State of Missouri

Gateway to Better Health Demonstration

Number 11-W-00250/7

Amended Evaluation Design

December 30, 2017

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I. General Background

Program Overview

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 and specialty care. CMS approved a one-year extension of the Demonstration on September 27, 2013, July 16, 2014, December 11, 2015, June 16, 2016, and again on September 1, 2017 for a five-year extension. The State has been authorized to spend up to $30 million (total computable) annually to preserve and improve primary and specialty care in St. Louis in lieu of spending that amount of statutorily authorized funding on payments to disproportionate share hospitals (DSHs). The Demonstration includes the following main objectives:

I. Preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured.

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

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

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

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

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

The Missouri legislature did not expand Medicaid eligibility during its 2013-2017 legislative sessions. Therefore, on September 27, 2013, July 16, 2014, December 11, 2015, and again on June 16, 2016, CMS approved one-year extensions of the Gateway Demonstration program for patients up to 100% FPL. On September 1, 2017, CMS approved a five-year extension of the demonstration program.

Section XII, item 40 of the amended Special Terms and Conditions (STCs), issued in September 2017, requires the State to submit to CMS for approval an amended draft evaluation design. This document is intended to meet this term of the Demonstration for the duration of the current approval period. During the current approval period there will be no significant changes to the program.

Historical Background

[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.

The current funding provided by this Demonstration Project (Number: 11-W-00250/7) builds on and maintains the success of the "St. Louis Model," which was first implemented through the "Health Care for the Indigent of St. Louis" amendment to the Medicaid Section 1115 Demonstration Project (Number: 11-W00122/7). This amendment authorized the diversion of 6.27 percent of the Statewide DSH cash distributions, previously allocated to St. Louis Regional Hospital, to a "St. Louis Safety Net Funding Pool," which funded primary and specialty care for the uninsured. The downsizing and ultimate closure of St. Louis Regional Hospital in 1997 led to the "St. Louis Model." Under this model, the DSH funds were distributed directly to the legacy clinics of St. Louis Regional Hospital, which were operated by St. Louis ConnectCare[2], Affinia Healthcare (formerly known as Grace Hill Health Centers) and Myrtle Hilliard Davis Comprehensive Health Centers. The funds were distributed directly to these organizations through June 30, 2012. As of July 1, 2012, this funding was converted to a "coverage model" per the conditions of the Demonstration.

The SLRHC was established under this waiver to coordinate, monitor and report on the safety net network's activities and to make recommendations as to the allocation of these funds. Today, the SLRHC is charged with improving health care access and delivery to the uninsured and underinsured in the St. Louis region, and is the fiscal agent for this Demonstration.

The Commission works within a large network that includes St. Louis County and its public health department, area Federally Qualified Health Centers (FQHCs), the St. Louis City health department, as well as area hospitals and medical schools. Over the last decade, the work of the safety net providers in the St. Louis region has focused on helping patients establish a medical home in one of the community health centers in an effort to reduce health disparities and increase the effective utilization of the community's health care resources. The Demonstration Project is intended to continue these efforts while preparing patients and safety net provider organizations for an effective transition to coverage that will be available under health care reform.

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

Population Impacted

The demonstration project is designed to maintain and increase access to primary and specialty care for the uninsured in St. Louis City and County. As a result, the evaluation will focus on uninsured patients who are served by the health care safety net in St. Louis. For the extension period, the evaluation will examine clinical activities for uninsured adults, aged 19-64, in St. Louis City and St. Louis County.

The St. Louis health care safety net is comprised of the five St. Louis area community health centers, including Betty Jean Kerr People's Health Centers, Family Care Health Centers, Affinia Healthcare (formerly known as Grace Hill), Myrtle Hilliard Davis Comprehensive Health Centers and St. Louis County

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

Department of Public Health. The St. Louis safety net also includes area academic medical institutions (Washington University School of Medicine and St. Louis University School of Medicine). These organizations are members of the St. Louis Integrated Health Network (IHN). The IHN is a 501(c)(3) comprised of primary and specialty medical care providers in the St. Louis region. The goal of the IHN is to ensure access to health care for the uninsured and underinsured through increased integration and coordination of a safety net of health care providers.

External Evaluator

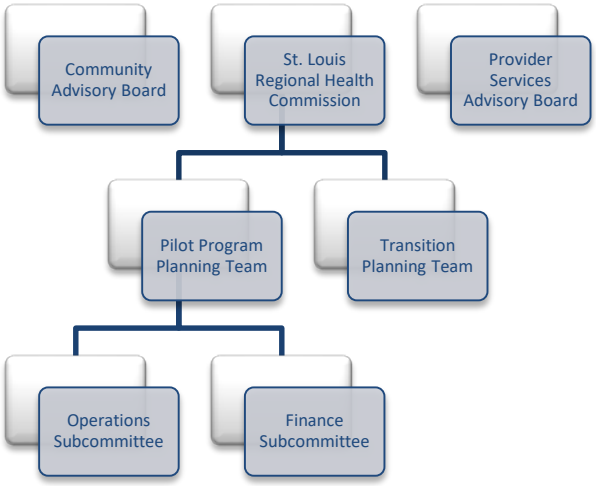
Mercer Government Human Services Consulting has been selected to serve as the external evaluator for the Gateway to Better Health demonstration program. A request for proposals (RFP) was released in August 2017, and the due date for proposals was October 31, 2017. A total of six proposals were submitted to the RHC and evaluated on cost, experience, evaluation approach and overall flexibility.

Building on past program evaluations, Mercer will assist the SLRHC in developing the final evaluation design for the 2018 – 2022 approval period. Data analysis for the evaluation will be conducted by the SLRHC and Mercer will evaluate the effectiveness of the program in achieving objectives. The program evaluation design work with Mercer is being conducted according to the timeline below, with the final evaluation plan being completed in April 2018. The final program evaluation will be completed in 2022. See Appendix IV for a full schedule of evaluation activities.

Topic/Task	Target Date
Mercer to facilitate kick off meeting with SLRHC	November 17, 2017
Mercer to facilitate onsite meeting with Pilot Program Planning Team to review updated driver diagram, methodology and data analysis plan, and measures	February 2, 2018
Mercer to complete measure selection and specification description	February 24, 2018
Mercer to submit draft report to Program Staff	March 23, 2018
Mercer receives feedback on draft report from Program Staff	March 28, 2018
Mercer to submit updated draft report to Pilot Planning Team	April 4, 2018
Mercer receives feedback on draft report from Pilot Planning Team	April 9, 2018
Mercer to submit final draft report to the SLRHC	April 13, 2018
Mercer receives feedback on the final draft report from SLRHC	April 20, 2018
Mercer to submit Final Report to SLRHC	April 23, 2018

Organizational Structure

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



The organizational structure is described below. Other sub-teams may be established during the planning process as needed.

St. Louis Regional Health Commission

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

Roles for the RHC under the Demonstration include:

- Serving as the Fiscal Agent for diverted DSH funds (July 2010 – December 2022);
- Creating a transition plan for implementation of a pilot coverage program (submitted June 27, 2012, and again on June 25, 2014);
- Creating an operational plan to implement the pilot program (submitted December 30, 2011);
- Collecting data and making funding recommendations for $24 million allocation to Affiliation Partners in spring 2011;
- Developing a pilot program planning team and staffing team to meet deliverable timeline; and
- Providing the operational infrastructure to operate the pilot program as described in the Memorandum of Understanding between the RHC and the State of Missouri.

Additional key roles related to both the RHC's mission and the Demonstration activities include:

- Initiating dialogue, seeking input and engaging the community on the issues of the health care safety net in the St. Louis region;
- Filtering and analyzing data, facts and various points-of-view;
- Proposing and recommending changes to the current system and developing priorities and coordinating areas of focus for action;
- Building support for change through communication, education and organization support and commitment;
- Mobilizing and coordinating resources for achieving progress towards improving the regional safety net and implementing the Demonstration; and
- Developing vehicles for measurement and communication of success on a long-term basis.

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

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

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

Pilot Program Planning Team

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

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

The team is composed of the following members:

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

Kate Becker
President, SSM St. Mary's Health Center and SSM Cardinal Glennon Children's Hospital

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

Alan Freeman
President and Chief Executive Officer, Affinia Healthcare (formerly known as Grace Hill)

Angela Clabon
Chief Executive Officer, Myrtle Hilliard Davis Comprehensive Health Centers

Joe Yancey
Executive Director, Places for People

Faisal Khan, MBBS, MPH
Director, St. Louis County Department of Public Health

Jennifer Tidball
Director, MO HealthNet Division, Department of Social Services, State of Missouri

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

Angela Brown (ex officio)
Chief of Staff, St. Louis Regional Health Commission

Operations Subcommittee

Reporting to the Pilot Program Planning Team, the Operations subcommittee has a charge to monitor and recommend necessary adjustments to Gateway operational functions, including but not limited to:

- Specialty care referral process
- Pay for performance metrics
- Performance and utilization management data from participating providers
- Enrollment and outreach efforts
- Patient and provider engagement activities

The Operations Subcommittee is composed of the following members:

Gretchen Leiterman (Chair)
Chief Operating Officer
SSM Health Saint Louis University Hospital

Bernard Ceasor
GBH Section Supervisor
Family Support Division

Deneen Busby
Director of Operations
Myrtle Hilliard Davis Health Centers

Yvonne Buhlinger
Vice President, Development and Community Relations
Affinia Healthcare

Vickie Wade
Vice President of Clinical Services
Betty Jean Kerr People's Health Centers

Peggy Clemens
Practice Manager
Mercy Clinic Digestive Diseases

Kitty Famous
Manager, CH Orthopedic & Spine Surgeons
BJC Medical Group

Cindy Fears
Director, Patient Financial Services
Affinia Healthcare

Felecia Cooper
Nursing Supervisor
North Central Health Center

Renee Riley
Managed Care Operations Manager
MO HealthNet Division (MHD)

Tony Amato
Assistant Director, Managed Care
SLUCare

Linda Hickey
Practice Manager
Mercy Clinic Heart & Vascular

Andrew Johnson
Senior Director, A/R Management
Washington University School of Medicine

Lynn Kersting
Chief Operating Officer
Family Care Health Centers

Danielle Landers
Community Referral Coordinator
St. Louis Integrated Health Network

Jody Wilkins
Nursing Supervisor
South Count Health Center

Antonie Mitrev
Director of Operations
Family Care Health Centers

Harold Mueller
Director, Planning and Development
Barnes-Jewish Hospital

Gina Ivanovic
Manager, Referral Programs
Washington University School of Medicine

Dr. James Paine
Chief Operating Officer
Myrtle Hilliard Davis Health Centers

Jacqueline Randolph
Director, Ambulatory Services
BJH Center for Outpatient Health

Finance Subcommittee

Reporting to the Pilot Program Planning Team, the Finance Subcommittee has a charge to monitor financial results of the Pilot Program and recommend adjustments in order to achieve financial goals.

The Finance Subcommittee is composed of the following members:

Mark Barry/Denise Lewis-Wilson
Fiscal Director/Patient Accounts Manager,
St. Louis County Department of Health

Janet Voss
Vice President and Chief Financial Officer,
Affinia Healthcare

Gregory Stevenson
Chief Financial Officer, Myrtle Hilliard Davis Comprehensive Health Centers

Dennis Kruse
Chief Financial Officer, Family Care Health Centers

Connie Sutter
Senior Auditor, MO HealthNet Division, Missouri Department of Social Services

Andrew Johnson
Senior Director, A/R Management
Washington University School of Medicine

Hewart Tillett
Chief Financial Officer, Betty Jean Kerr People's Health Centers

Transition Planning Team

Reporting to the Commission, the Transition Planning Team has a charge to develop a Transition Plan for ensuring access to primary and specialty care services for the low-income population of St. Louis City and County after the scheduled conclusion of the Gateway to Better Health Demonstration Project on December 31, 2022. In particular, the plan will discuss how the state plans to coordinate the transition of Demonstration enrollees to a coverage option available under the Affordable Care Act. The interim Transition Plan was submitted to CMS on June 27, 2012, and again on June 25, 2014.

The Transition Planning Team is composed of the following members:

Cheryl Walker (Chair)
Attorney, Bryan Cave, LLP

Kate Becker
President, SSM Health St. Louis University Hospital

James Buford
Civic Leader

Alan Freeman
Chief Executive Officer, Affinia Healthcare (formerly known as Grace Hill)

Faisal Khan, MBBS, MPH
Director, St. Louis County Public Health Department

Bethany Johnson-Javois
Chief Executive Officer, St. Louis Integrated Health Network

Robert K. Massie, D.D.S.
Chief Executive Officer, Family Care Health Centers

Will Ross, M.D
Associate Dean and Director of the Office of Diversity, Washington University School of Medicine

Melba Moore
Director, St. Louis City Department of Health

II. Evaluation Questions and Hypotheses

Targets for Improvement

The Gateway to Better Health Demonstration Project will be evaluated to determine if the project meets the established objectives as well as to gain knowledge about the challenges, opportunities and benefits of a coverage model designed for low-income uninsured adult patients who do not qualify for Medicaid or Medicare.

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

I. Preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured.

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

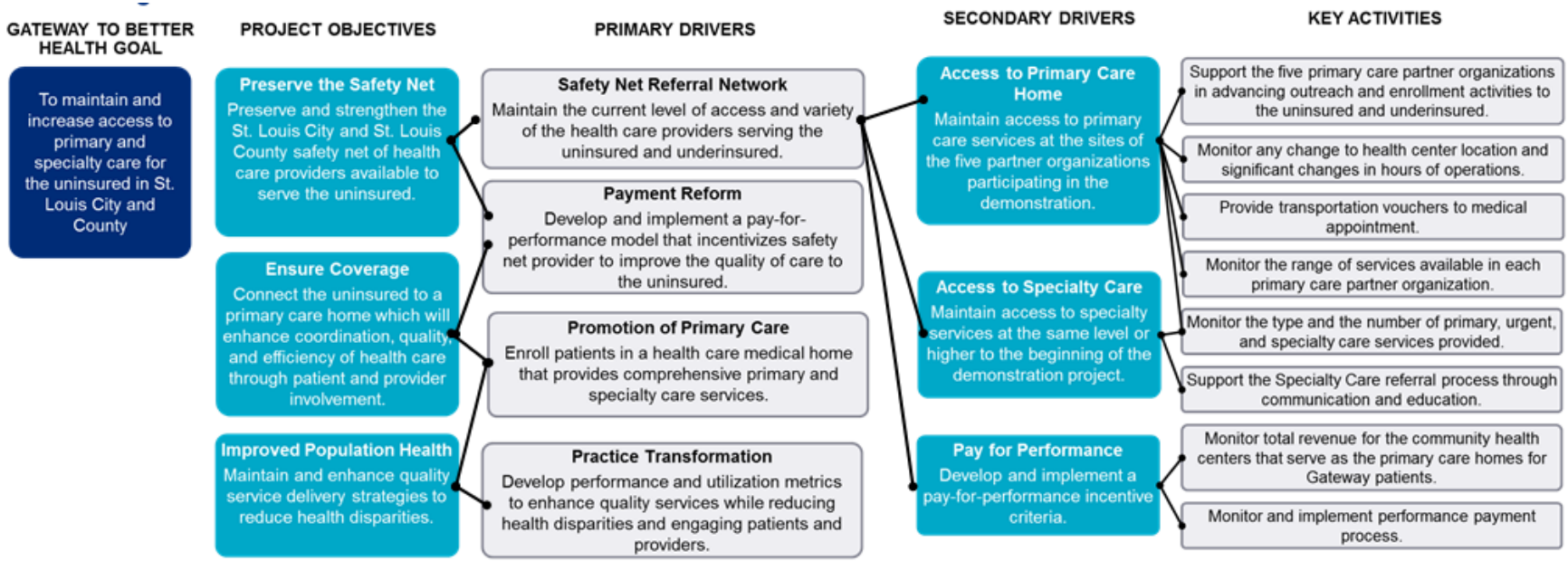
III. Maintain and enhance quality service delivery strategies to reduce health disparities.

These Demonstration Objectives translate into the following quantifiable targets.

Objective	Target
Preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured.	Sustain and increase access and availability of health providers (provider network size including specialty area coverage) and health services (utilization of routine visits, screenings, and prevention visits) for uninsured individuals in St. Louis City and St. Louis County
Connect the uninsured to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement;	Increase membership in a primary care home to improve performance on service/system quality indicators, frequency of care coordination, and decrease medical costs associated with medical complications, preventable hospitalizations and ER visits.
Maintain and enhance quality service delivery strategies to reduce health disparities	Health Indicators (Appendix VI) results are comparable across race and ethnicity.

Portion of the Final Driver Diagram

The following diagram is a small portion of the configuration of the completed driver diagram that identifies: project objectives and some primary drivers of each objective; secondary drivers of the safety net referral network primary driver; key activities that support the secondary drivers. For each portion of the diagram additional drivers and activities may be identified and analyzed during refinement of the evaluation plan. This diagram establishes the logical chain between objectives and activities, and is the basis for the development of evaluation questions and outcome metrics to assess those activities.



Hypotheses

Although a review of the final, complete Driver Diagram will refine the hypotheses for this program evaluation, the hypotheses developed at this point are as follows.

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

II. Gateway coverage connects low-income, otherwise uninsured, adults to health care services across a spectrum of medical needs and allows for proper continuity of care, which enhances the patient and provider experience.

III. Patients who have access to affordable outpatient coverage through Gateway will demonstrate quality health outcomes comparable to other insured populations within community health centers or better than uninsured populations in communities similar to St. Louis, as available.

These hypotheses promote the objectives of Title XIX, i.e. Medicaid, by ensuring coverage and access to healthcare services remain available for low-income individuals. Coinciding with the time period of the Demonstration, community health centers led organization-wide outreach efforts to enroll eligible patients into available coverage, including Gateway to Better Health, Medicaid programs and private insurance available through the federal exchange. Additionally, the Gateway program serves as an important coverage bridge for individuals who may be eligible for Medicaid coverage in the State of Missouri. More than 15,000 individuals, who would otherwise be uninsured, have transitioned from Gateway coverage into Missouri Medicaid programs.

Alignment of Research Questions, Hypotheses, and Goals of the Demonstration

The chart below depicts the initial key evaluation questions for the demonstration project, as well as their relationship to the demonstration's objectives and initial hypotheses. The final hypotheses and evaluation questions will be refined based upon the completed Driver Diagram. Their alignment will be a function of the relationships established in the final Driver Diagram.

Table 1. Initial Key Evaluation Questions

Demonstration Objective	Demonstration Hypothesis	Key Evaluation Question
1. Preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured.	By preserving health care services at safety net providers, services will be maintained in the urban core where the greatest health disparities exist, enabling low-income patients to receive preventive, specialty and primary care under the coverage model.	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 health care services at a level provided at the beginning of the demonstration project? Did the types of services available (e.g., nutrition education, lab tests, radiology) in July 2010 remain available throughout the Demonstration project?
2. Connect the uninsured to a primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement.	By preserving health care services at safety net providers, services will be maintained in the urban core where the greatest health disparities exist, enabling low-income patients to receive preventive, specialty and primary care under the coverage model.	How many uninsured patients had a medical home at Gateway primary care organizations each year of the Demonstration project? Did the number and percentage increase from baseline relative to benchmarks?
	Gateway coverage connects low-income, otherwise uninsured, adults to health care services across a spectrum of medical needs and allows for proper continuity of care, which enhances the patient and provider experience.	How did Gateway patients and providers rate overall coordination, quality and delivery of healthcare services and did it improve over time?
3. Maintain and enhance quality service delivery strategies to reduce health disparities.	Patients who have access to affordable outpatient coverage through Gateway will demonstrate quality health outcomes comparable to other insured populations within community health centers or better than uninsured populations in communities similar to St. Louis, as available..	Did health disparity metrics, by race and ethnicity, improve over time? How do health outcomes (as measured by health indicators in Appendix VI) compare to other urban communities in the state and region?
	Gateway coverage connects low-income, otherwise uninsured, adults to health care services across a spectrum of medical needs and allows for proper continuity of care, which enhances the patient and provider experience.	Did providers implement programs that maintained and enhanced quality as well as reduced health disparities?

III. Methodology

Introduction

The evaluation will weave together multiple data sources, including but not limited to UDS reported data, utilization data from organizations participating in the pilot project, pay-for-performance incentive data (see Appendix VII for Incentive Payment Protocol), annual survey data reported to the St. Louis Regional Health Commission, as well as data from patient and physician/medical professional focus groups and surveys. Where available, data from the approval period will be compared to previous years of the demonstration project to show trends and progress over time.

Because this demonstration project includes a pilot program designed to provide a bridge for patients to health care reform, the evaluation will not merely report metrics against objectives. It also will explore some of the contributing factors that led to the pilot program's outcomes, enabling other regions to learn from the experience in St. Louis.

Evaluation Design

In order to monitor and assess process measures associated with objectives one and two, a run chart will be created for each of the individual health centers for selected measures for the 12 months preceding the evaluation period for the interim report and ongoing thereafter. For example analysis will be conducted to assess access and utilization of primary care services, frequency of care coordination, and network size. The average and median of those measures will be calculated across the clinics. The mean and median will be used to detect changes from baseline to follow-up periods on all measures for which baseline data are available, as well as to detect shifts, trends or outliers in the subsequent 12 months.

To evaluate outcomes associated with each of the three hypotheses, annual measures will be compared with both internally generated and national and regional benchmarks from health systems with comparable populations. Performance indicator and consumer survey data that are available from federal and state sources (e.g., state innovation models, CPC programs, and the like), will be used. For example, analysis will identify outliers through the use of standard deviation of the data or pre-established growth percentages.

In order to evaluate the impact of the Demonstration, a comparison group will be identified for the third hypothesis. After conducting a review of available historical information, one of two options will be selected to evaluate impact. In one option, post-only outcome scores on the Health Indicators identified in Appendix VI would be compared between the target group and the comparison group. A second option would be to compare results with national/regional benchmarks.

Target and Comparison Populations

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 track and assess key variables such as utilization

across various levels of care in the patient population and to isolate the outcomes of this program. Furthermore, the "coverage model" provides utilization data and quality metrics for the population enrolled in the Pilot Program, enabling the project team to isolate outcomes to the targeted population. Performance and health indicator outcomes will be compared with averages of other community health centers in the State, as well as outcomes from uninsured populations in comparable communities.

Evaluation Period

For the Interim Evaluation report due to CMS December 31, 2020, the evaluation period will be October 1, 2018 through September 30, 2019 with three month run out of encounter data. The Final Evaluation report that is due Jun 30, 2023, will entail an evaluation period of October 1, 2018 through September 30, 2022, also with a three month run out of encounter data.

Evaluation Measures and Data Sources

The following table outlines measures, data source, analytic method, and comparison groups as applicable based upon the initial Driver Diagram and associated evaluation questions.

Table 2. Demonstration Project Evaluation Design

Evaluation Question	Evaluation Measures	Data Source	Analytical Method	Comparison Population, where applicable
Hypothesis 1: *By preserving health care services at safety net providers, services will be maintained in the urban core where the greatest health disparities exist, enabling low-income patients to receive preventive, specialty and primary care under the coverage model.*				
Were primary health care services maintained in the neighborhoods where they existed at the beginning of the demonstration project (July 2010)?	- Health center locations and hours of operation - Provider revenue data	- Health center websites and validated by health center staff - Gateway claims data by federal fiscal year	- A comparison of measures of target providers with a benchmark using descriptive statistics	N/A
Did St. Louis City and St. Louis County uninsured individuals maintain access to health care services at a level provided at the beginning of the demonstration project?	- Primary care encounters by payor and service line at safety net primary care organizations - Urgent care encounters at Gateway urgent care sites - Specialty care encounters and diagnostic services	- Self-reported from safety net organization electronic health record (EHR) system - Census data and data provided by MO HealthNet	- Percent change over time in number of encounters and number of uninsured and Medicaid individuals in St. Louis	- Comparison across various payor groups served in the St. Louis Region

	provided by safety net providers - Number of uninsured individuals in St. Louis and County - Number of individuals covered by Medicaid in St. Louis and County			
Did the types of services available (e.g., nutrition education, lab tests, radiology) in July 2010 remain available throughout the Demonstration project?	- Services available at Gateway provider organizations	- Health center websites and validated by health center staff	- A comparison of services offered each year at primary care sites	N/A
How many uninsured patients had a medical home at Gateway primary care organizations each year of the Demonstration project? Did the number and percentage increase from baseline relative to benchmarks?	- Number of uninsured primary care patients seen by Gateway provider - Number of new enrollees in the program	- Self-reported from safety net organization EHR system - Automated Health Systems (enrollment vendor)	- Percent change over time in the number of Gateway enrollees by health center	- Trends in uninsured rate over time in the St. Louis region and comparison of uninsured rate to those similar communities
Hypothesis 2: *Gateway coverage connects low-income, otherwise uninsured, adults to health care services across a spectrum of medical needs and allows for proper continuity of care, which enhances the patient and provider experience.*				
How did Gateway patients and providers rate overall coordination, quality and delivery of healthcare services and did it improve over time?	- Patient and provider satisfaction results	- Paper and electronic surveys	- A comparison of results over time	- Trends in satisfaction results over time
Did providers implement new programs with the aim to maintain and enhance quality as well as reduce health disparities?	- Results from the Healthcare Learning Collaborative that Gateway primary care providers are engaged in.	- Alive and Well STL	- Discussion around the trauma informed practices implemented by providers.	N/A
Hypothesis 3: *Patients who have access to affordable outpatient coverage through Gateway will demonstrate quality health outcomes comparable to other insured populations within community health centers or better than uninsured populations in communities similar to St. Louis, as available.*				
How do health outcomes compare to other urban communities in the state and region?	- UDS quality measures (tobacco use and cessation, cervical cancer	- Self-reported by safety net providers using EHR	- A comparison of health outcomes in	- UDS quality measures for Gateway patients compared to

	screening, adult weight screening and follow up, blood pressure and diabetes control) reported by race and age - Wait times at safety net primary care specialty care providers		similar communities using descriptive statistics	overall health center State and national averages in the as reported to HRSA, and as compared to communities similar to St. Louis
Did health disparity metrics, by race and ethnicity, improve over time?	- Pay for performance quality results - Number of enrollees in program by primary care home, zip code, age, gender, race/ethnicity	- Electronic health records - Automated Health Systems (enrollment vendor)	- A comparison of how quality metrics have changed over time	- Trends in pay for performance metrics over time and as compared to standard threshold levels defined in the Incentive Payment Protocol and across race/ethnicity

IV. Methodological Limitations

While every effort is made to ensure the evaluation is conducted in a robust and accurate manner, there are still a number of limitations in the evaluation design. Multiple sources of data are utilized in this evaluation, including electronic health records, self-reported data from health care providers, census data, enrollment and claims data, as well as data from qualitative and quantitative survey tools. The STLRHC takes great effort to validate all data collected, as it relates to the demonstration project. Health care providers are given the opportunity to verify their data for accuracy prior to public release. To help mitigate limitations, the STLRHC also completes an additional verification step by comparing self-reported data to external data sources, such as UDS health center data and data from Azara Data Reporting & Visualization System (DRVS). DRVS is a centralized reporting system for community health centers that pulls data directly from electronic health records. While the STLRHC cannot attest to the complete accuracy of all data reported, these efforts significantly reduce the potential for data collection and reporting errors.

It is important to note that the pilot program has been in place since July 2012 and has been operating successfully and with minimal changes since its inception. The only changes the program has experienced are related to program enhancements, which include adding an additional pharmacy benefit and expanding the provider network. Since 2012, the program has demonstrated its need and success in the St. Louis community. Because of this success, the program has been extended by CMS each year since it was implemented. The Gateway program has become an important bridge for the St. Louis safety net system and is ingrained in the overall healthcare system in the region. Additionally, the program has operated without any administrative changes, budgetary issues or appeals/grievances. The demonstration has met all program milestones and completed all deliverables in a timely manner.

Appendix I
Independent Evaluator

As part of the Standard Terms and Conditions (STCs), as set forth by the Centers for Medicaid and Medicare Services (CMS), the demonstration project is required to hire an independent party to conduct an evaluation of the program and to ensure that the necessary data is collected to research approved hypotheses and evaluation questions. To fulfill this requirement, the STLRHC released a request for proposals (RFP) on August 23, 2017. Proposals were due back to the STLRHC but October 31, 2017. Below is the list of qualifications for the external evaluator, as expressed in the RFP.

Desired Qualifications

- Experience working with federal programs and/or demonstration waivers
- Experience with evaluating effectiveness of complex, multi-partnered programs
- Familiarity with CMS federal standards and policies for program evaluation
- Familiarity with nationally-recognized data sources
- Analytical skills and experience with statistical testing methods

A total of six proposals were submitted to the RHC and were ranked based on the following criteria: cost, experience, evaluation approach, and overall flexibility and culture fit. Based on these criteria, Mercer Government Human Services Consulting was selected as the external evaluator.

Mercer has over 25 years assisting state governments with the design, implementation and evaluation of publicly sponsored health care programs. Mercer currently have over 25 states under contract and have worked with over 35 different states in total. They have assisted states like Arizona, Connecticut, Missouri and New Jersey in performing independent evaluations of their Medicaid programs; many of which include 1115 demonstration waiver evaluation experience. Mercer also has unique knowledge of the State of Missouri given they're experience with the MO HealthNet Division, where they provide annual evaluation reports for the Children's Health Insurance Program (CHIP) and the 1115 demonstration Women's Health program. These evaluations include the collection and analysis of eligibility, enrollment, encounter and financial data and production of year-over-year comparisons. Additionally, they have extensive experience in conducting 1915(b) waiver design and cost effectiveness analyses. In 2010, in cooperation with MO HealthNet staff, the Commission selected Mercer to perform the initial Gateway to Better Health program evaluation. Given their previous work with the Gateway program and their current work the MO HealthNet, the Mercer team is well-equipped to effectively as the external evaluator for the Gateway program. Below is contact information for the lead coordinators from Mercer for the Gateway to Better Health evaluation:

Wendy Woske
Engagement Leader
Wendy.Woske@mercer.com

Heather Huff, MA
Program Manager
Heather.Huff@mercer.com

Michal Anne Pepper, PhD
Lead Evaluator
MichalAnne.Pepper@mercer.com

Wendy S. Woske, RN, MHA

QUALIFICATIONS

Wendy specializes in government-sponsored health. She has extensive experience working with various health care delivery models and waiver programs building sustainable health care delivery systems for vulnerable populations. She is adept at bridging both the technical and clinical world to develop solutions to transform care delivery.

Wendy's true passion is focused in the long term care arena where she has worked with various states including: Connecticut, Delaware, Massachusetts, New Jersey, New York, Ohio and Pennsylvania. Her project work has encompassed implementation of managed long term services and supports programs, development of managed care contract terms, readiness reviews, creation of a single Level of Care assessment system, design of Quality Improvement/Management Strategies, technical support of 1915(c) waiver consolidation, quality metric and performance measure development, provision of clinical support in the development of a risk adjusted rate model for managed long term care actuarial rate setting and state administrative operations assessment for efficiency and effectiveness in overseeing various waiver programs.

EXPERIENCE

Prior to joining Mercer, Wendy, worked as a computer programmer for close to a decade before obtaining her nursing license. Since then, Wendy has held senior-level positions within both managed care and large physician-led organizations focusing on clinical and quality program development, implementation and evaluation. The focus of Wendy's experience has been targeted at utilizing health information technology and process re-engineering to build clinical and quality environments that are sustainable.

Wendy S. Woske, RN, MHA
Principal

EDUCATION

Master's degree, Health Care Administration Seton Hall University

Bachelor's degree, International Relations Mount Holyoke College

Associate's degree, Applied Science – Nursing Morris County Community College

Certified in Computer Programming Chubb Institute of Technology

EXPERIENCE

24 years professional experience

CORE COMPETENCIES

Managed care operations External quality review

Performance measurement to support continuous quality improvement

Long term services and supports for aging and disabled populations

AFFILIATION

Registered Nurse (AZ and NJ – license number available upon request)

Member of the American Medical Informatics Association

Member of the Patient Centered Primary Care Collaborative

Since joining Mercer, Wendy's experience has included:

- Assisting States with the design, implementation and oversight and monitoring of managed long-term service and supports programs. This work includes development of operational protocols to transition care management functions and to ensure continuity of care, design of interfaces to integrate self-directed and Money Follows the Person (MFP) program elements and creation of quality strategies and performance measurement approaches. Most recently Wendy has been working with the State of New Jersey to operationalize the State's value-based purchasing

strategy for its MLTSS program, known as Any Willing Qualified Provider (AWQP).

- Acting as the Engagement Leader for the Delaware External Quality Review (EQR) contract responsible for leading Mercer's team in evaluating the State's Medicaid Managed Care program compliance with Balanced Budget Act requirements for quality, access and timeliness of service delivery, providing technical assistance to health plans on performance measure (PM) development and performance improvement projects (PIPs), performing validation of PMs and PIPs and conducting focused studies.
- Performing audits, readiness reviews, operational analyses and efficiency reviews of Medicaid Managed Care contractors assessing compliance in areas such as: the Center for Medicare & Medicaid Services guidance, federal regulations for Medicaid and Managed Care and State rules and contractual requirements. Most recently this experience was brought to bear for MassHealth as Mercer completed a review of Massachusetts Senior Care Options (SCO) and Aging Services Access Point contractors.
- Developing and maintaining the underlying clinical methodology and coding of Mercer's suite of clinical efficiency analyses used during actuarial rate setting, development of pay-for-performance programs or to assist states with monitoring program efficiency and effectiveness through dashboard reporting. Applied these tools to quantify areas of known inefficiency within the delivery system in areas such as low acuity non-emergent (LANE) Emergency Department utilization, Potentially Preventable Admissions (PPA), various Ambulatory Care Sensitive (ACS) conditions as well as, high cost radiology and durable medical equipment.
- Conducting focused studies and clinical audits to determine fidelity of practice guidelines and compliance with state and federal regulations. Examples of study topics include: Childhood Overweight and Obesity, DME/DMS/Laboratory and Radiology claims analysis and assessment of gaps in care for managed long term care supports and services. Most recently developed a series of reports to assist the New Jersey Division of Aging Services in linking functional assessment data to LTSS service utilization.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Realizing the Value in Value-Based Purchasing of Long Term Services and Supports, facilitated roundtable discussion between CMS, New Jersey Division of Aging Service and Tennessee Division of Long Term Services and Supports
- Medicaid and CHIP Final Rule: Quality, Access and MLTSS, Co-presenter, Mercer National Webinar, August, 2016.
- Building an Overarching Quality Enterprise, Presenter with Lowell Arye, Deputy Commissioner, New Jersey Department of Human Services, National Association on States United for Aging and Disability (NASUAD) National Home and Community Based Services (HCBS) Conference; August, 20015; Washington, DC.
- Readiness Considerations for Integrated LTSS Managed Care Programs: Implementing MLTSS, Ready or Not?, Presenter with Lisa Zimmerman, Deputy Director, Delaware Division of Medicaid and Medical Assistance, NASUAD, National HCBS Conference September, 2013.
- Long Term Services and Supports Care Management Transition Planning moving from Fee-for-Service to Managed Care, Presented with New Jersey Division of Aging Services, State MLTSS Stakeholder Meeting, March 2013

Heather Huff, MA

QUALIFICATIONS

Heather leads clinical quality, clinical efficiency and behavioral health projects for Medicaid/CHIP and long term care (LTC) populations. Heather has led performance based contracting, compliance, quality measurement and management activities for Connecticut, Delaware, District of Columbia, Florida, New Jersey, Oklahoma, Pennsylvania and Texas. Her knowledge of nationally recognized performance measures, accuracy with data analysis, ability to translate data into actionable steps and project management skills result exceptional deliverables for client projects.

EXPERIENCE

Prior to joining Mercer, Heather worked for a health care quality improvement and quality review organization. Heather's responsibilities included:

- Data integrity testing.
- Conducting data analysis.
- Developing and disseminating data files and reports.
- Educating data users and stakeholders on findings and applications.

Heather's current responsibilities at Mercer include:

- Acting as team lead and coordinator for conducting External Quality Review Organization and managed care organization clinical and operational assessment review activities including desk review, onsite interviews, and evaluation. Validating performance measures and performance improvement projects for external quality reviews. Assisting with Information Systems Capabilities Assessments. Heather has led managed care organization review activities in Delaware and Pennsylvania.
- Conducting managed care organization readiness and clinical and operational efficiency reviews to ensure success during new program implementations or current program operations in Delaware, District of Columbia, Kansas, Pennsylvania and New Jersey.
- Designing performance based incentive structures and performance measures, implementing incentive initiatives and evaluating performance measure outcomes for Delaware, District of Columbia, New Jersey and Pennsylvania.
- Interpreting and implementing nationally recognized performance measures such as Healthcare Effectiveness Data and Information Set (HEDIS®), measures endorsed by the National Quality Forum, and Centers for Medicaid and Medicare Services core set of adult and pediatric health care quality measures for Medicaid in Connecticut, Delaware, District of Columbia, New Jersey, New Mexico, and Pennsylvania.

Heather Huff, MA
Senior Associate

EDUCATION
Master's degree, Sociology
University of Akron
Bachelor's degree, Sociology
Mount Vernon Nazarene University

EXPERIENCE
24 years
Professional experience

CORE COMPETENCIES
Performance based contracting
Quality measurement and reporting
Focus study design, data collection, analysis and presentation
External quality review and regulatory compliance
Project management

- Researching and recommending national benchmarks utilizing data sources such as Quality Compass and Substance Abuse and Mental Health Services Administration for Connecticut, Delaware, and Pennsylvania.
- Developing performance measure technical specifications to establish accurate and consistent reporting across contractors in Delaware, District of Columbia, New Mexico and Pennsylvania.
- Analyzing emerging trends in health care data and policy to be certain clients are leveraging current opportunities and adhering to regulations.
- Developing innovative compliance and readiness review tools to accurately measure and report contractor performance.
- Developing quality management strategies to align with the National Quality Strategy and assist with state oversight of Medicaid/CHIP and LTC populations.
- Leading and managing multiple client projects to ensure complete, accurate and on-time deliverables within project budgets.

Michal Anne Pepper, PhD

QUALIFICATIONS

Michal Anne joined Mercer's Clinical and Behavioral Health

Solutions group in June 2013. She brings wide-ranging experience in mental health and substance abuse, including five years working in a national managed care company for commercial and public sector behavioral health plans and twenty years as a service provider across all age groups and treatment modalities. Prior to her managed care experience, she owned and managed an independent psychology practice for 13 years, provided clinical supervision and administrative oversight in a variety of treatment settings, and taught as both Instructor and Visiting Adjunct Professor. Michal Anne has worked on Mercer teams for California, Arizona, New Mexico, Pennsylvania and North Carolina contracts.

EXPERIENCE

Michal Anne's experience with Mercer includes:

- Technical assistance and development of SAMHSA grant application, implementation and outcome evaluation design, and development of a process for clinic certification to assist in state's winning application for Stage Two Certified Community Behavioral Health Clinic (CCBHC) application. Led cross-system team that designed ongoing implementation evaluation using continuous quality improvement principles, and outcomes study of the state-wide initiative.
- Benchmarking and measure development for MN 1115 waiver bonus payments.
- Network and service access analysis for multiple populations/benefits (IDD, Foster Children, MLTSS, BH) in several states.
- Development of quality improvement approaches and tools for multiple states, including the development of a self assessment tool for BH MCOs to use in the assessment of their own quality initiatives as part of a state-wide cost driver project.
- Clinical support to physical health and behavioral health rate setting teams in the development of rates for new services/initiatives. Assisted six states to develop rates for ABA for ASD.
- Participation New York City procurement process, including standards development, readiness tool development and desk reviews for utilization management and medical management.

Michal Anne Pepper, PhD
Senior Associate

EDUCATION

Doctoral degree in psychology
Texas Women's University

Master's degree in psychology
Texas Women's University

Bachelor's degree in psychology/philosophy
Baylor University

EXPERIENCE

36 years professional experience

CORE COMPETENCIES

Research design and program evaluation

Readiness/audit tool development and training

Child, adolescent and adult mental health, substance use disorder, and intellectual/developmental disabilities

Behavioral Health (BH) and Integrated MCO audits

Managed Care BH Quality Initiatives

Data reports

AFFILIATIONS

Member American Psychological Association

- Health plan reviews and BH MCO audits on behalf of government clients to ensure compliance with clinical and performance standards.
- Support to North Carolina's Local Management Entities (LME's) clinical operations as they transitioned from quasi-governmental BH clinics to managed care entities through annual reviews and recommendations.
- State-wide system evaluation of the role of support coordinators for individuals receiving services associated with developmental/neurological disabilities.

Prior to joining Mercer, Michal Anne worked in managed care, providing clinical oversight and project management in the implementation of new/expanded Chip and Medicaid plans in Texas and Hawaii, analyzing utilization management operations with the development of operational processes and utilization data reports, conducting clinical and compliance reviews as well as providing leadership in organizational redevelopment. Michal Anne has also worked as a service provider, supervisor, treatment center administrator, and adjunct professor.

Past experience and accomplishments include:

- Led a cross-disciplinary team for a year-long post-launch review of two Medicaid expansion and CHIP managed care contract implementations, including redesign of workflows, knowledge management and organizational redevelopment to support deliverables.
- Development and leadership of a new MCO's clinical initiative to implement a statewide pain management protocol for Medicaid beneficiaries that incorporated a cross disciplinary team of clinicians from physical health, behavioral health and pharmacy.
- Redesign of clinical operations to support National Committee for Quality Assurance requirements for a managed care organization covering 6.5 M lives that resulted in 100% compliance and Plan accreditation for the maximum allowable number of years.
- Clinical supervision of a 14 member clinical team functioning as "front door" for all Dallas county children and adolescents seeking community BH services.
- Successful author of multiple publications, including books, a book chapter and articles on clinical issues, including recovery/resiliency and the intersection of spirituality and psychology.
- Visiting Professor for the APA approved psychology department at Texas Woman's University as well as ongoing part time instructor positions.

Appendix II
Conflict of Interest

The St. Louis Regional Health Commission has taken steps to ensure that the selected external evaluator does not have any conflicts of interest in completing an impartial evaluation of the Gateway to Better Health program. Mercer is a national company, with contracts for multiple State Medicaid programs and demonstration waivers. Mercer has no vested interest in the State of Missouri, the St. Louis Regional Health Commission or the Gateway to Better Health demonstration wavier. Additionally, Mercer has signed a contract with the SLRHC that includes a "no conflict" clause, as outlined below:

"No Conflict. MERCER currently does not have or has not had a business or other relationship with any entity or individual that (i) could give rise to an economic or ethical conflict, or (ii) could reasonably be determined to impact the independence of MERCER."

Appendix III
Evaluation Budget

GATEWAY TO BETTER HEALTH

Evaluation Budget

2018-2022

	2018	2019	2020	2021	2022	Total
Salaries, Benefits & Taxes						
Total Salaries, Benefts & Taxes	214,570	225,300	236,570	248,390	260,820	1,185,650
Office Expense						
Occupancy	16,600	17,100	17,610	18,140	18,680	88,130
Supplies & Printing	3,000	3,150	3,310	3,480	3,650	16,590
Technology & Equipment	5,000	5,000	5,000	5,000	5,000	25,000
Total Office Expense	24,600	25,250	25,920	26,620	27,330	129,720
Professional fees						
Mercer	125,000	51,000	51,000	51,000	51,000	329,000
MPCA	10,000	10,000	10,000	10,000	10,000	50,000
AHS	150,000	150,000	150,000	150,000	150,000	750,000
Accounting	27,000	28,350	29,770	31,260	32,820	149,200
Total Professional Fees	312,000	239,350	240,770	242,260	243,820	1,278,200
Total Cost	676,170	540,900	554,260	568,270	582,970	2,922,570

Appendix IV
Timeline and Major Milestones

The table below highlights key milestones evaluation milestones and activities for the Gateway program and their timelines for completion.

Milestone	**STC Reference**	**Date**
Procure external vendor for evaluation services	Section XI (#39)	12/1/2017
Submit Amended Evaluation Design	Section XI (#40)	12/30/2017
Finalize Evaluation Design	Section XI, (#41)	4/30/2018
Submit Quarterly Reports	Section IX (#34)	Ongoing – due 60 days at the end of each quarter
Submit Draft Annual Report for DY9 (October 2017 – September 2018)	Section IX (#34/#35)	2/1/2019
Submit Draft Annual Report for DY10 (October 2018 – September 2019)	Section IX (#34/#35)	2/1/2020
Submit Interim Evaluation	Section XI (#47)	12/31/2020
Submit Draft Annual Report for DY11 (October 2019 – September 2020)	Section IX (#34/#35)	2/1/2021
Submit Draft Annual Report for DY12 (October 2020 – September 2021)	Section IX (#34/#35)	2/1/2022
Submit Draft Annual Report for DY13 (October 2021 – September 2022)	Section IX (#34/#35)	2/1/2023
Submit Summative Evaluation Report	Section XI (#48)	6/30/2023
Submit Draft Final Report	Section IX (#34/#35)	9/1/2022

Appendix V
Demonstration Objectives, Baselines and Goals

Appendix V provides baselines and goals for each Demonstration objective. Unless otherwise noted, data is collected by the St. Louis Regional Health Commission by written provider survey on an annual basis. The data is self-reported by each provider organization.

<u>Demonstration Objective I</u>: Preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured.

- Hours of Operation by Site

All Primary and Specialty Care Sites: Hours of Operation

Partner Site	***2011***	***2010***	***2009***
Affinia Healthcare			
North Florissant	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	NA
Lemp	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm
South Broadway	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm	NA	NA
Biddle	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm	M, T, TH, F- 8:30am-5:30pm; W-8:30am-7pm	M,T,TH, F-8:30am-5:30pm; W-8:30am-7pm; Sa-10am-4pm
BJC Behavioral Health	M-F-8:30am-5pm	NA	NA
St. Patrick	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 - 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
Comp I	M, T, Th, F-8am-5pm; W-8am-8pm	NA	NA
Betty Jean Kerr People's Health Centers			
Central	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)	NA	NA
West	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	NA	NA
Forest Park	M, W, Th, F-8am-4:30pm; T-8am-7pm; Sa-9am-2pm	NA	NA

Partner Site	*2011*	*2010*	*2009*
St. Louis County Health Centers			
North Central	M, T, F-8am-5pm; W, Th-8am-9pm	NA	NA
South County	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-4:30pm (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)

Goal will be to maintain or improve hours of operation by site throughout the Demonstration.

- Primary care encounters by payor and by service line for primary care legacy sites and all Gateway primary care provider 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.

Affinia Healthcare: Encounters by Service Line, 2009-2011

Year	*Service Line*	*All Affinia Sites*	*Murphy O'Fallon**	*Soulard Benton**
2011	Primary Medical Care	106,421	32,146	24,110
	Dental	22,261	7,431	6,974
	Mental Health	6,474	4,298	1,489
	Substance Abuse	10,422	0	0
	Enabling Services	13,009	4,553	348
	Other (podiatry and optometry)	4,237	2,151	802
	Total	162,824	50,579	33,723
2010	Primary Medical Care	99,008	28,993	24,158
	Dental	19,967	7,017	6,802
	Mental Health	6,200	4,117	1,103
	Substance Abuse	8,657	0	0
	Enabling Services	11,819	4,106	112
	Other (podiatry and optometry)	3,777	1,721	957
	Total	149,428	45,954	33,132
2009	Primary Medical Care	96,796	27,752	23,657
	Dental	16,273	6,274	5,663
	Mental Health	6,609	4,359	944
	Substance Abuse	7,959	0	0
	Enabling Services	26,087	9,063	5,653
	Other (podiatry and optometry)	3,046	2,693	166
	Total	156,770	50,141	36,083

**Denotes legacy sites of St. Louis Regional Hospital*

Affinia Healthcare: Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***All Affinia Sites***
2011	Uninsured	92,570
	Medicaid	59,156
	Medicare	4,913
	Private Insurance	6,185
	Total	162,824
2010	Uninsured	89,658
	Medicaid	50,805
	Medicare	5,977
	Private Insurance	2,988
	Total	149,428
2009	Uninsured	94,062
	Medicaid	53,302
	Medicare	6,271
	Private Insurance	3,135
	Total	156,770

Myrtle Hilliard Davis Comprehensive Health Centers: Encounters by Service Line, 2009-2011

Year	***Service Line***	***All Myrtle Hilliard Davis Sites***	***Homer G. Philips****	***Florence Hill****
2011	Primary Medical Care	75,204	14,460	14,692
	Dental	22,248	4,983	4,852
	Mental Health	0	0	0
	Substance Abuse	0	0	0
	Enabling Services	2,620	940	661
	Other (podiatry and optometry)	537	41	17
	Total	100,609	20,424	20,222
2010	Primary Medical Care	74,491	14,271	14,555
	Dental	22,033	4,914	4,798
	Mental Health	0	0	0
	Substance Abuse	0	0	0
	Enabling Services	2,544	929	602
	Other (podiatry and optometry)	573	54	2
	Total	99,641	20,168	19,957
2009	Primary Medical Care	77,990	15,852	14,411
	Dental	18,107	3,922	4,220
	Mental Health	0	0	0
	Substance Abuse	0	0	0
	Enabling Services	3,032	968	457
	Other (podiatry and optometry)	428	38	18
	Total	99,557	20,780	19,106

**Denotes legacy sites of St. Louis Regional Hospital*

Myrtle Hilliard Davis Comprehensive Health Centers: Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***All Myrtle Hilliard Davis Sites***
2011	Uninsured	66,076
	Medicaid	22,977
	Medicare	3,700
	Private Insurance	7,856
	Total	100,609
2010	Uninsured	40,853
	Medicaid	31,885
	Medicare	15,943
	Private Insurance	10,960
	Total	99,641
2009	Uninsured	47,848
	Medicaid	36,265
	Medicare	6,757
	Private Insurance	8,687
	Total	99,557

All Other Primary Care Gateway Participants: Encounters by Service Line, 2011

Year	***Service Line***	***BJK People's, All Sites***	***Family Care, All Sites***	***STL County, All Sites***
2011	Primary Medical Care	91,955	50,222	52,562
	Dental	13,843	7,468	8,480
	Mental Health	1,630	4,475	281
	Substance Abuse	0	0	0
	Enabling Services	0	2,483	0
	Other (podiatry and optometry)	12,146	2,043	7,665
	Total	119,574	66,691	68,988

All Other Primary Care Gateway Participants: Encounters by Payor Mix, 2011

Year	***Payor Category***	***BJK People's, All Sites***	***Family Care, All Sites***	***STL County, All Sites***
2011	Uninsured	47,739	24,009	39,553
	Medicaid	54,740	29,344	23,828
	Medicare	4,686	4,668	4,933
	Private Insurance	12,409	8,670	674
	Total	119,574	66,691	68,988

St. Louis ConnectCare: Encounters by Service Line, 2009-2011

Year	***Service Line***	***St. Louis ConnectCare***
2011	Urgent Care	12,716
	Specialty Care	
	Cardiology	2,130
	Dermatology	1,176
	Endocrinology	1,015
	Other	0
	General Surgery	1,621
	Gastroenterology	2,878
	Urology	957
	Infectious Disease	0
	Nephrology	1,606
	Neurology	1,726
	Gynecology (Surgical)	0
	Orthopedics	1,148
	Otolaryngology	1,136
	Pulmonary	554
	Rheumatology	0
	Total Specialty Care Encounters	15,947
	Diagnostic Services	
	Endoscopy	1,132
	Radiology	8,330
	Total Diagnostic Services Encounters	9,462
	STD Clinic Encounters	5,753
	Total	43,878
2010	Urgent Care	13,269
	Specialty Care	
	Cardiology	2,201
	Dermatology	1,122
	Endocrinology	1,130
	Other	35
	General Surgery	11,625
	Gastroenterology	3,585
	Urology	1,043
	Infectious Disease	0
	Nephrology	1,850
	Neurology	1,702
	Gynecology (Surgical)	50
	Orthopedics	1,707
	Otolaryngology	1,202
	Pulmonary	579
	Rheumatology	295
	Total Specialty Care Encounters	18,126
	Diagnostic Services	
	Endoscopy	1,434
	Radiology	10,801
	Total Diagnostic Services Encounters	12,235
	STD Clinic Encounters	5,898

Year	*Service Line*	*St. Louis ConnectCare*
	Total	49,528
2009	Urgent Care	15,502
	Specialty Care	
	Cardiology	2,749
	Dermatology	1,203
	Endocrinology	1,105
	Other	169
	General Surgery	1,923
	Gastroenterology	3,906
	Urology	1,032
	Infectious Disease	0
	Nephrology	1,864
	Neurology	1,690
	Gynecology (Surgical)	633
	Orthopedics	1,933
	Otolaryngology	1,291
	Pulmonary	622
	Rheumatology	1,601
	Total Specialty Care Encounters	21,721
	Diagnostic Services	
	Endoscopy	1,306
	Radiology	8,961
	Total Diagnostic Services Encounters	10,267
	STD Clinic Encounters	6,153
	Total	53,643

St. Louis ConnectCare: Specialty Clinic Encounters by Payor Mix, 2009-2011

Year	*Payor Category*	*St. Louis ConnectCare Specialty Clinics*
2011	Uninsured	9,472
	Medicaid	3,498
	Medicare	2,174
	Private Insurance	803
	Total	15,947
2010	Uninsured	11,248
	Medicaid	3,922
	Medicare	2,500
	Private Insurance	456
	Total	18,126
2009	Uninsured	13,240
	Medicaid	4,724
	Medicare	2,619
	Private Insurance	1,138
	Total	21,721

St. Louis ConnectCare: Urgent Care Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***St. Louis ConnectCare Specialty Clinics***
2011	Uninsured	7,132
	Medicaid	2,981
	Medicare	892
	Private Insurance	1,711
	Total	12,716
2010	Uninsured	7,530
	Medicaid	2,917
	Medicare	1,013
	Private Insurance	1,809
	Total	13,269
2009	Uninsured	9,512
	Medicaid	2,848
	Medicare	1,041
	Private Insurance	2,101
	Total	15,502

St. Louis ConnectCare: Diagnostic Service Care Encounters by Payor Mix, 2009-2011

Year	***Payor Category***	***Diagnostic Service Care***
2011	Uninsured	6,425
	Medicaid	1,649
	Medicare	733
	Private Insurance	655
	Total	9,462
2010	*Uninsured*	*8,375*
	Medicaid	*1,976*
	Medicare	*1,080*
	Private Insurance	*804*
	Total	*12,235*
2009	Uninsured	6,956
	Medicaid	1,557
	Medicare	841
	Private Insurance	913
	Total	10,267

Goal will be to increase uninsured encounters by 2% at Gateway primary care organizations.

- Baseline Services

Services Available at Affinia Healthcare, Myrtle Hilliard Davis and St. Louis ConnectCare, 2009-2011

Affiliation Partner Organization	***2011***	***2010***	***2009***
Affinia Healthcare (formerly known as Grace Hill)	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, 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,	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics,	Urgent care, specialty care (cardiology, dermatology, endocrinology, general surgery, gastroenterology, urology, nephrology, neurology, gynecology (surgical), orthopedics,

Affiliation Partner Organization	*2011*	*2010*	*2009*
	pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.	otolaryngology, pulmonary, rheumatology), diagnostic services (endoscopy and radiology), and STD clinic services.

2011 Services Available at Other Gateway Primary Care Providers

Betty Jean Kerr People's Health Centers	*Family Care Health Centers*	*St. Louis County Health Centers*
Primary medical care, women's health, pediatrics, dental, podiatry, optometry, WIC, enabling services (social services, mental health, substance abuse counseling, HIV/AIDS counseling and testing), outreach (school-linked programs, abstinence education, community health nursing, health education, mobile health services), laboratory/x-ray, and referral for specialty services.	Primary medical care, dental, optometry, behavioral health, nutrition, WIC, pharmacy, laboratory, HIV/AIDS counseling and testing, and referral for specialty services.	Primary medical care, women's health, pediatrics, dental, podiatry, ophthalmology, WIC, health education classes (childbirth and diabetes), immunization clinic, lead screening and treatment services, nutrition counseling, public health nursing, STD testing and counseling, teen care, and referral for specialty services.

Goal will be to maintain or expand current services available at primary care organizations throughout the Demonstration. Benefits offered through the pilot program may impact service offerings at primary care organizations.

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

- Number of patients who are uninsured or covered by Medicaid

Gateway Primary Care Providers: Uninsured and Medicaid Users, 2009-2011

Provider	*Payor Category*	*2011*	*2010*	*2009*
Affinia Healthcare (formerly known as Grace Hill)	Uninsured	26,088	24,886	24,867
	Medicaid	16,885	13,757	13,736
	Total	42,973	38,643	38,603
Myrtle Hilliard Davis Comprehensive Health Centers	Uninsured	11,306	14,460	12,767
	Medicaid	12,109	9,017	9,411
	Total	23,415	23,477	22,178
Betty Jean Kerr People's Health Centers	Uninsured	15,493	Not applicable. Betty Jean Kerr People's Health Centers, Family Care Health Centers, and St. Louis County Health Centers	
	Medicaid	17,765		
	Total	33,258		
Family Care Health Centers	Uninsured	6,825		

	Medicaid	8,342	began receiving funding through the Demonstration in July 2012. Data from 2011 is provided as a baseline.
	Total	15,167	
St. Louis County Department of Health	Uninsured	21,756	
	Medicaid	10,066	
	Total	31,822	

Goal will be to increase uninsured encounters by 2% at Gateway primary care organizations.

<u>Demonstration Objective III:</u> Maintain and enhance quality service delivery strategies to reduce health disparities.

- *(Data Source: UDS reports)*

<u>Diabetes by Race and Hispanic/Latino Identity - All Federally Qualified Health Centers</u>						
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 or equal to 9% at the time of the last reading in the measurement year. Results in four categories.						
Hispanic/Latino	Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c< 7% (3c)	Patients with 7%≤HbA1c<8% (3d)	Patients with 8%≤HbA1c≤9% (3e)	Patients with HbA1c>9% or No Test During Year (3f)
1a. Asian	-	-	-	-	-	-
1b1. Native Hawaiian	-	-	-	-	-	-
1b2. Pacific Islander	4	-	-	-	-	-
1c. Black/African American	6	1	-	-	-	1
1d. American Indian/ Alaska Native	4	2	2	-	-	-
1e. White	50	2	1	-	1	-
1f. More Than One Race	-	-	-	-	-	-
1g. Unreported/Refused to Report Race	145	6	2	1	1	2
Subtotal Hispanic/Latino	209	11	5	1	2	3
Non-Hispanic Latino						
2a. Asian	91	2	1	1	-	-
2b1. Native Hawaiian	-	-	-	-	-	-
2b2. Pacific Islander	14	1	1	-	-	-
2c. Black/African American	5,364	193	78	35	19	61
2d. American Indian/ Alaska Native	10	-	-	-	-	-
2e. White	1,102	69	29	13	10	17
2f. More Than One Race	6	-	-	-	-	-
2g. Unreported/Refused to Report Race	201	-	-	-	-	-
Subtotal Hispanic/Latino	6,788	265	109	49	29	78
Unreported/ Refused to Report Ethnicity						
h. Unreported/Refused to Report Race and Ethnicity	61	4	-	1	1	2
i. Total	7,058	280	114	51	32	83
Percent			41%	18%	11%	30%

2011 Baseline – Percentage of patients with HbA1c less than or equal to nine percent: 70%
2017 Goal: Percentage of patients with HbA1c less than or equal to nine percent: 75%

Hypertension by Race and Hispanic/Latino Identity - All Federally Qualified Health Centers				
Proportion of patients born between January 1, 1927, and December 31, 1993, with diagnosed hypertension whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading				
Hispanic/Latino	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)	% Patients with HTN Controlled
1a. Asian	-	-	-	
1b1. Native Hawaiian	-	-	-	
1b2. Pacific Islander	4	3	2	
1c. Black/African American	21	-	-	
1d. American Indian/ Alaska Native	5	-	-	
1e. White	70	5	3	
1f. More Than One Race	1	-	-	
1g. Unreported/Refused to Report Race	191	183	120	
Subtotal Hispanic/Latino	292	191	125	65%
Non-Hispanic Latino				
2a. Asian	203	63	43	
2b1. Native Hawaiian	-	-	-	
2b2. Pacific Islander	22	10	9	
2c. Black/African American	15,416	5,411	2,725	
2d. American Indian/ Alaska Native	29	24	13	
2e. White	2,684	923	539	
2f. More Than One Race	8	1	1	
2g. Unreported/Refused to Report Race	563	14	6	
Subtotal Hispanic/Latino	18,925	6,446	3,336	52%
Unreported/ Refused to Report Ethnicity				
h. Unreported/Refused to Report Race and Ethnicity	134	134	83	
i. **Total**	19,351	6,637	3,461	52%

2011 Baseline – Percentage of patients with hypertension controlled: 52%
2017 Goal – Percentage of patients with hypertension controlled: 64%

APPENDIX VI
Proposed Health Indicators

The Proposed Health Indicators in this appendix are for evaluation of the Demonstration and general reporting; as such, they are not related to provider incentive payments. Baselines are provided using data from calendar year 2011.

The state will use the Missouri Primary Care Association (MPCA) data warehouse as the data source for the health indicators in this appendix. The health indicators were selected because they are UDS/HITECH measures reported on a standard basis by each Gateway primary care provider.

The metrics will be reported for the population group receiving primary and specialty care through the Demonstration by age, gender and race/ethnicity, as data is available.

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
1. Tobacco Use Assessment & Cessation Intervention[3] Percentage of adults age 18 and older assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy	Number of patients for whom documentation demonstrates that patients were queried about their tobacco use at least once within 24 months of their last visit (during measurement year) about any and all forms of tobacco use AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user	Number of patients who were 18 years of age or older during the measurement year with at least one medical visit during the reporting year, and with at least two medical visits ever, or a statistically valid sample of these patients	NA	TBD	UDS
2. Hypertension: Blood Pressure Control Proportion of patients 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading	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); 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 these patients	59%	64%	UDS

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

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
3. Hypertension: Blood Pressure Measurement Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, or a statistically valid sample of these patients	54%	59%	HITECH Meaningful Use
4. Cervical Cancer Screening Percentage of women 24 to 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 2 calendar years prior to the measurement year among those women included in the denominator; OR, for women who were 30 years of age or older at the time of the test who choose to also have an HPV test performed simultaneously, during the measurement year or during the 4 calendar years prior to the measurement year	Number of all female patients age 24-64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sample of these women	61%	66%	UDS
5. Diabetes: HbA1c Control Proportion of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading in the measurement year. Results are reported in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9% or untested	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 these patients	70%	75%	UDS

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
6. Adult Weight Screening and Follow-Up Percentage of patients aged 18 and over who had documentation of a calculated BMI during the most recent visit or within the 6 months prior to that visit	Number of patients who had their BMI (not just height and weight) documented during their most recent visit or within 6 months of the most recent visit and if the most recent BMI is outside parameters, a follow-up plan is documented	Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, or a statistically valid sample of these patients	19%	24%	UDS
7. Flu Shot for Patients 6 Months of Age and Older Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	The number of patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	All patients aged 6 months and older seen for a visit between October 1 and March 31 of the measurement year	NA	TBD	HITECH Meaningful Use
8. Breast Cancer Screening Percentage of female patients 42 to 69 years of age that received a mammogram to screen for breast cancer	The number of female patients 42-69 years of age who received one or more mammograms during the measurement year or the year prior to the measurement year	Number of all female patients 42-69 years of age as of December 31 of the measurement year or the year prior to the measurement year who had at least one medical visit during the reporting year, or a statistically valid sample of these patients	NA	TBD	HITECH Meaningful Use
9. Chlamydia Screening in Women Ages 21 to 24 Percentage of female patients 21 to 24 years of age that were identified as sexually active and that had at least one test for Chlamydia during the measurement year	The number of female patients 21-24 years of age that have had at least one Chlamydia test during the measurement year	Number of all female patients 21-24 years of age as of December 31 of the measurement year who were dispensed prescription contraceptives or had at least one medical visit during the reporting year, or a statistically valid sample of these patients	NA	TBD	HITECH Meaningful Use

Metric	Numerator	Denominator	Baseline	Goal	Metric Source
10. 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	The number of chronic disease patients that have had two or more office visits within the first 6 months following initial program enrollment or diagnosis during the measurement year	Number of chronic disease patients enrolled in the program during the reporting year	TBD	80%	Pay-for-Performance Reporting
11. Primary Care Follow-Up After Hospitalization 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.	The number of patients contacted by a clinical staff member at the patient's established primary care home within 7 days of hospital discharge	Number of patients whose primary care home was notified of their hospitalization by the gateway Call Center during the reporting year	TBD	50%	Pay-for-Performance Reporting

APPENDIX VII
Incentive Payment Protocol

Incentive Payments

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

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

Reporting Periods:

- July 1, 2012 – December 31, 2012
- January 1, 2013 – June 30, 2013
- July 1, 2013 – December 31, 2013
- January 1, 2014 – June 30, 2014
- July 1, 2014 – December 31, 2015
- January 1, 2016 – June 30, 2016
- July 1, 2016 – December 31, 2016
- January 1, 2017 – June 30, 2017
- July 1, 2017 – December 31, 2017
- January 1, 2018 – June 30, 2018
- July 1, 2018 – December 31, 2018
- January 1, 2019 – June 30, 2019
- July 1, 2019 – December 31, 2019
- January 1, 2020 – June 30, 2020
- July 1, 2020 – December 31, 2020
- January 1, 2021 – June 30, 2021
- July 1, 2021 – December 31, 2021
- January 1, 2022 – June 30, 2022
- July 1, 2022 – December 31, 2022

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

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

TABLE 1

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

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

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

TABLE 2

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

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

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

Primary Care Health Center (PCHC) Calculations:

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

- IP = PCHC Payments Earned x 7%

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

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

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

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

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

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

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

- PS = RPCIF x (CMM/TMM)

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

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

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

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

- RPCIFP = PS x IPW

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

SCENARIO 1

Key assumptions:

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

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

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

Remaining Primary Care Incentive Funds

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

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

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

Step 6

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

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

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

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

SCENARIO 2

Key assumptions:

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

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

STEP 3

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

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

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

Step 6

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

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

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

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

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