical referrals are based on Automated Health Systems data as of April 6, 2015. Referral types include diagnostic, specialty and surgical procedures. Rate of referral is determined by using the total referrals divided by the average monthly enrollment.*

Primary Care Appointment Wait Times

Figure 4. Primary Care Wait Times (Non-Urgent Appointments in Days), as of March 31, 2015*



**Wait times self-reported by individual health center as of May 13, 2015, and are calculated for Gateway patients only. **Affinia Healthcare was formerly known as Grace Hill Health Centers.*

Updates on Provider Incentive Payments:

Table 4. Summary of Provider Payments and Withholds, January – March 2015*

Providers	**Provider Payments Withheld**	**Provider Payments Earned****
BJK People's Health Centers	$ 36,767	$ 560,718
Family Care Health Centers	$ 16,719	$ 263,127
Grace Hill Health Centers	$ 104,970	$ 1,656,104
Myrtle Hilliard Davis Comprehensive Health Centers	$ 39,988	$ 629,045
St. Louis County Department of Health	$ 32,929	$ 522,867
Voucher Providers	$ -	$ 1,912,873
Total for All Providers	$ 231,373	$ 5,544,733

**Payments in the table above are subject to change as additional claims are submitted by providers. Reported provider payments and withholds are based on data as of April 5, 2015 for reporting period January - March 2015.*

***Amount represents payments made during the quarter, net of incentive withholds.*

As documented in previous quarterly reports, the Incentive Payment Protocol requires 7% of provider funding to be withheld from Gateway providers. The 7% withhold is tracked and managed on a monthly basis. The SLRHC is responsible for monitoring the health centers' performance against the pay-for-performance metrics in the Incentive Payment Protocol.

Pay-for-performance incentive payments are paid out at six-month intervals of the Pilot Program based on performance during the following 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
- January 1, 2015 – June 30, 2015
- June 30, 2015 – December 31, 2015

The community health centers continue to improve in the pay-for-performance criteria measures. During the July 1, 2014- December 31, 2014 reporting period, community health centers met five to six of the six clinical quality measures. Family Care Health Centers and St. Louis County Department of Health achieved all of the measures.

For this reporting period, the community health centers exceeded the thresholds in five of the six measures (exceeded the thresholds in four of the six measures prior period): 86% of patients with chronic diseases had two primary care visits (threshold 80%); 90% of patients with diabetes had their HgbA1c drawn within 4 months (threshold 85%); 68% of patients with diabetes had a HgbA1c measure <9% (threshold 60%); 78% of hospitalized patients received follow-up within 7 days of discharge; and the referral rate for specialists was 338/1000 (threshold 680/1000). 74% of patients had a primary care visit during this period, with a threshold of 80%.

See Attachment II for a comprehensive review of pay-for-performance results for the July – December 2014 reporting period.

Updates on Budget Neutrality Worksheets:

Please see attached worksheets (Attachment III).

Evaluation Activities and Interim Findings:

The SLRHC and the State of Missouri continues to track program outcomes, which will be reported in the annual report for the current demonstration year.

Updates on Plans to Secure Financial Sustainability:

Planning for financial sustainability of the Affiliation Partners and SLRHC has been underway throughout the demonstration period. Updates are provided below:

Affiliation Partners

The Affiliation Partners successfully transitioned from a direct payment methodology to a coverage model on July 1, 2012. The move to a coverage model has required these providers to understand underlying cost structures and streamline operations in preparation for the post-Demonstration environment. The long-term sustainability of the Affiliation Partners depends on the expansion of Medicaid in the State of Missouri. Gateway has been an important bridge to this expansion. However, as of May 2015, the Missouri legislature has not approved expansion, making the ongoing operations of Gateway to Better Health critical to the lasting financial sustainability of the health centers: Grace Hill, Family Care, BJK People's, Myrtle Hilliard Davis, and St. Louis County Health Department.

St. Louis Regional Health Commission Sustainability

At the current time, 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. The SLRHC continues to sustain its non-Gateway operations through contributions from St. Louis City and County.

Updates on Pilot Program and Implementation Activities:

As documented in previous quarterly reports, the Pilot Program was implemented on July 1, 2012; patients enrolled in Gateway to Better Health began receiving health care services under the coverage model as of that date. First convened in July 2010, the Pilot Program Planning Team serves to monitor the progress of the Pilot Program. Topics monitored include: specialty care referrals, enrollment, call center performance, consumer complaints, evaluation findings and budgets compared to actual expenses. The Planning Team also provides guidance and feedback throughout the operation of the program.

As in previous quarters, the State's Family Support Division continues to determine eligibility and to enroll individuals into Gateway to Better Health Pilot Program. Similarly, the MO HealthNet Division continues to monitor the progress of the program and implementation of the claims adjudication system.

Updates on Transition Plan:

The state submitted a transition plan on June 25, 2014. When the state determines a long-term solution for covering this population, the transition plan will be updated explaining how the patients will be transitioned into new coverage options.

Updates on any Amendment Requests:

Submitted February 2015, an amendment is currently under review with CMS to add insulin and inhaler medication coverage to the benefit package for Gateway members. Updates on the status of this amendment will be provided in future reports. No other new amendments are pending currently.

Updates on the State's Success in Meeting the Milestones Outlined in Section XII:

Table 6. Updates on the State's Success in Meeting Section XII Milestones

Date – Specific	Milestone	STC Reference	Date Submitted
10/01/2010	Submit strategic plan for developing the pilot plan	Section XII (#55a)	09/24/2010
11/25/2010	Submit Draft Evaluation Design	Section XII (#57)	11/19/2010
01/01/2011	Submit draft plan for the pilot program including business plans for the SLRHC, CRC Program, and each of the Affiliation Partners	Section XII (#55b)	12/30/2010
01/28/2011	Submit draft annual report for DY 1 (July 2010 – September 2010)	Section IX (#38)	1/28/2011
07/01/2011	Submit plan for the pilot program, including any needed amendments to the Demonstration and final business plans for the SLRHC, CRC Program, and each of the Affiliation Partners	Section XII (#55c)	6/30/2011
07/01/2011	Submit financial audit of ConnectCare	Section XII (#55d)	6/30/2011
10/01/2011	Submit draft operational plan for the pilot program	Section XII (#55e)	9/29/2011
01/01/2012	Submit operational plan for the pilot program	Section XII (#55f)	12/30/2011
01/27/2012	Submit draft annual report for DY 2 (October 2010 – September 2011)	Section IX (#38)	01/27/2012
07/01/2012	State must implement the pilot program, contingent on CMS approval	Section XII (#56a)	Implemented 07/1/2012
07/01/2012	Submit draft Transition Plan	Section III (#16)	6/27/2012
08/01/2012	Submit MOU between the State and SLRHC for CMS review	Section XIV	7/30/2012
09/01/2012	Incentive protocol	Section V (#21)	8/16/2012
10/31/2012	Submit revised evaluation design	Section XIII, (#57)	10/31/2012
01/28/2013	Submit draft annual report for DY 3 (October 2011 – September 2012)	Section IX, (#38)	01/28/2013
12/31/2013	ConnectCare, Grace Hill, and Myrtle Davis attain financial sustainability	Section XII (#56b)	See page 9
12/31/2013	SLRHC and CRC must attain financial sustainability	Section XII (#56d)	12/31/2013
01/28/2014	Submit draft annual report for DY 4 (October 2012 – September 2013)	Section IX (#38)	1/28/2014
01/29/2014	Submit revised Evaluation Design	Section XIII (#57)	1/29/2014
06/30/2014	Submit Transition Plan	Section III (#16)	6/25/2014
11/19/2014	Submit revised Evaluation Design	Section XIII (#55)	11/19/2014
	Submit draft annual report for DY5 (October 2013-September 2014)	Section IX (#36)	1/20/2015
07/01/2016	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)	Ongoing

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

Enclosures/Attachments:

Attachment I: Gateway Team Rosters

Attachment II: Pay-for-Performance Results

Attachment III: Updated Budget Neutrality Worksheets

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Date Submitted to CMS:

May 29, 2015

Pilot Program Planning Team
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GATEWAY TO BETTER HEALTH

Pay-for-Performance Incentive Payment Results

Reporting Period: July - December 2014

Background

The State withholds 7% from payments made to the primary care health centers. The amount withheld is tracked on a monthly basis. Primary care health centers provided self-reported data to SLRHC within 30 days of the end of the reporting period for those patients who were enrolled for the entire reporting period. SLRHC validated the data by taking a random sample of the self-reported data and comparing it to the claims data. SLRHC has calculated the funds due to the providers based on the criteria and methodologies described in the Incentive Protocol, approved by CMS. Results for the fifth reporting period, July - December 2014, are summarized below.

Primary Care Health Center Pay-for-Performance Results

The potential incentive payment amount totaled $502,576.69 and 100% will be paid to primary care providers. The following table outlines the pay-for-performance thresholds in comparison to the actual results of each metric.

Table 1 **Pay-for-Performance Criteria**	**Threshold**	*Actual Outcomes Achieved*					
		GH	**MHD**	**FC**	**BJKP**	**County**	**Total**
1 – New patients (1 visit)	80%	65%	75%	81%	80%	88%	74%
2 - Patients with chronic diseases (2 visits)	80%	80%	92%	96%	82%	97%	86%
3 - Patients with diabetes HgbA1c tested	85%	91%	91%	100%	81%	92%	90%
4 - Patients with diabetes HgbA1c <9%	60%	61%	77%	71%	62%	80%	68%
5 - Hospitalized Patients	50%	83%	88%	50%	62%	65%	78%

The number of metrics met by each health center for the first round of metrics is depicted by the green highlighted fields in Table 1 above. The health centers earned $423,853.45 of the initial incentive pool leaving a remaining balance of $78,723.24.

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

Table 2 **Pay-for-Performance Criteria**	**Weight**	**Threshold**	*Actual Outcomes Achieved*					
			GH	**MHD**	**FC**	**BJKP**	**County**	**Total**
Referral Rate to Specialty Care	100%	680/1000	272	287	518	425	506	338

Incentive Pool Percentage Earned	**100%**		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

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

Table 3 – Amount Due to Each Health Center

Health Center	Incentive Pool	First Round Earnings	Second Round Earnings	Total Due to Providers
GH	$231,256.60	$185,005.28	$36,212.68	$221,217.96
MHD	$86,415.94	$69,132.75	$13,382.95	$82,515.70
FC	$35,560.79	$35,560.79	$5,510.63	$41,071.42
BJKP	$75,943.63	$60,754.90	$11,808.49	$72,563.39
County	$73,399.73	$73,399.73	$11,808.49	$85,208.22
Total	$502,576.69	$423,853.45	$78,723.24	$502,576.69

APPENDIX A: SUMMARY OF CALCULATIONS

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

Step 1: Determine the initial pool amount.

Step 2: Determine which of the following first-tier performance metrics were achieved for each organization:

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

Step 3: Calculate the earnings for the initial pool based on the number of first-tier metrics achieved.

Step 4: Determine the second pool amount, which is unearned amount from the initial pool.

Step 5: Calculate health center's share of available earnings based on enrollment.

Step 6: Determine which of the following second-tier performance metrics were achieved:

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

Step 7: Calculate the earnings for the second pool based on the number of second-tier metrics achieved.

Step 8: Calculate the total payment to the health center by summing the earnings from both pool.

APPENDIX B:
PRIMARY CARE TRENDING REPORT

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

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

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

Budget Neutrality

Gateway to Better Health (Total Computable)

	DY 1 FFY 2010 07/28/2010 - 09/30/2010	DY 2 FFY 2011 10/01/2010 - 09/30/2011	DY 3 FFY 2012 10/01/2011- 9/30/2012	DY 4 FFY 2013 10/01/2012- 09/30/2013	DY 5 FFY 2014 10/01/2013- 9/30/2014	DY 6 FFY 2015 10/01/2014- 09/30/15	DY 7 FFY 2016 10/01/2015- 12/31/2015	Total - 5.5 year demonstration 07/28/2010 to 12/31/2015
No. of months in DY	**3 months**	**12 months**	**12 months**	**12 months**	**12 months**	**12 months**	**3 months**	
No. of months of direct payments to facilities	**3 months**	**12 months**	**9 months**	**0 months**	**0 months**	**0 months**	**0 months**	
No. of months of Pilot Program (will be implemented on 07/01/2012)	**0 months**	**0 months**	**3 months**	**12 months**	**12 months**	**12 months**	**3 months**	
Without Waiver Projections								
Estimated DSH Allotment**	$189,681,265	$748,599,611	*$764,632,976*	*$764,632,976*	$764,632,976	*$764,632,976*	*$181,600,332*	**$4,178,413,112**
Without Waiver Total	**$189,681,265**	**$748,599,611**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$181,600,332**	**$4,178,413,112**
With Waiver Projections								
Residual DSH	$175,037,571	$679,083,062	*$738,644,994*	*$735,638,937*	*$738,258,382*	*$735,195,278*	*$175,104,377*	$3,976,962,600
St. Louis ConnectCare	$4,850,000	$18,150,000	$14,879,909	*$3,148,648*	$118,489	$0	$0	$41,147,045
Grace Hill Neighborhood Health Centers	$1,462,500	$5,850,000	*$5,071,706*	*$5,016,507*	*$6,073,656*	$6,346,422	*$1,486,063*	$31,306,854
Myrtle Davis Comprehensive Health Centers	$937,500	$3,750,000	*$3,097,841*	*$2,108,161*	*$1,838,040*	$2,408,979	*$569,675*	$14,710,196
Contingency Provider Network	$0	$0	*$379,372*	*$4,254,902*	*$5,469,199*	$5,532,050	*$1,339,081*	$16,974,605
Voucher	$0	$0	$0	*$4,541,262*	*$6,358,786*	$8,599,092	*$2,150,865*	$21,650,006
Infrastructure	$0	$0	$975,000	*$1,925,000*	*$0*	$0	$0	$2,900,000
SLRHC Administrative Costs	$75,000	$300,000	$300,000	*$300,000*	*$75,000*	*$0*	*$0*	$1,050,000
SLRHC Administrative Costs Coverage Model			$584,155	*$4,328,950*	*$3,692,463*	$4,024,400	*$950,271*	$13,580,240
CRC Program Administrative Costs	$91,684	$700,000	$700,000	*$700,000*	*$175,000*	*$0*	*$0*	$2,366,684
Actual expenditures for DY3 DOS				$2,670,607	*$33,308*	*$0*	*$0*	$2,703,915
Projected expenditures for DY4 DOS*				$0	*$0*	*$0*	*$0*	$0
Actual expenditures for DY4 DOS				$0	*$2,540,653*	*-$13,612*	*$0*	$2,527,041
Projected expenditures for DY5 DOS*						*$4,801*	*$0*	$4,801
Actual expenditures for DY5 DOS						*$2,535,565*	*$0*	$2,535,565
Total With Waiver Expenditures	**$182,454,255**	**$707,833,062**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$764,632,976**	**$181,600,332**	**$4,127,879,187**
Amount under (over) the annual waiver cap	$7,227,010	$40,766,549	$0	$0	$0	$0	$0	$50,533,925
Annual expenditure by DY Payment Date as reported on CMS 64s (Demo expenses NOT including residual DSH)			$25,987,982	$28,994,039	$26,374,594	$29,437,698	$6,495,955	
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$7,416,684	$28,750,000	$28,691,897	$28,850,473	$26,340,999	$26,910,943	$6,495,955	

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

**FFY 2012 through FY 2014 DSH allotments have not been finalized. Therefore, the regular FFY 2011 allotment was used as a proxy for FFY 2012 through FFY 2014. DSH allotment is shown as (total computable) above. For reference, DSH allotment in Federal share is shown below:

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

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