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August 31, 2018

Timothy Hill
Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop S2-26-12
Baltimore, MD 21244

Dear Mr. Hill:

Please see the attached request to amend the Gateway to Better Health Section 1115 demonstration to authorize coverage of office visits and generic prescriptions for substance use treatment. In addition to adding a substance use disorder benefit, the State seeks to amend the Demonstration to expressly clarify that it is not required to seek rebates from manufacturers for drugs covered through Gateway. As we explain in more detail in the attached request, adding a substance use treatment benefit to the Demonstration's benefit package would reduce barriers for patients in accessing these interventions, which are critical to reducing health disparities and to reducing preventable emergency department visits and hospitalizations.

This amendment request complies with the requirements in Paragraphs 7 and 14 in the demonstration's Special Terms and Conditions.

Please feel free to contact Tony Brite at (573) 751-1092, if you have any questions about this amendment request.

Sincerely,

[redacted]

Jennifer Tidball
Acting Director
MO HealthNet Division

Attachment
cc: James Scott
Felix Milburn

Gateway to Better Health Demonstration

Amendment Request

August 31, 2018

Number: 11-W-00250/7

Background

On July 28, 2010, CMS approved the State of Missouri's "Gateway to Better Health" Demonstration, which preserves access to ambulatory care for low-income, uninsured individuals in St. Louis City and County. CMS approved a one-year extension of the Demonstration on September 27, 2013; July 16, 2014; December 11, 2015; and again on June 16, 2016. On September 2, 2017, CMS approved a five-year extension of the current Demonstration, which began on January 1, 2018. The State has been authorized to spend up to $30 million (total computable) annually to preserve and improve primary care and specialty care in St. Louis in lieu of spending that amount of statutorily authorized funding on payments to disproportionate share hospitals (DSHs).

The Demonstration includes the following main objectives:

I. Preserve 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, from July 28, 2010, through June 30, 2012, certain providers referred to as Affiliation Partners were paid directly for uncompensated care. These providers included St. Louis ConnectCare, Grace Hill Health Centers (now known as Affinia Healthcare), and Myrtle Hilliard Davis Comprehensive Health Centers (now known as CareSTL Health).

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

From July 1, 2012, to December 31, 2013, the Demonstration provided primary, urgent, and specialty care coverage to uninsured adults in St. Louis City and St. Louis County, aged 19-64, who were below 133% of the Federal Poverty Level (FPL), as well as specialty care coverage to the same population up to 200% of the FPL.

Starting on September 27, 2013, when CMS first approved a one-year extension of the Demonstration, eligibility requirements changed to cover uninsured adults in the St. Louis City and County, aged 19-64 who were below *100%* of the FPL. The eligibility population remained the same in all subsequent extensions.

The Demonstration delivers services to this population via a network that includes St. Louis County and its public health department, area Federally Qualified Health Centers (FQHCs), and area hospitals and medical schools.

Amendment Description

New Substance Use Disorder Services

This amendment proposes to authorize the State to cover office visits and generic prescriptions for substance use treatment, specifically for the disorders listed in Table 1. Currently, the Demonstration covers tobacco cessation counseling provided at the primary care centers, but no other substance use treatments (drugs or interventions) are covered. All pharmaceuticals covered by the Demonstration, including the additional drugs for substance use treatment, would continue to be dispensed by patients' primary care homes and covered through the alternative payment methodology used to reimburse community health centers for medical and dental services and pharmaceuticals.

Prior to this amendment, some patients enrolled in Gateway have had access to substance use treatment through avenues outside of the demonstration, such as through their health centers' sliding fee scales; pharmaceutical manufacturers' Prescription Assistance Programs (PAPs); and community-based behavioral health safety net providers. By covering the generic drugs listed below in Table 2 and services listed in Table 3, patients would be able to receive treatment at their health center without any further administrative requirement and at a lower cost than the sliding fee scale.

There is a clear need for this benefit. Annually, on average between 2005 and 2010, 9.5 percent or 219,000 people aged 12 or older in the St. Louis MSA were classified as having a substance use disorder in the past year. In the entire state of Missouri, this metric was estimated to be 8.9 percent of the population or approximately 433,000 individuals (SAMHSA 2012). According to the Missouri Department of Mental Health, in 2008, the average cost to treat a substance-addicted individual was $1,346, compared to a $17,300 cost to society not to treat the individual. The substance use disorder treatment benefit would, therefore, be of great value to the St. Louis City and County by expanding access to treatment services and reducing overall costs to society.

Furthermore, substance use treatment is directly related to the Demonstration's evaluation and incentive measures, which are designed to improve the health of the uninsured and underinsured population in the St. Louis region.

This amendment request is being made after significant consultation with the program's providers, patients and other community stakeholders, who indicated that substance use treatment is a top priority for the Gateway patient population. After consulting with these stakeholders, it was determined that adding a substance use treatment benefit to the Demonstration's benefit package would reduce barriers for patients in accessing these interventions, which are critical to reducing health disparities and to reducing preventable emergency department visits and hospitalizations.

In addition, for the reasons explained in the "Financial Analysis" section below, the State also seeks to amend the waiver to decrease the enrollment cap to 16,000.

Table 1: Diagnosis Codes (First Three Digits)

ICD10 Code10 Code	Description
F10	Alcohol related disorders
F11	Opioid related disorders
F12	Cannabis related disorders
F13	Sedative, hypnotic, or anxiolytic related disorders
F14	Cocaine related disorders
F15	Other stimulant related disorders
F16	Hallucinogen related disorders
F17	Nicotine dependence
F18	Inhalant related disorders

Table 2: Generic Drugs Included (but not limited to)

Drug
Baclofen
Buprenorphine HCl
Buproban
Bupropion HCL, Bupropion HCL SR , Bupropion Xl
Desipramine HCL
Disulfiram
Gabapentin
Mirtazapine
Naltrexone HCL
Paroxetine CR, Paroxetine ER, Paroxetine HCL
Topiramate

Table 3: CPT and HCPC Procedure Codes

Code	Description
3016F	Patient screened for unhealthy alcohol use using a systematic screening method
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90837	Psychotherapy, 60 minutes with patient
90839	Psychotherapy for crisis; first 60 minutes
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying

	or supportive psychotherapy); 30 minutes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report
96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
96151	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; reassessment
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Annual depression screening, 15 minutes
H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0004	Behavioral health counseling and therapy, per 15 minutes
H0005	Alcohol and/or drug services; group counseling by a clinician
H0006	Alcohol and/or drug services; case management
H0024	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0046	Mental health services, not otherwise specified
H0048	Alcohol and/or other drug testing: collection and handling only, specimens other than blood
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour

H2019	Therapeutic behavioral services, per 15 minutes
H2021	Community-based wrap-around services, per 15 minutes
H2036	Alcohol and/or other drug treatment program, per diem
S9480	Intensive outpatient psychiatric services, per diem
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem
T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification

Drug Manufacturer Rebates

In addition to adding a substance use disorder benefit, the State seeks to amend the Demonstration to expressly clarify that it is not required to seek rebates from manufacturers for drugs covered through Gateway.

The Gateway Demonstration operates under a waiver of Section 1902(a)(10)(B) permitting it to offer benefits that differ from the benefits offered under the state plan. The Gateway benefit package is limited to primary care, certain specialty care, and pharmacy benefits restricted to "generics provided through the [participating] community health centers and brand name insulin and inhalers that are not available in a generic alternative." *See* STC 26. In part because of the limited nature of Gateway's prescription drug benefit, Gateway has never been required to adhere to the provisions of Section 1927, which requires Medicaid coverage of any drug for which a manufacturer has entered into a rebate agreement.

It has been the State's understanding that the provisions of Section 1927, including the requirement to seek rebates, do not apply to Gateway, because Gateway does not cover the full scope of prescription drugs required under Section 1927, and because Gateway is funded through a demonstration and the requirement to pursue rebates applies only for drugs "for which payment was made under the [state] plan". *See* SSA § 1927(b)(2)(A). However, recently, the Missouri state auditor questioned whether the State is required to pursue rebates for the drugs reimbursed through the Gateway demonstration, both for the limited drugs dispensed as outpatient drugs and for physician-administered drugs that may be part of a specialty service.

It would be challenging for the State to claim rebates on the physician-administered drugs covered by the Demonstration, as Gateway reimburses both participating community health centers and specialty providers at the Medicare rate, *see* STC 17, 18. Medicare does not pay a drug rebate and the Gateway claims processing system is not set up to require the National Drug Code numbers that would allow the Department to claim rebates. Moreover, reprogramming the system to be able to claim rebates would not be cost-effective, given: the small size of the Gateway program; the limited benefit package available to Gateway enrollees; the fact that most covered drugs are generics (and thus qualify for a lower rebate amount than innovator drugs); and the fact that four of the five health community clinics that participate in Gateway also participate in the 340B program, and thus any drugs dispensed through them would be covered by the organized health care exemption in Section 1927(j).

Therefore, the State requests that the Demonstration be amended to expressly specify that the rebate requirements of Section 1927 do not apply to the limited prescription drugs provided to Gateway enrollees. We do not believe this requires any change to the waivers or expenditure authorities, but can

be clarified by a sentence to STCs 17 and 18 expressly confirming that the State is not required to pursue rebates.

Financial Analysis of the Amendment

New Substance Use Disorder Services

With an anticipated implementation date of January 1, 2019, the five community health centers in the Gateway to Better Health network would receive an estimated additional $13.11 per member per month (PMPM) to cover office visits and generic prescriptions for substance use treatment in 2019. The non-federal share of these additional Demonstration expenditures would come from appropriations from St. Louis County, which recently announced additional funding for substance use disorder services.

The Wakely Consulting Group was engaged to determine the PMPM rate, and to estimate the financial impact of the amendment over the course of the demonstration. Wakely Consulting's estimates are shown in Table 4:

Table 4: Cost Projection and Covered Members Estimated 2019-2022 (Any Diagnosis)

Services	2019	2020	2021	2022
Clinic capitation PMPM	$61.41	$63.87	$66.42	$69.08
Transportation PMPM	$1.30	$1.30	$1.30	$1.30
FFS PMPM	$49.33	$51.05	$52.84	$54.69
Substance Use PMPM	$6.14	$6.54	$6.97	$7.44
Total PMPM	**$118.18**	**$122.76**	**$127.53**	**$132.51**
Proposed Enrollment Cap	16,000	16,000	16,000	16,000
Projected Expenditures	$22,690,560	$23,569,229	$24,485,963	$25,441,516

The program would remain budget neutral with the implementation of this amendment. See Appendix I for a complete analysis of budget neutrality with the amendment and without the amendment.

The Demonstration has an enrollment cap of 21,432, but program membership has averaged 14,892 over the past year, and current enrollment is approximately 14,300. To bring the cap closer to the Demonstration's historic enrollment and to ensure there is sufficient funding to cover all Demonstration benefits, including the new substance use disorder services, the State proposes to lower the enrollment cap to 16,000, effective January 1, 2019.

Drug Manufacturer Rebates

There will not be any financial impact caused by amending the waiver to clarify that the State need not pursue rebates from manufacturers for drugs purchased through the Gateway Demonstration. As

explained above, the State has never sought rebates for these drug purchases.

Public Input

The request for this amendment is a result of the public process by which the Commission manages the Demonstration in partnership with the State of Missouri. The SLRHC's Community and Provider Services Advisory Boards indicated that substance use treatment is a top priority for the Gateway patient population. Coverage of services and medications for substance use disorder treatment would enhance the ability of Gateway to Better Health to continue to secure high-quality, low-cost care for uninsured, low-income individuals.

The State and the SLRHC solicited input from the public about this proposed amendment in compliance with paragraphs 7 and 14 of the Demonstration's Special Terms and Conditions.

On July 31, 2018, the State posted a notice on its website in the State's administrative record in accordance with the State's Administrative Procedure Act. The notice included a summary description of the demonstration, the location and times of the two public hearings, and an active link to the full public notice document. On July 31, 2018, the State also made the full public notice document available on the State's website at https://dss.mo.gov/mhd/waivers/1115-demonstration-waivers/gateway-to-better-health.htm and made a draft of the Gateway to Better Health Waiver amendment available on the State's public website at http://dss.mo.gov/mhd/. In addition, for the duration of the comment period, interested individuals were able to make appointments to view a hard copy of the draft of the extension application, by calling 314-446-6454, ext. 1032. Appointments could be made during regular business hours, 8:00 a.m. - 4:30 p.m., Monday through Friday. Review of the hard copy, if requested, would occur at 1113 Mississippi Avenue, St. Louis, MO 63104.

Comments were accepted until August 30, 2018, and at the following address:

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

The Commission also sent an e-mail to its list serve to announce the amendment and notify stakeholders of the public hearings. The e-mail attached the public notice document and the draft waiver amendment.

Public hearings were held at the following dates and locations (with telephone conference capabilities made available for individuals wishing to participate by phone):

Tuesday, August 7, 2018, 7:30 – 8:30 am
Ethical Society of St. Louis
9001 Clayton Road, St. Louis, MO 63117

Wednesday, August 8, 2018, 3:30 - 4:30 pm
Forest Park Visitor and Education Center
Voyagers Room
5595 Grand Drive St. Louis, MO 63112

The meeting on August 7, 2018, was the regularly-scheduled Provider Services Advisory Board meeting, which was open to the public and designated as a public forum for providers and community members to provide input on the amendment request. 20 people attended this meeting, and expressed sentiments of satisfaction that we are considering adding a substance use benefit. Some of the comments made included:

"Do it." (Multiple people repeated this statement.)

"It will save lives."

One person attended the public hearing on August 8, 2018. No public comments were made.

In addition, prior to the opening of the formal public comment process, on June 19, 2018, a post-award public hearing was held pursuant to 42 C.F.R. § 431.420(c), during which the potential substance use treatment benefit was discussed. This meeting was held as part of the regularly scheduled Community Advisory Board of the St. Louis Regional Health Commission. 33 people attended the meeting. Attendees received information on the number of people served and the number of services and visits provided by Gateway. The current membership of the program, including the distribution of chronic conditions and a demographic profile of Gateway members, was also presented. An overview of patient and provider satisfaction feedback as well as results from quality metrics were reviewed. The audience was given an opportunity to provide feedback on the program's success to date as well as provide feedback about the proposed amendment.

Impact on Evaluation Design

The current Evaluation Design requires tracking a number of quality measures that could be impacted by the implementation of this amendment. These measures include but are not limited to the following metrics:

- Available primary care services – number and type of primary care services endorsed by Gateway providers in primary care services
- Barrier to healthcare self-report – percentage of enrollees who report barriers to healthcare without Gateway program
- Barrier to healthcare provider report – percentage of providers who report enrollee barriers to healthcare without Gateway program
- Medical service line utilization – average number of office visits per Gateway enrollee
- Wellness self-report – percentage of providers who report improved Gateway enrollee health
- Tobacco use and assessment and cessation intervention – percentage of Gateway enrollees assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy

Additionally, to measure the impact of this benefit, the following annual measures will be added to the Evaluation Design:

- Number of encounters with substance use as the primary or secondary diagnosis
- Number of users with substance use as the primary or secondary diagnosis
- Number of covered drugs (see Table 2) prescribed to treat substance use
- Percent of patients prescribed a medication for alcohol use disorder (AUD)
- Percent of patients prescribed a medication for opioid use disorder (OUD)

An updated evaluation design has been included in Appendix II.

Appendix I: Budget Neutrality Analysis

Budget Neutrality *without* Amendment: *Budget neutrality projections are through the end of calendar year 2022, the projected end of the Gateway to Better Health Demonstration, unless the Missouri legislature approves Medicaid expansion prior.*

	DY 1 FFY 2010	DY 2 FFY 2011	DY 3 FFY 2012	DY 4 FFY 2013	DY 5 FFY 2014	DY 6 FFY 2015	DY 7 FFY 2016	DY 8 FFY 2017	DY 9 FFY 2018	DY 10 FFY 2019	DY 11 FFY 2020	DY 12 FFY 2021	DY 13 FFY 2022	DY 14 FFY 2023	Total to Date
	07/28/2010 - 09/30/2010	10/01/2010 - 09/30/2011	10/01/2011- 9/30/2012	10/01/2012- 09/30/2013	10/01/2013- 9/30/2014	10/01/2014- 09/30/15	10/01/2015- 9/30/2016	10/01/2016- 9/30/2017	10/01/2017- 09/30/2018	10/01/2018- 09/30/2019	10/01/2019- 09/30/2020	10/01/2020- 09/30/2021	10/01/2021- 09/30/2022	10/01/2022- 12/31/2022	07/28/2010 to 12/31/2022
No. of months in DY	3 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	3 months	
No. of months of direct payments to facilities	3 months	12 months	9 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	
No. of months of Pilot Program (will be implemented on 07/01/2012)	0 months	0 months	3 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	3 months	
Without Waiver Projections															
Estimated DSH Allotment**	$189,681,265	$748,599,611	*$766,126,399*	*$811,102,775*	$814,509,721	*$809,021,633*	*$812,093,381*	$812,093,381	$801,292,456	$801,292,456	$801,292,456	$801,292,456	$801,292,456	$801,292,456	**$10,570,982,902**
Without Waiver Total	**$189,681,265**	**$748,599,611**	**$766,126,399**	**$811,102,775**	**$814,509,721**	**$809,021,633**	**$812,093,381**	**$812,093,381**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	$10,570,982,902
With Waiver Projections															
Residual DSH	$167,785,998	$679,083,062	*$675,602,811*	*$735,329,474*	*$713,152,789*	*$714,046,801*	*$787,095,768*	*$788,949,862*	*$775,218,847*	*$776,582,281*	*$776,506,582*	*$776,498,438*	*$776,490,611*	*$795,039,779*	$9,937,383,103
St. Louis ConnectCare	$4,850,000	$18,150,000	$14,879,909	*$3,148,648*	$118,489	$0	$0	$0	$0	$0	$0	$0	$0	$0	$41,147,045
Grace Hill Neighborhood Health Centers	$1,462,500	$5,850,000	*$5,071,706*	*$5,016,507*	*$6,073,656*	$5,648,970	*$4,805,114*	*$4,669,864*	*$4,755,256*	*$5,023,422*	*$5,126,156*	*$5,138,589*	*$5,150,673*	*$1,301,212*	$65,093,625
Myrtle Davis Comprehensive Health Centers	$937,500	$3,750,000	*$3,097,841*	*$2,108,161*	*$1,838,040*	$2,157,443	*$2,098,142*	*$2,099,527*	*$1,977,021*	*$2,087,619*	*$2,074,873*	*$2,079,905*	*$2,084,796*	*$526,681*	$28,917,549
Contingency Provider Network	$0	$0	*$379,372*	*$4,254,902*	*$5,469,199*	$3,937,955	*$5,035,278*	*$4,771,728*	*$4,941,245*	*$5,197,319*	*$5,004,105*	*$5,016,242*	*$5,028,038*	*$1,329,390*	$50,364,775
Voucher	$0	$0	$0	*$4,541,262*	*$6,358,786*	$6,926,811	*$6,649,760*	*$5,433,044*	*$7,449,620*	*$8,650,208*	*$8,829,134*	*$8,807,676*	*$8,786,732*	*$2,157,492*	$74,590,526
Infrastructure	$0	$0	$975,000	*$1,925,000*	*$0*	$0	$0	$0	$0						$2,900,000
SLRHC Administrative Costs	$75,000	$300,000	$300,000	*$300,000*	*$75,000*	*$0*	*$0*	*$0*	*$0*						$1,050,000
SLRHC Administrative Costs Coverage Model			$584,155	*$4,328,950*	*$3,692,463*	$3,098,002	*$3,477,955*	*$3,377,953*	*$3,784,373*	*$3,751,606*	*$3,751,606*	*$3,751,606*	*$3,751,606*	*$937,902*	$38,288,177
CRC Program Administrative Costs	$91,684	$700,000	$700,000	*$700,000*	*$175,000*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	$2,366,684
Actual expenditures for DY3 DOS				$2,670,607	*$33,308*	*$0*	*-$83*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	$2,703,832
Actual expenditures for DY4 DOS				$0	*$2,540,653*	*$6,559*	*$229*	*-$325*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	$2,547,116
Actual expenditures for DY5 DOS						*$2,402,336*	*$267,821*	*-$11,644*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	$2,658,513
Actual expenditures for DY6 DOS							*$2,663,397*	*-$2,117*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	$2,661,279
Actual expenditures for DY7 DOS								*$2,805,489*	*$30,062*	*$0*	*$0*	*$0*	*$0*	*$0*	$2,835,552
Actual expenditures for DY8 DOS									$2,908,203	*$0*	*$0*	*$0*	*$0*	*$0*	$2,908,203
Projected expenditures for DY7 DOS									*$292,072*	*$0*	*$0*	*$0*	*$0*	*$0*	$292,072
Projected expenditures for DY8 DOS									*-$64,244*	*$0*	*$0*	*$0*	*$0*	*$0*	-$64,244
Total With Waiver Expenditures	**$175,202,682**	**$707,833,062**	**$701,590,793**	**$764,323,513**	**$739,527,383**	**$738,224,877**	**$812,093,381**	**$812,093,381**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$10,258,643,809**
Amount under (over) the annual waiver cap	$14,478,583	$40,766,549	$64,535,605	$46,779,262	$74,982,338	$70,796,756	$0	$0	$0	$0					$312,339,093
Annual expenditure by DY Payment Date as reported on CMS 64s (Demo expenses NOT including residual DSH)			$25,987,982	$28,994,039	$26,374,594	$24,178,076	$24,997,613	$23,143,519	$26,073,609	$24,710,175	$24 785,874	$24,794,018	$24,801,845	$6,252,677	
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$7,416,684	$28,750,000	$28,691,897	#REF!	$26,470,790	$24,430,460	$25,163,811	$20,287,872	$22,907,515	$24,710,175	$24 785,874	$24,794,018	$24,801,845	$6,252,677	

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

**FFY 2012 through FY 2014 DSH allotments have not been finalized. FFY 2012 through FFY 2015 DSH allotments are based on actual CMS-64 reported expenditures. DSH allotment is shown as (total computable) above. For reference, DSH allotment in Federal share is shown below:

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Total Allotment (Federal share)	$489,453,536

Note: FFY 2010 FMAP for MO = 64.51%; FFY 2011 FMAP for MO = 63.29%; FFY 2013 FMAP = 61.37%. FFY 2014 FMAP = 62.03%; FFY 2015 FMAP= 63.45%; FFY 2016 FMAP=63.26%; FFY 2017 FMAP=63.21%; FFY 2018 FMAP=64.61%; FFY 2019 FMAP=65.40%

Budget Neutrality *with* Amendment: *Budget neutrality projections are through the end of calendar year 2022, the projected end of the Gateway to Better Health Demonstration, unless the Missouri legislature approves Medicaid expansion prior.*

	DY 1 FFY 2010 07/28/2010 - 09/30/2010	DY 2 FFY 2011 10/01/2010 - 09/30/2011	DY 3 FFY 2012 10/01/2011- 9/30/2012	DY 4 FFY 2013 10/01/2012- 09/30/2013	DY 5 FFY 2014 10/01/2013- 9/30/2014	DY 6 FFY 2015 10/01/2014- 09/30/15	DY 7 FFY 2016 10/01/2015- 9/30/2016	DY 8 FFY 2017 10/01/2016- 9/30/2017	DY 9 FFY 2018 10/01/2017- 09/30/2018	DY 10 FFY 2019 10/01/2018- 09/30/2019	DY 11 FFY 2020 10/01/2019- 09/30/2020	DY 12 FFY 2021 10/01/2020- 09/30/2021	DY 13 FFY 2022 10/01/2021- 09/30/2022	DY 14 FFY 2023 10/01/2022- 12/31/2022	Total to Date 07/28/2010 to 12/31/2022
No. of months in DY	3 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	3 months	
No. of months of direct payments to facilities	3 months	12 months	9 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	0 months	
No. of months of Pilot Program (will be implemented on 07/01/2012)	0 months	0 months	3 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	3 months	
Without Waiver Projections															
Estimated DSH Allotment**	$189,681,265	$748,599,611	*$766,126,399*	*$811,102,775*	$814,509,721	*$809,021,633*	*$812,093,381*	$812,093,381	$801,292,456	$801,292,456	$801,292,456	$801,292,456	$801,292,456	$801,292,456	**$10,570,982,902**
Without Waiver Total	**$189,681,265**	**$748,599,611**	**$766,126,399**	**$811,102,775**	**$814,509,721**	**$809,021,633**	**$812,093,381**	**$812,093,381**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	$10,570,982,902
With Waiver Projections															
Residual DSH	$167,785,998	$679,083,062	*$675,602,811*	*$735,329,474*	*$713,152,789*	*$714,046,801*	*$787,095,768*	*$788,949,862*	*$775,218,847*	*$775,827,073*	*$775,943,894*	*$775,944,700*	*$775,944,909*	*$794,955,569*	$9,934,881,556
St. Louis ConnectCare	$4,850,000	$18,150,000	$14,879,909	*$3,148,648*	$118,489	$0	$0	$0	$0	$0	$0	$0	$0	$0	$41,147,045
Grace Hill Neighborhood Health Centers	$1,462,500	$5,850,000	*$5,071,706*	*$5,016,507*	*$6,073,656*	$5,648,970	*$4,805,114*	*$4,669,864*	*$4,755,256*	*$5,280,353*	*$5,200,843*	*$5,202,746*	*$5,204,849*	*$1,301,212*	$65,543,576
Myrtle Davis Comprehensive Health Centers	$937,500	$3,750,000	*$3,097,641*	*$2,108,161*	*$1,838,040*	$2,157,443	*$2,098,142*	*$2,099,527*	*$1,977,021*	*$2,137,286*	*$2,105,103*	*$2,105,873*	*$2,106,724*	*$526,681*	$29,045,342
Contingency Provider Network	$0	$0	*$379,372*	*$4,254,902*	*$5,469,199*	$3,937,955	*$5,035,278*	*$4,771,728*	*$4,941,245*	*$5,417,524*	*$5,331,119*	*$5,324,469*	*$5,318,315*	*$1,329,579*	$51,510,687
Voucher	$0	$0	$0	*$4,541,262*	*$6,358,786*	$6,926,811	*$6,649,760*	*$5,433,044*	*$7,449,620*	*$8,647,196*	*$8,651,331*	*$8,654,503*	*$8,657,494*	*$2,164,373*	$74,134,181
Infrastructure	$0	$0	$975,000	*$1,925,000*	*$0*	$0	$0	$0	$0						$2,900,000
SLRHC Administrative Costs	$75,000	$300,000	$300,000	*$300,000*	*$75,000*	$0	$0	$0	$0						$1,050,000
SLRHC Administrative Costs Coverage Model			$584,155	*$4,328,950*	*$3,692,463*	$3,098,002	*$3,477,955*	$3,377,953	$3,784,373	$3,983,025	*$4,060,165*	*$4,060,165*	*$4,060,165*	*$1,015,041*	$39,522,413
CRC Program Administrative Costs	$91,684	$700,000	$700,000	*$700,000*	*$175,000*	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,366,684
Actual expenditures for DY3 DOS				$2,670,607	*$33,308*	$0	-$83	$0	$0	$0	$0	$0	$0	$0	$2,703,832
Actual expenditures for DY4 DOS				$0	*$2,540,653*	$6,559	$229	-$325	$0	$0	$0	$0	$0	$0	$2,547,116
Actual expenditures for DY5 DOS						*$2,402,336*	*$267,821*	-$11,644	$0	$0	$0	$0	$0	$0	$2,658,513
Actual expenditures for DY6 DOS							*$2,663,397*	-$2,117	$0	$0	$0	$0	$0	$0	$2,661,279
Actual expenditures for DY7 DOS								$2,805,489	$29,977	$0	$0	$0	$0	$0	$2,835,466
Actual expenditures for DY8 DOS									$2,875,745	$0	$0	$0	$0	$0	$2,875,745
Projected expenditures for DY7 DOS									$292,158	$0	$0	$0	$0	$0	$292,158
Projected expenditures for DY8 DOS									-$31,786	$0	$0	$0	$0	$0	-$31,786
Total With Waiver Expenditures	**$175,202,682**	**$707,833,062**	**$701,590,793**	**$764,323,513**	**$739,527,383**	**$738,224,877**	**$812,093,381**	**$812,093,381**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$801,292,456**	**$10,258,643,809**
Amount under (over) the annual waiver cap	$14,478,583	$40,766,549	$64,535,605	$46,779,262	$74,982,338	$70,796,756	$0	$0	$0	$0					$312,339,093
Annual expenditure by DY Payment Date as reported on CMS 64s (Demo expenses NOT including residual DSH)			$25,987,982	$28,994,039	$26,374,594	$24,178,076	$24,997,613	$23,143,519	$26,073,609	$25,465,383	$25,348,562	$25,347,756	$25,347,547	$6,336,887	
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$7,416,684	$28,750,000	$28,691,897	#REF!	$26,470,790	$24,430,460	$25,163,896	$20,320,330	$22,907,515	$25,465,383	$25,348,562	$25,347,756	$25,347,547	$6,336,887	

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

**FFY 2012 through FY 2014 DSH allotments have not been finalized. FFY 2012 through FFY 2015 DSH allotments are based on actual CMS-64 reported expenditures. DSH allotment is shown as (total computable) above. For reference, DSH allotment in Federal share is shown below:

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State of Missouri

Gateway to Better Health Demonstration

Number 11-W-00250/7

Amended Evaluation Design

August 31, 2018

Table of Contents

I. General Background Information

A. Program History and Overview

The closure of the last public hospital in St. Louis in 2001 jeopardized the viability of the St. Louis healthcare safety net that provided healthcare services to uninsured and under insured individuals. The St. Louis Regional Health Commission (SLRHC) was formed and charged with developing strategies to improve the sustainability of the St. Louis healthcare safety net and improve health care access and delivery to this population in St. Louis. Over the next few years, an area of emerging concern was how to provide healthcare services for uninsured adults until a longer term solution could be formulated.

In partnership with the State of Missouri, the SLRHC reviewed options and elected to address the issue with an 1115 demonstration called "Gateway to Better Health" (Gateway). Approved on July 28, 2010, by the Centers for Medicare and Medicaid Services (CMS), the Gateway demonstration provides a bridge to sustainable health care for safety net providers and their uninsured patients in the St. Louis City and St. Louis County until coverage options are available through federal health reform. The 1115 demonstration waiver authorizes outpatient care services for uninsured adults in the St. Louis area.

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 designed to support these efforts while preparing patients and safety net provider organizations for an effective transition to coverage that will be available under health care reform.

Gateway provides up to $30 million annually in funding for primary and specialty care, as well as other outpatient services. It preserves access to primary and specialty healthcare services for approximately 22,000 low-income, uninsured individuals in St. Louis City and County. Enrollees select a primary care home from five community health centers that coordinate additional outpatient care with covered specialists.

The demonstration was amended in June 2012 to enable the Safety Net Pilot Program to be implemented by July 1, 2012. In August 2018, the State of Missouri, Department of Social Services, is requesting authority to further amend the Gateway program to include a substance use treatment benefit with an implementation date of January 1, 2019. The proposed benefit covers outpatient substance use services, including pharmacotherapy, for Substance Use Disorder (SUD) treatment of Gateway enrollees with a primary or secondary diagnosis of ICD-10 Codes F10-F18. All office visits and pharmaceuticals are to be provided by the primary care home and is considered a core primary care service.

CMS approved one-year extensions of the demonstration on September 27, 2013, July 16, 2014, December 11, 2015, and June 16, 2016. On September 2,2017, a five-year extension of the current demonstration (Number: 11-W-00250/7) was approved that began on January 1,

2018. This program evaluation is designed to assess this demonstration extension, using 2017 as a baseline year for all measures except those associated with SUD treatment. The baseline year for measures associated with SUD treatment is 2019. Other than the implementation of SUD treatment as a core primary care service, no additional demonstration program changes are planned during the approval period.

B. Population Impacted

The demonstration targets uninsured adults, aged 19 to 64, in St. Louis City and St. Louis County who are served by the health care safety net in St. Louis. To be considered "uninsured," applicants must not be eligible for coverage through the State Medicaid Plan. Screening for Medicaid eligibility is the first step of the Gateway eligibility determination.

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), CareSTL Health (formerly known as Myrtle Hilliard Davis Comprehensive Health Centers) and the St. Louis County Department of Public Health. These community health centers are the primary care Gateway providers.

II. Evaluation Questions and Hypothesis

A. Targets for Improvement

Three demonstration objectives have provided the foundation for the design of the Gateway Program since its inception.

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.

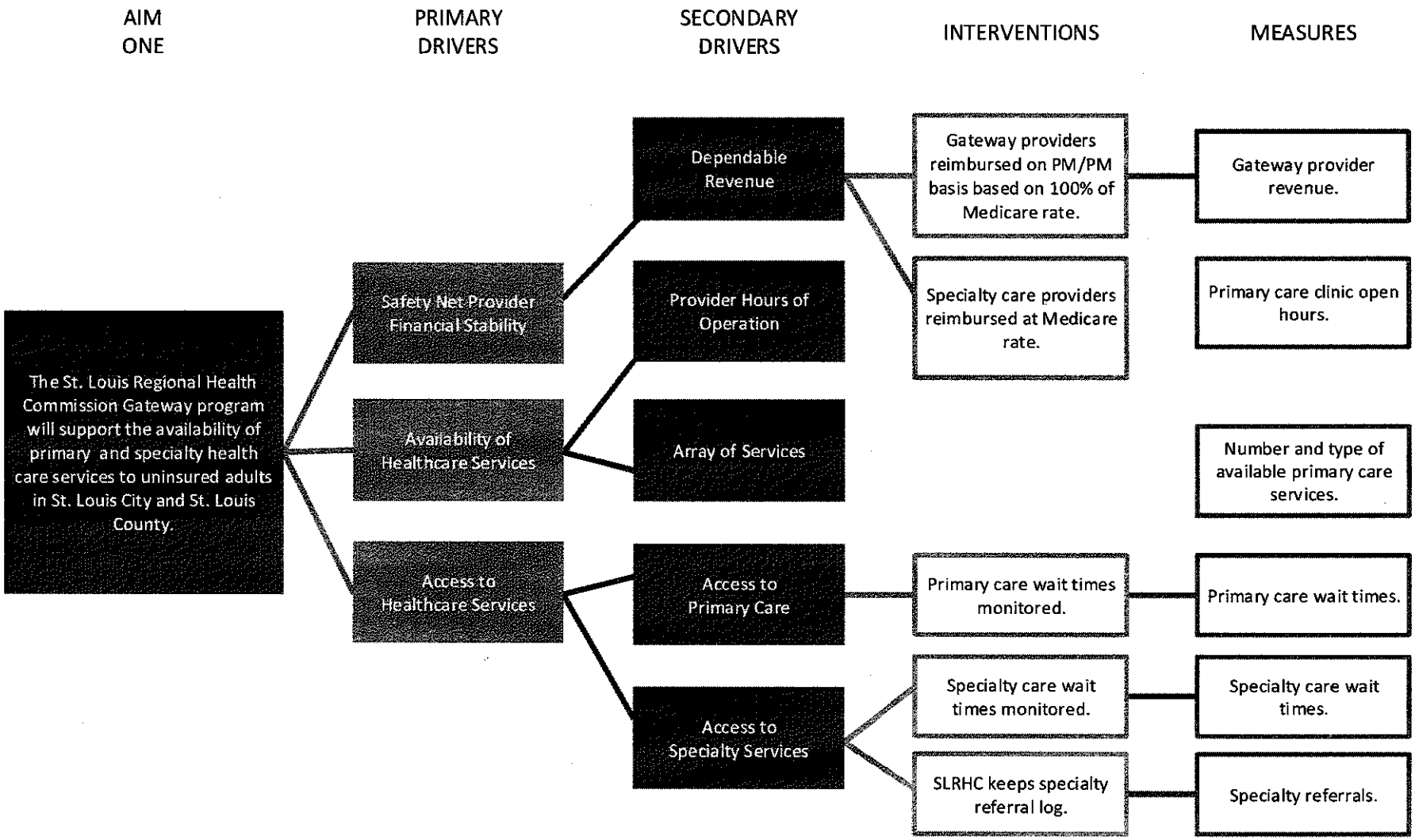
Each of these objectives is translated into quantifiable targets for improvement so that the performance of the demonstration in relation to these targets can be measured. These targets for improvement are used to create the aims in the Driver Diagram and to support the hypotheses in the program evaluation design. The primary focus of the first objective is the support of outpatient services to uninsured adults. The focus of the second objective is maintaining or increasing primary care utilization levels. And the primary focus of the last objective is healthcare quality. The corresponding improvement target for each of the demonstration objectives is identified in the following table.

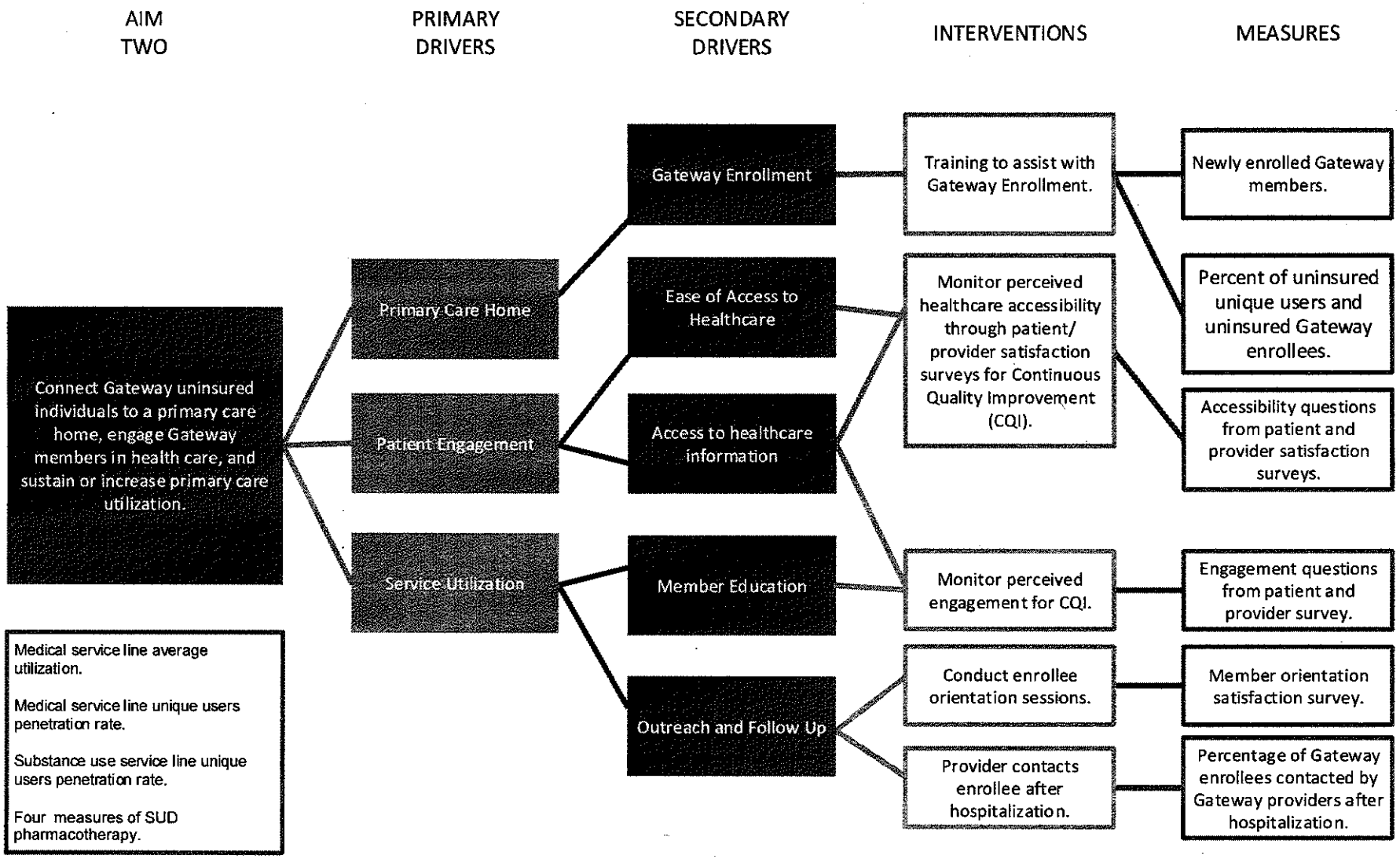
Table A. Program Objectives Translated into Quantifiable Targets for Improvement

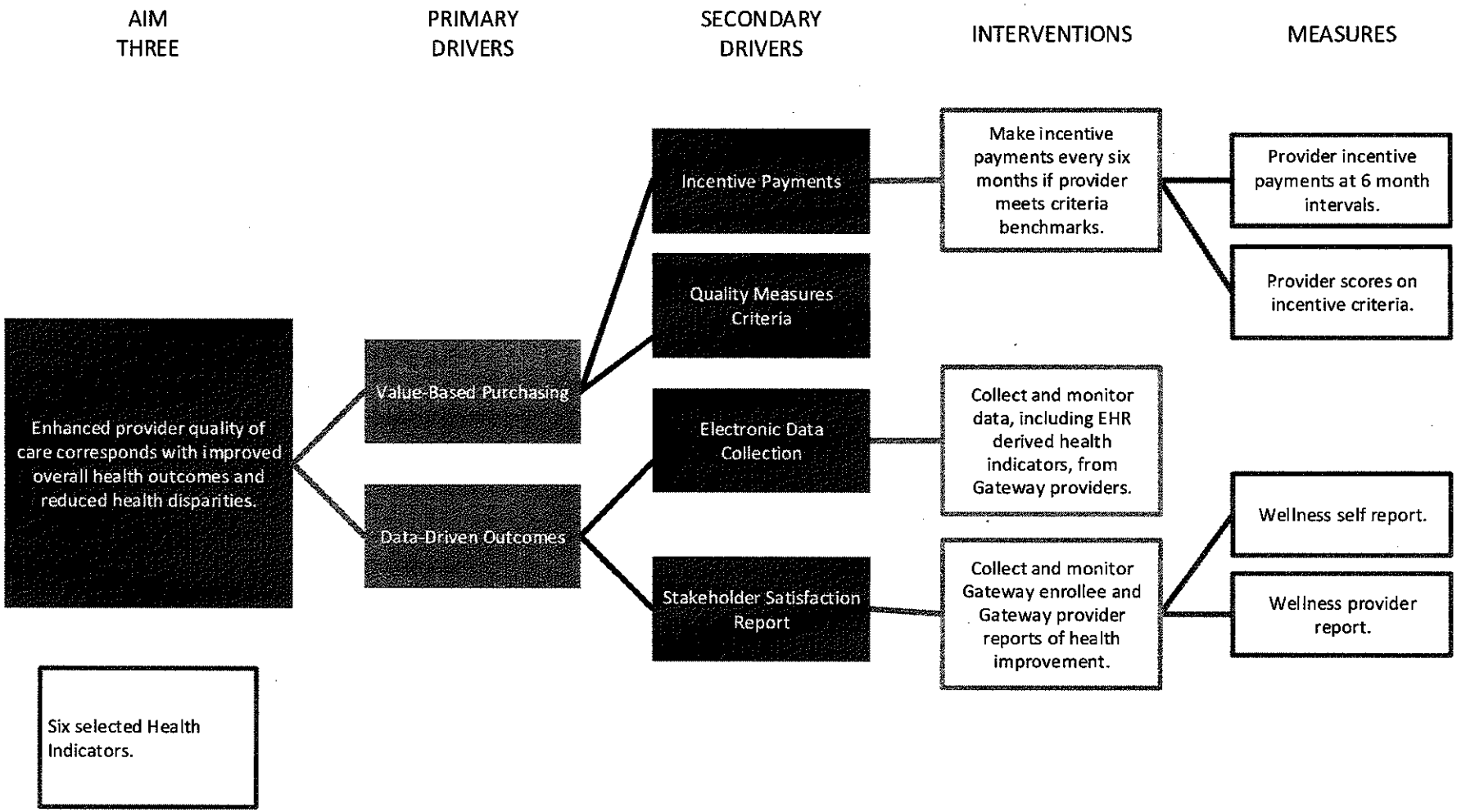
GATEWAY OBJECTIVES	TARGET FOR IMPROVEMENT
I. Preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured.	I. The Gateway program will support the availability of primary and specialty health care services to uninsured adults in St. Louis City and St. Louis County.
II. Connect the uninsured to primary care home which will enhance coordination, quality and efficiency of health care through patient and provider involvement.	II. Connect Gateway uninsured individuals to a primary care home, engage Gateway members in health care and sustain or increase primary care utilization and engagement.
III. Maintain and enhance quality service delivery strategies to reduce health disparities.	III. Enhanced provider quality of care corresponds with improved overall health outcomes and reduced health disparities.

B. Driver Diagram

The demonstration's underlying theory of desired change is modeled in the following Driver Diagram. Each of the three targets for improvement constitutes one of the three aims. The diagram models the relationship between the three aims and drivers presumed to support the aims. Specific interventions, identified in the orange boxes, which have been used throughout the demonstration, are postulated to impact the various drivers. Process project measures associated with the interventions are identified in the blue boxes on the right. Outcome measures, utilized in Aims 2 and 3, are also in blue boxes and are positioned under the Aim. While SLRHC historically has tracked numerous measures, only those measures that help to answer the research questions and inform the hypotheses are used in the evaluation design.


AIM ONE
PRIMARY DRIVERS
SECONDARY DRIVERS
INTERVENTIONS
MEASURES
The St. Louis Regional Health Commission Gateway program will support the availability of primary and specialty health care services to uninsured adults in St. Louis City and St. Louis County.
Safety Net Provider Financial Stability
Availability of Healthcare Services
Access to Healthcare Services
Dependable Revenue
Provider Hours of Operation
Array of Services
Access to Primary Care
Access to Specialty Services
Gateway providers reimbursed on PM/PM basis based on 100% of Medicare rate.
Specialty care providers reimbursed at Medicare rate.
Primary care wait times monitored.
Specialty care wait times monitored.
SLRHC keeps specialty referral log.
Gateway provider revenue.
Primary care clinic open hours.
Number and type of available primary care services.
Primary care wait times.
Specialty care wait times.
Specialty referrals.


AIM TWO
PRIMARY DRIVERS
SECONDARY DRIVERS
INTERVENTIONS
MEASURES
Connect Gateway uninsured individuals to a primary care home, engage Gateway members in health care, and sustain or increase primary care utilization.
Primary Care Home
Patient Engagement
Service Utilization
Gateway Enrollment
Ease of Access to Healthcare
Access to healthcare information
Member Education
Outreach and Follow Up
Training to assist with Gateway Enrollment.
Monitor perceived healthcare accessibility through patient/ provider satisfaction surveys for Continuous Quality Improvement (CQI).
Monitor perceived engagement for CQI.
Conduct enrollee orientation sessions.
Provider contacts enrollee after hospitalization.
Newly enrolled Gateway members.
Percent of uninsured unique users and uninsured Gateway enrollees.
Accessibility questions from patient and provider satisfaction surveys.
Engagement questions from patient and provider survey.
Member orientation satisfaction survey.
Percentage of Gateway enrollees contacted by Gateway providers after hospitalization.
Medical service line average utilization.
Medical service line unique users penetration rate.
Substance use service line unique users penetration rate.
Four measures of SUD pharmacotherapy.


AIM THREE
PRIMARY DRIVERS
SECONDARY DRIVERS
INTERVENTIONS
MEASURES
Enhanced provider quality of care corresponds with improved overall health outcomes and reduced health disparities.
Six selected Health Indicators.
Value-Based Purchasing
Data-Driven Outcomes
Incentive Payments
Quality Measures Criteria
Electronic Data Collection
Stakeholder Satisfaction Report
Make incentive payments every six months if provider meets criteria benchmarks.
Collect and monitor data, including EHR derived health indicators, from Gateway providers.
Collect and monitor Gateway enrollee and Gateway provider reports of health improvement.
Provider incentive payments at 6 month intervals.
Provider scores on incentive criteria.
Wellness self report.
Wellness provider report.

C. Hypotheses, Research questions and Demonstration Objectives

As noted in Table B (Summary Program Evaluation Table), demonstration goals I, II and III are supported by hypotheses and research questions as noted in the following paragraphs.

Hypothesis 1: The SLRHC Gateway project supports the availability of primary and specialty health care services to uninsured adults in St. Louis City and St. Louis County.

1. Does the coverage approach to provider reimbursement and incentive payments provide a stable revenue stream?
2. What variance, if any, exists in primary care provider availability and primary care service array across the evaluation period?
3. What variance, if any, exists in access to primary care across the evaluation period?

Hypothesis 1 identifies specific characteristics associated with demonstration objective I (preserve and strengthen the St. Louis City and St. Louis County safety net of health care providers available to serve the uninsured). A requisite condition for supporting the availability and accessibility of healthcare services for uninsured individuals is stable revenue that supports provider operations. Research question 1 demonstrates the extent to which the Gateway program provides ongoing revenue for the safety net providers in the Gateway program. Questions 2 and 3 demonstrate variability in access and availability of healthcare services. This hypothesis and its questions provides the SLRHC the opportunity to monitor core process measures (revenue, access and availability of healthcare) associated with the Gateway program.

Hypothesis 2: Connecting and engaging uninsured individuals to a Gateway primary care home corresponds with sustained or increased primary care utilization.

1. Have uninsured adults in St. Louis City and St. Louis County connected to a primary care home?
2. Has Gateway enrollment reduced the perception of barriers to primary and specialty care for enrollees and providers?
3. Have Gateway members been engaged by their primary care home with member education, outreach and follow-up?
4. Do Gateway enrollees connected to a primary care home demonstrate sustained or increased utilization of medical services year to year?
5. Do Gateway enrollees connected to a primary care home demonstrate sustained or increased utilization of substance use treatment services year to year?

Hypothesis 2 examines the outcomes of a core component of the Gateway program, the enrollment of uninsured individuals in a primary care home. The presumptive consequence of an increase in Gateway member engagement and the perceived removal of barriers to healthcare is an increase in primary care utilization. Question 1 evaluates Gateway program enrollment. Questions 2 and 3 consider the perception of barriers to healthcare, and research Questions 4 and 5 assesses primary care utilization. This hypothesis and associated research questions allow SLRHC to assess, over time, primary care utilization for Gateway enrollees.

Hypothesis 3: Enhanced provider quality of care corresponds with improved overall health outcomes and reduced health disparities.

1. Does using value-based purchasing for provider reimbursement correspond with providers meeting incentive criteria on health and quality of care indicators?
2. Do Gateway members have perceived improved health outcomes?
3. Do Gateway members have improved health outcomes year over year?
4. Do health indicators, when calculated separately for African American, Caucasian and Hispanic Gateway enrollees exhibit statistically significant differences?

Hypothesis 3 examines another important component of the Gateway program, the improvement in provider quality and its relationship with improved health outcomes and reduced health disparities. Research question 1 examines the relationship of incentive payments and health indicator criteria. Questions 2 and 3 assess the change, and the perception of improvement, of health outcomes across time. Research question 4 evaluates health disparities on health indicators between African American, Caucasian and Hispanic Gateway enrollees.

Hypotheses/research questions promote Title XIX objective

A core objective of the Medicaid program is to serve the health and wellness needs of our nation's vulnerable and low-income individuals and families. The Gateway program promotes this core objective by providing access to primary and specialty care to a population of low-income individuals who would not otherwise have access to health care. The Gateway program serves as an important bridge for individuals who may be eligible for Medicaid coverage in the State of Missouri. More than 33,000 individuals, who would otherwise be uninsured, have transitioned from Gateway coverage into Missouri Medicaid programs since the demonstration project's inception.

The hypotheses and research questions used to evaluate the performance of the Gateway program also support this core objective with their focus on the evaluation of the impact of connecting uninsured, low income individuals to a primary care home, improving healthcare utilization in this population, improving health outcome measures and decreasing health disparities in health indicators for this low-income adult population.

III. Methodology

A. Evaluation Design

The program evaluation design encompasses an integrated process and outcome evaluation of the Gateway demonstration performance utilizing the three hypotheses associated with the demonstration's three objectives. The focus of the evaluation is to monitor and evaluate change over time to determine if the Gateway program continues to support safety net providers, provide healthcare to the uninsured and produce desired healthcare outcomes.

The *process evaluation* utilizes systemic measures of the safety net health care provider system, which allows ongoing monitoring of the demonstration's operations. These measures consist of a short series of aggregated data such as the number of primary care clinic business hours measured annually from 2017 to 2021. By representing these measures visually in a descriptive time series, any changes in these measures can be readily noted, allowing an opportunity for needed programmatic changes.

The *outcome evaluation* utilizes disaggregated enrollee level data in addition to provider and enrollee summative data. Enrollee level of data allows for an analysis to determine any statistically significant differences over time in rates or counts. The analytic approach used in the outcome evaluation controls for differences in patient characteristics such as gender, race and age.

This study design does not include an impact evaluation due data availability constraints discussed in the Methodological Limitations section.

B. Target and Comparison Populations

The target population for Hypothesis 1 consists of the five Gateway providers. Four of the five providers are Federally Qualified Health Centers: Affinia Healthcare, Betty Jean Kerr People's Health Center, Family Care Health Centers and CareSTL Health. The fifth Gateway provider is the St. Louis County Department of Public Health. Each of the providers has the following number of clinic locations, all of which may be accessed by Gateway enrollees.

Table B. Number of Gateway Provider Clinic Locations

PROVIDER	NUMBER OF CLINIC LOCATIONS
Affinia Healthcare	6
Betty Jean Kerr People's Health Centers	4
Family Care Health Centers	2
CareSTL Health	4
St. Louis County Department of Public Health	3
Total number of clinic locations	**19**

The target population for Hypotheses 2 and 3 consists of all adults enrolled in the Gateway program. Hypothesis 3 also includes one research question in which the target population is the providers. To qualify for inclusion in the Gateway program and in the Gateway program evaluation, participants must be between 19 and 64 years of age, ineligible for MO HealthNet (Medicaid) or Medicare, have no other insurance, live in St. Louis City or County and have an income at or below 100% of the federal poverty level ($12,060 per year for an adult living alone or $24,600 per year for a family of four).

Because data from the entire population of Gateway enrollees will be used in the analyses, no sampling plan is required. The evaluation design does not include a comparison group.[1]

C. Evaluation Period

The evaluation period is January 1, 2017 through December 31, 2022. The analysis will allow for a three month run out of encounter data for the encounter-based measures. Results across this time period will be included in the final evaluation report due to CMS on June 30, 2024.

Interim results derived from a portion of this evaluation period, January 1, 2017 through December 31, 2020 (with a three month run out of encounter data) will be reported in the Interim Evaluation report due to CMS on December 31, 2021.

Because the SUD treatment benefit will not be implemented until January 1, 2019, the evaluation period for this treatment will begin on the implementation date of the benefit, and continue through the end dates noted in the preceding paragraphs.

D. Evaluation Measures and Data Sources

Primary and specialty care information specific to Gateway enrollees is collected from Gateway providers and their Electronic Health Records (EHR) as well as an encounter claims data. Measures for the program evaluation are derived from data from the following sources:

- **Gateway Provider Survey Data** is collected annually from Gateway primary care providers and specialty care providers. The data is submitted on excel templates and includes information for clinic enrollees. Templates used to collect data can be found in Attachment E. Gateway Provider Survey Templates.
- **Quarterly Gateway Provider Wait Time Reports** are submitted by Gateway providers with data pertaining to Gateway enrollees.
- **Gateway Claims Data** is submitted by Gateway providers for payment for services provided to Gateway enrollees and compiled by the Gateway Program.
- **EHRs** are the sources of data associated with health indicators which is collected annually by a SLRHC vendor and used to calculate Gateway-specific health quality measures.
- **Automated Health Systems (AHS)** is the enrollment vendor that extracts data from the provider portal pertaining to enrollment and specialty care referrals.

[1] See discussion in the Methodological Limitations section

- **Uniform Data System (UDS)** is data collected from FQHCs by the Health Resources and Services Administration (HRSA).
- **Provider and Enrollee Surveys** are two different surveys requesting information from providers and enrollees pertaining to their experience with the Gateway program. Copies of the surveys may be found in Attachment F. Enrollee Satisfaction Survey and Attachment G. Provider Satisfaction Survey. The Enrollee Satisfaction Survey uses a sample of convenience and is collected over a three month period from May through July of each year. Gateway enrollees are asked to complete a survey after their clinic visit at each of the five primary care health centers. The Provider Satisfaction survey uses a convenience sample of Gateway medical providers and support staff involved in the referral process at the five primary care health centers. During the month of May, an email with a link is sent to the survey population, inviting them to take an online survey.
- **American Community Survey of the United States (US) Census** is the source for the total number of uninsured individuals in the city and county of St. Louis.

The following table identifies proposed evaluation measures, their descriptions, sources and steward (if applicable). A table of measures with detailed measure specifications, including numerator and denominator information, can be found in Attachment F. Measure Specifications.

Table C. Evaluation Measures[2]

MEASURE	MEASURE DESCRIPTION	DATA SOURCE	STEWARD
Gateway provider revenue	Annual gross receipts for Gateway enrollees	Gateway Program	NA
Primary care clinic business hours/week	Number of hours clinic is open during normal business hours (8:00 a.m. – 5:00 p.m. Monday-Friday).	Gateway Program	NA
Primary care clinic non business hours/week	Number of hours clinic is open outside of normal business hours.	Gateway Program	NA
Total primary clinic hours/week	Total clinic business hours and primary clinic non business hours.	Gateway Program	NA
Available primary care services	Number and type of primary care services endorsed by Gateway providers on primary care services.	Gateway Program	NA
Primary care non-urgent wait times new patients	Number of days until third next non-urgent appointment for new patients.	Provider Report	NA
Primary care non-urgent wait times established patients	Number of days until third next non-urgent appointment for established patients.	Provider Report	NA

[2] Measures are presented in the order that aligns with the hypotheses as presented in Table E. Summary Program Evaluation Table

MEASURE	MEASURE DESCRIPTION	DATA SOURCE	STEWARD
Primary care urgent wait times new patients	Number of days until next urgent appointment [3] for new patients.	Provider Report	NA
Primary care urgent wait times established patients	Number of days until next urgent appointment for established patients.	Provider Report	NA
Specialty care wait times for patients	Number of days until third next non-urgent appointment for patients.	Quarterly Wait Time Report	NA
Specialty care referrals	Number of specialty care referrals made by Gateway providers.	Provider Report	NA
Number of uninsured adults newly enrolled in Gateway	Monthly total number of uninsured adults enrolled in the Gateway program.	AHS	NA
Percent uninsured unique users.	Percentage of uninsured adults in St. Louis city and county receiving primary care services through Gateway program.	Provider Survey Data/ US Census	NA
Percent uninsured adults enrolled in Gateway.	Percentage of uninsured adults in St. Louis city and county who are enrolled in the Gateway program.	Gateway Program/ US Census	NA
Barrier to healthcare self-report	Percentage of enrollees who report barriers to healthcare without Gateway program.	Enrollee Satisfaction	NA
Barrier to healthcare provider report	Percentage of providers who report enrollee barriers to healthcare without Gateway program.	Provider Satisfaction	NA
Engagement self-report	Percentage of Gateway enrollees who report timely information and help from their provider.	Enrollee Satisfaction	NA
Newly enrolled office visit	Percentage of Gateway newly enrolled members who have an office visit.	Provider Report	NA
Medical service line average utilization	Average number of office visits per medical service line unique user.	Provider Survey Data/ Gateway Program	NA
Medical service line unique users penetration	Percentage of Gateway enrollees who receive services in the medical service line.	Provider Survey Data/ Gateway Program	NA
Substance use service	Percentage of Gateway enrollees who receives	Provider	NA

[3] Gateway providers are required to reserve a portion of open appointments for urgent patients.

MEASURE	MEASURE DESCRIPTION	DATA SOURCE	STEWARD
line unique users penetration	services in the substance use service line.	Survey Data/ Gateway Program	
Alcohol withdrawal medication management	Percentage enrollees with an Alcohol Use Disorder (AUD) diagnosis who receive medication for withdrawal symptoms.	Provider Survey Data	NA
Opioid withdrawal medication management	Percentage enrollees with an Opioid Use Disorder (OUD) diagnosis who receive medication for withdrawal symptoms.	Provider Survey Data	NA
AUD medication maintenance	Percentage enrollees with an Alcohol Use Disorder (AUD) diagnosis who receive maintenance medication.	Provider Survey Data	NA
OUD medication maintenance	Percentage enrollees with an Opioid Use Disorder (OUD) diagnosis who receives maintenance medication.	Provider Survey Data	NA
Primary care provider incentive payments	Bi-annual dollar amount paid as incentive payments.	Gateway Program	NA
P4P incentive criteria scores	Percentage of Pay-For-Performance (P4P) criteria benchmarks[4] met.	Gateway Program	NA
Wellness self-report	Percentage of Gateway enrollees who report improved health.	Enrollee Satisfaction	NA
Wellness provider report	Percentage of providers who report improved Gateway enrollee health.	Provider Satisfaction	NA
Tobacco use assessment and cessation intervention	Percentage of Gateway enrollees assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy.	EHR Data/ Gateway Program	AMA[5]
Hypertension: blood pressure control	Percentage of Gateway enrollees with diagnosed HTN whose blood pressure was less than 140/90 (adequate control).	EHR Data/ Gateway Program	NCQA[6] CMS165
Diabetes: HbA1c Control	Percentage of Gateway enrollees diagnosed with Diabetes whose HbA1c level during the measurement year is less than or equal to 9%.	EHR Data/ Gateway Program	NCQA CMS122
Adult Weight Screening and Follow-Up	Percentage of Gateway enrollees seen for a visit who had a Body Mass Index (BMI) taken during the most recent visit or within the 6 months prior to that visit.	EHR Data/ Gateway Program	CMS CMS69

[4] Criteria and Benchmarks found in Attachment I. Pay for Performance Criteria and Benchmarks; formula for determining P4P incentive criteria score can be found in Attachment B.
[5] AMA-convened Physician Consortium for Performance Improvement
[6] National Council of Quality Assurance

MEASURE	MEASURE DESCRIPTION	DATA SOURCE	STEWARD
Flu Shot for Adult Patients	Percentage of Gateway enrollees seen for a visit between October 1 and March 31 who receive flu shot or who reported receipt of flu shot.	EHR Data/ Gateway Program	NCQA
Use of Appropriate Medications for Asthma	Percentage of Gateway enrollees who were identified as having persistent asthma and were appropriately ordered medication during the measurement period.	EHR Data/ Gateway Program	CMS CMS126

E. Analytic Methods

Two complementary analytic approaches will be utilized for the evaluation, a) descriptive time series graphs that provide a visual representation of changes in measures over time, and b) regression based analysis that separates the effect of enrollee demographic characteristic variation from other sources of variability across time.

Descriptive Time Series.

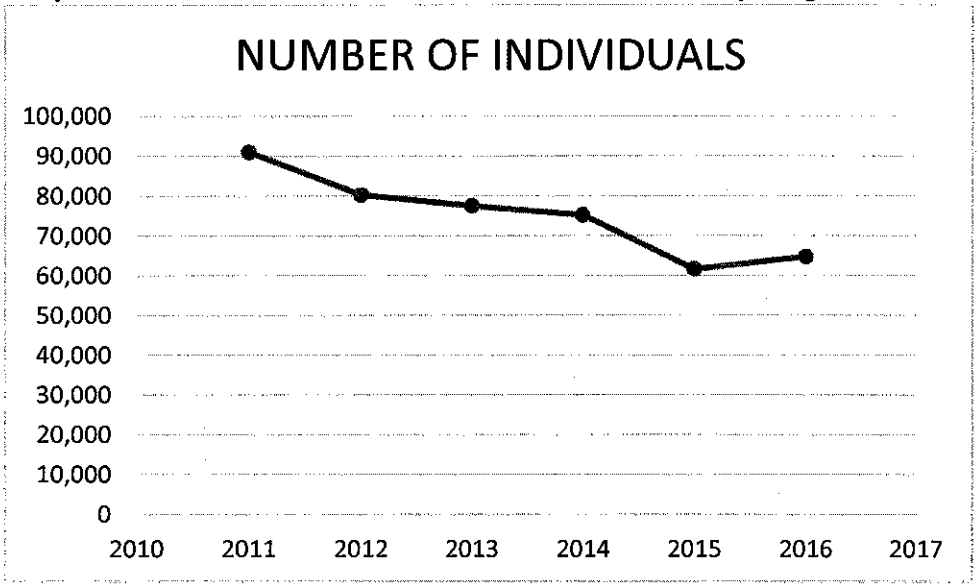
Measures used in the process evaluation (measures of systemic variables of the safety net health care providers), such as provider revenue, and measure of aggregated data of Gateway enrollees are analyzed with descriptive time series graphs. These measures are a single value for each year, or in some cases, each quarter. The following table and graph illustrates one method of a time series analysis using data from the demonstration Year 8 (DY8) Interim Evaluation Report for the number of uninsured individuals enrolled in the Gateway Program[7].

Table D. Uninsured Individuals Enrolled in the Gateway Program

YEAR	NUMBER INDIVIDUALS SERVED
2011	90,924
2012	80,193
2013	77,521
2014	75,216
2015	61,618
2016	64,709

[7] This measure and analysis is not used in the program evaluation, and is offered as an illustration only.

Graph 1. Uninsured Individuals Enrolled in the Gateway Program [8]



In this illustration, the number of uninsured individuals served by Gateway providers presents information on the trend over time as well as the magnitude of the measure in each time period (e.g. 64,709 enrollees in 2017).

Regression Based Analysis

Although a descriptive time series analyzes and displays change over time, it does not provide information on factors contributing to the change. A multiple regression analysis can be used to determine if changes in the measures result from changes in the demographic mix of Gateway enrollees, or result from other factors. The multiple regression analysis supplements the time series graphical analysis, and can only be used when enrollee level data, with demographic information, is available.

The following table illustrates the structure and types of required enrollee level data needed for multiple regression analysis for five hypothetical enrollees. In this table of hypothetical data related to primary care penetration rates, each row of the table corresponds to a single enrollee during a single year. The first variable, *Primary Care Service*, can have a value of 1 or 0, depending upon whether or not an enrollee received a primary care service. If the enrollee received one or more primary care services during the year, the value is 1. If the enrollee did not receive one or more primary care services during the year, the value zero.

The variables 2017, 2018 and 2019 are also binary variables. Each of these variables has a value of 1 if the individual was enrolled in that year, and a 0 if the individual was not enrolled in the Gateway program that year. By definition, exactly one of the three binary year variables has the value one, since each row corresponds to a single enrollee during a single year. The remaining

[8] The decrease in the number of Gateway enrollees reflects a corresponding decrease in the total number of uninsured adults during this time period.

variables represent the demographic characteristics of the enrollee during the year, with 1 indicating the presence of that characteristic, and 0 indicating the absence of that characteristic. [9]

Table F. Hypothetical Enrollee Level Data for Primary Care Services

Row #	Primary Care Service	Enrolled 2017	Enrolled 2018	Enrolled 2019	African American	Caucasian	Male	Female	Age In Years
1	1	1	0	0	1	0	0	1	36
2	1	0	0	1	0	1	0	1	29
3	0	1	0	0	0	1	1	0	45
4	1	0	1	0	1	0	0	1	23
5	0	1	0	0	1	0	1	0	28
6	0	0	1	0	1	0	1	0	57
7	1	0	0	1	0	1	1	0	47
8	1	1	0	0	0	1	1	0	31
9	1	1	0	0	1	0	0	1	42
10	0	0	1	0	1	0	0	1	45

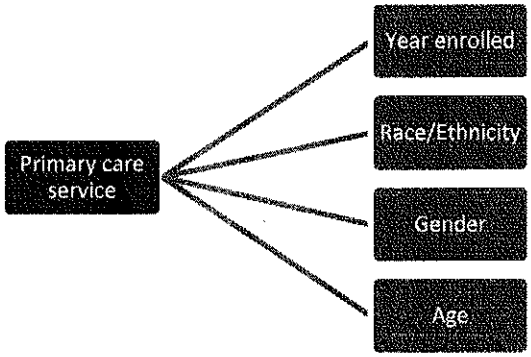
The *Medical service line unique users penetration rate*[10] reports the percentage of unique users of medical services, including primary care services. It is calculated separately by year, using enrollee data taking the structure of Table F. In this example, there are five hypothetical enrollees in 2017 (rows 1, 3, 5, 8 and 9), three of whom have received primary care services, resulting in a penetration rate of 60%. For 2018, the hypothetical penetration rate is one of three 2018 enrollees, or 33%. While the comparison of annual penetration rates shows declining primary care use, the annual rates do not provide information on why the rate declines between the two years.

One possible explanation for changes in annual rates is a changing demographic mix of Gateway enrollees. Some types of services have large differences in utilization rates between men and women, or between younger or older enrollees. In monitoring the Gateway program, it is helpful to understand if changes in measures over time are associated with a changing demographic mix of enrollees, or other unmeasured factors, such as changes in policies or procedures.

Multiple regression analysis also isolates annual changes in evaluation measures after controlling for changes in the demographic mix of enrollees. In the primary care penetration rate example, the binary variable *Primary Care Service* is the dependent variable in a linear regression model, and the binary year variables, the binary race and gender variables, and the continuous age variable are all independent variables, as noted in the following diagram.

[9] For simplicity of illustration, other racial/ethnic categories are not included in the example.
[10] See Attachment B

Dependent Variable **Independent Variables**



A linear model of the relationship between the dependent and independent variables can be estimated with multiple regression analysis. The resulting slope coefficient for each independent variable, and their statistical significance, is generated in the analysis. In the case of the 2018 binary variable (primary care service), the corresponding slope coefficient represents the average difference in the dependent variable (primary care service) for 2018 observations as compared to the 2017 base year. The slope coefficient associated with the 2019 binary variable (primary care service) represents the average difference in the dependent variable for 2019 observations as compared to the 2017 base year, again controlling for differences in the demographic variable. These two slope coefficients measure year to year change in primary care penetration and provide the statistical significance of the differences.

Using a multiple regression has two key advantages as compared to simply calculating the 60% or 33% rates reported above. First, the estimation of year to year change with regression analysis is made *after controlling for differences in the other independent variables, including the race, gender and age variables.* [11] For program monitoring purposes, it is helpful to know if change is for reasons beyond Gateway's control, such as changing demographics, or if policy changes may have led to observed changes. Second, regression analysis provides the statistical significance of the binary year variables, which may be used to identify if year to year change is statistically significant.

The form of the multiple regression analysis used is dependent upon the type of the independent variable. In the primary care service example, the dependent variable is binary (received services vs. did not receive services), so the specific form of the regression function is logarithmic. For other measures, the enrollee dependent variable is continuous, and different regression functions are used.[12] For example, the *Medical service line average utilization* is defined as the total number of primary care encounters divided by the number of enrollees. In this case, the enrollee dependent variable is a count of the number of primary care encounters

[11] See Wooldridge, J.(2002) Econometric Analysis of Cross Sections and Panel Data. Massachusetts Institute of Technology. 170-182

[12] In all cases, a general linear model will be used. The specific link function is dependent on the characteristics of the dependent variable.

for each enrollee, and not a binary variable indicating the enrollee did or did not receive any primary care services. Because this variable is approximately continuous, ordinary least squares instead of logarithmic regression will be utilized.[13] Finally, multiple regression analysis is also used to address the research question, *do health indicators, when calculated separately for African American, Caucasian and Hispanic Gateway enrollees, exhibit statistically significant differences?* An example of a health indicator is *Diabetes: HbA1c Control*, which is calculated with the following formula:

$$\frac{\text{[Number of enrollees with a diagnosis of Type I or Type II diabetes whose most recent hemoglobin A1c level during the measurement year is less than or equal to 9\%]}}{\text{[Number of enrollees year with a diagnosis of Type I or II diabetes and; who have been seen in the clinic for medical services at least twice during the reporting year]}}$$

The health indicators are calculated separately for each racial group to identify differences in rates. To determine statistically significant differences in these rates, logarithmic regression and client level data with a structure analogous to Table F is used. The data is limited to patients meeting the denominator condition (seen in the clinic twice), and the dependent variable will be a binary indicator satisfying the condition in the numerator (hemoglobin A1c less than or equal to 9%).

Using a logistic regression analysis, the estimated coefficient associated with each of the race variables indicates a change in the odds associated with meeting the health indicator condition, controlling for year of enrollment, gender and age. The coefficient's statistical significance measures if each of the races have a statistically significant differences in the odds of meeting the health condition.

F. Summary Design Table for the Evaluation of the Demonstration

The following table outlines the core components of the program evaluation. Each of the three hypotheses is followed by supporting research questions as well as the measures and analytic approach for each question. A table with detailed measure specifications can be found in Attachment B.

[13] For any measure that is based on a count of services per enrollee, if the data is zero dominated, a hurdle model will be estimated. See Wooldrige (2002) 536-537.

Table E. Summary Program Evaluation Table

RESEARCH QUESTION	MEASURE	POPULATION	FREQUENCY	ANALYTIC METHOD
Hypothesis 1: The St. Louis Regional Health Commission Gateway project supports the availability of primary and specialty health care services to uninsured adults in St. Louis City and St. Louis County.				
Does the coverage approach to provider reimbursement and incentive payments provide a stable revenue stream?	Gateway provider revenue	Gateway Providers	Annually	Descriptive time series
What variance, if any, exists in primary care provider availability and primary care service array across the evaluation period?	Primary care clinic business hours/week	Gateway Providers	Annually	Descriptive time series
	Primary care clinic non-business hours/week	Gateway Providers	Annually	Descriptive time series
	Total primary care clinic hours/week	Gateway Providers	Annually	Descriptive time series
	Available primary care services	Gateway Providers	Annually	Descriptive time series
What variance, if any, exists in access to primary and specialty care across the evaluation period?	Primary care non-urgent and urgent wait times for new and established patients	Gateway Providers	Quarterly	Descriptive time series
	Specialty care wait times for patients	Gateway Providers	Annually	Descriptive time series
	Specialty care referrals	Gateway Providers	Biannually	Descriptive time series

Hypothesis 2: Connecting and engaging uninsured individuals to a Gateway primary care home corresponds with sustained or increased primary care utilization.				
Have uninsured adults in St. Louis City and St. Louis County connected to a primary care home?	Uninsured adults newly enrolled in Gateway	Gateway enrollees	Biannually	Descriptive time series
	Percent uninsured unique users	Gateway enrollees/All uninsured adults	Annually	Descriptive time series
	Percent of uninsured adults enrolled in Gateway	Gateway enrollees/All uninsured adults	Annually	Descriptive time series
Has Gateway enrollment reduced the perception of barriers to primary and specialty care for enrollees and providers?	Barrier to healthcare self-report	Gateway enrollees	Annually	Descriptive time series
	Barrier to healthcare provider report	Gateway providers	Annually	Descriptive time series
Have Gateway members been engaged by their primary care with member education, outreach and follow-up?	Engagement self-report	Gateway Enrollees	Annually	Descriptive time series
	Newly Enrolled Office Visit	Gateway Enrollees	Biannually	Regression based analysis
Do Gateway enrollees connected to a primary care home demonstrate sustained or increased utilization of outpatient medical services year to year?	Medical service line average utilization	Gateway Enrollees	Annually	Regression based analysis
	Medical service line unique users penetration rate	Gateway Enrollees	Annually	Regression based analysis
Do Gateway enrollees connected to a primary care home demonstrate sustained or increased	Substance use service line unique users	Gateway Enrollees	Annually	Regression based analysis

utilization of outpatient substance use services year to year?	penetration			
	Four AUD and OUD withdrawal and maintenance pharmacotherapies described in Attachment B	Gateway Enrollees	Annually	Regression based analysis
Hypothesis 3: Enhanced provider quality of care corresponds with improved overall health outcomes and reduced health disparities.				
Does using value-based purchasing for provider reimbursement correspond with providers meeting incentive criteria on health and quality of care indicators?	Primary care provider incentive payments	Gateway providers	Biannually	Descriptive Time Series
	P4P incentive criteria score	Gateway providers	Biannually	Descriptive Time Series
Do uninsured Gateway members have perceived improved health outcomes?	Wellness self-report	Gateway enrollees	Annually	Descriptive Time Series
	Wellness provider report	Gateway providers	Annually	Descriptive Time Series
Do uninsured Gateway members have improved health outcomes year over year?	Selected health indicators described in Attachment B	Gateway enrollees	Annually	Regression Based Analysis
Do health indicators, when calculated separately for African American, Caucasian and Hispanic Gateway enrollees, exhibit statistically significant differences?	Selected health indicators described in Attachment B	Gateway enrollees	Annually	Regression Based Analysis

IV. Methodological Limitations

Several sources of data are used to support the measures in this evaluation, including electronic health records, provider self-report, census data, enrollment and claims data, and data from survey tools. The data is collected by multiple organizations (e.g. providers and various sub-contractors) and submitted to the SLRHC. The variety of data sources and data suppliers creates risk for inaccuracy. The SLRHC mitigates this risk by providing data collection instructions and requiring standardized collection procedures as well as engaging in data validation activities after the data is collected. To address potential sources of error related to data collection, the SLRHC provides templates and instructions that specify parameters to identify each data type. To address potential errors within the data itself, data validation activities are implemented in which the collected data is compared with historical data and data from external sources, where applicable.

The design of the study does not include a quasi-experimental design, with a comparison group, propensity scoring or other measure of comparison group comparability, and an analytic method to determine demonstration impact and effect size, (e.g. a Difference-in-Difference strategy). Several significant constraints prevent the SLRHC from implementing this type of research design. The primary constraint is the invisibility of uninsured individuals. Healthcare data is not available for this population. For example, the most reasonable comparison group would be uninsured individuals whose income prevents them from enrolling in the Gateway program. However, no source of comparable healthcare data is available for these individuals.

Insured populations that could conceivably be a source of data do not match the uninsured population on important variables such as age and level of impairment. An additional impediment to comparability is that the Gateway program provides outpatient services, but is not insurance for all levels of care.

A third constraint on the research design is the longevity of the Gateway program, which started in 2012. Even if the barriers to a quasi-experimental design could be resolved, the threat to the validity of any effect size related design is the threat from history. Given the level of socio-economic changes, population movement and changes in healthcare, a comparison of current measures with those obtained prior to the implementation of the Gateway program, even if available, would not necessarily reflect the impact of the demonstration.

One strategy used in the current methodology to mitigate the lack of a comparison group and determination of demonstration effect size is the use of enrollee and provider reports of decreased barriers to healthcare and improved health through particular questions from the satisfaction surveys. Although neither report has the validity of an objective measure such as a health indicator, a consistency in enrollee and provider reports attesting to the impact of the demonstration provides useful information about the perception of demonstration impact for the two groups most closely involved in the program: enrollees and providers.

A. Gateway Provider Survey Templates

Primary Care Template Primary Care Data Request

Please provide the information requested for your institution for **calendar year 2016**. Please submit your responses electronically to mjohns@stlrhc.org by **July 31, 2017**. For questions, contact Marquisha Johns at 314-446-6454 x 1103 or mjohns@stlrhc.org.

Organization Information	
Name:	
Site	
Street:	
City:	
Zip:	

Survey Contact Person	
Name:	
Title:	
Phone/Ext.:	
Email:	

Key Definitions & Guidelines

When completing this survey, please follow the definitions and guidelines outlined below:

- -- **Encounter:** Encounters (or "visits") are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgement in the provision of services to the patient.
- -- **User:** Users (or "patients") are individuals who have had at least one encounter during the reporting year. Within a service category (i.e. medical, dental, etc.), an individual can only be counted once as a user. A person who received multiple types of services should be counted once (and only once) for each service.
- -- **Adult:** Users aged 18 and above.
- -- **Pediatric:** Users between the ages of 0-17.
- -- **Enabling Services:** Enabling services are non-clinical services that enable individuals to access health care and improve health outcomes, but do not include direct patient services. Enabling services can include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.
- -- The number of encounters should be greater than or equal to the number of users.
- -- Volumes provided should be unduplicated counts. If duplication exists, please note this for each line affected.
- -- **Volumes provided should match those submitted for calendar year 2016 UDS reporting** (for community health centers)

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Primary Care Data Request
Exhibit A-1 Operations Metrics

Duplication permitted across columns E-I on rows 10-14. In Column J, please provide unique users only.	Primary medical care	Dental	Mental health (primary or secondary diagnosis)	Substance Use (primary or secondary diagnosis)	Other	Clinical Total
Number of Users by Type:						
Pediatric (0-17)						
Obstetrics/Prenatal Care**						
Gynecology						
All other adult						
Total Users	-	-	-	-	-	-
New Users (office visit codes 99201-99205)						
All Users by Payor Category:						
Medicare (including Dual Eligibles)						-
Medicaid (Traditional FFS/Managed Medicaid)						-
Private/Commerical						-
Uninsured						
Gateway to Better Health						-
All Other Uninsured						-
Total Uninsured						-
Total Users	-	-	-	-	-	-
Number of Encounters by Type:						
Pediatric (0-17)						-
Preventative (cpt codes 99381-99385; 99391-99395)						-
All Other E/M Codes						-
OF ALL OTHER E/M CODES, how many enocunters were related to asthma management (J45 ICD10 Codes and/or 493.xx ICD9 Codes for ages 0-17)						-
Obstetrics/Prenatal Care						-
Gynecology						-
All other adult						-
Preventative (cpt codes 99381–99429)						-
All Other E/M Codes						-
OF ALL OTHER E/M CODES, how many encounters were related to chronic disease management for diabetes, hypertension, COPD/asthma, CVD/CHF/Heart Disease (see table 1 for diagnosis codes)						-
Other encounters:						
Podiatry						-
Optometry						-
Other (please specify): _____						-
Enabling services encounters						-
Total	-	-	-	-	-	-
All Encounters by Payor Category:						
Medicare (including Dual Eligibles)						-
Medicaid (Traditional FFS/Managed Medicaid)						-
Private/Commerical						-
Uninsured						

Table 1. Diagnosis Categories for Chronic Conditi

Chronic Conditions	ICD9 Category	ICD10 Category
Diabetes	250	E08 - E11, E13
Hypertension	401-405	I10-I15
COPD	490-496	J40 -J47
Heart Disease	420-429	I30-I52

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Primary Care Data Request
Exhibit A-1 Operations Metrics

Duplication permitted across columns E-I on rows 10-14. In Column J, please provide unique users only.		Primary medical care	Dental	Mental health (primary or secondary diagnosis)	Substance Use (primary or secondary diagnosis)	Other	Clinical Total
	Gateway to Better Health						-
	All Other Uninsured						-
	Total Uninsured						-
Total		-	-	-	-	-	-
Cost per User & Encounter*:							
User							
Encounter							

Primary Care Data Request
Exhibit A-2 Operations Metrics

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Physical Plant Capacity	Site 1 <Enter Name>	Site 2 <Enter Name>	Site 3 <Enter Name>	Site 4 <Enter Name>	Total
Patient exam room					-
Patient procedure room					-
Patient counseling room					-
Dental chairs					-
Health education room					-

Hours of Operation (excluding urgent care):	Site 1 <Enter Name>	Site 2 <Enter Name>	Site 3 <Enter Name>	Site 4 <Enter Name>
Monday Hours of Operation				
Time of Last Available Appointment for NEW Patients				
Time of Last Available Appointment for ESTABLISHED Patients				
Tuesday Hours of Operation				
Time of Last Available Appointment for NEW Patients				
Time of Last Available Appointment for ESTABLISHED Patients				
Wednesday Hours of Operation				
Time of Last Available Appointment for NEW Patients				
Time of Last Available Appointment for ESTABLISHED Patients				
Thursday Hours of Operation				
Time of Last Available Appointment for NEW Patients				
Time of Last Available Appointment for ESTABLISHED Patients				
Friday Hours of Operation				
Time of Last Available Appointment for NEW Patients				
Time of Last Available Appointment for ESTABLISHED Patients				
Saturday Hours of Operation				
Time of Last Available Appointment for NEW Patients				
Time of Last Available Appointment for ESTABLISHED Patients				
Sunday Hours of Operation				
Time of Last Available Appointment for NEW Patients				
Time of Last Available Appointment for ESTABLISHED Patients				

Primary Care Data Request
Exhibit A-3 Operations Metrics

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Please complete wait time data as close to July 1, 2017 as possible.

Days until THIRD next NON-URGENT appointment as of DATE (please enter DATE as of):	New Patient	Established Patient
Pediatric		
Obstetrical		
Adult		
Dental		
Days until next URGENT appointment as of DATE (please enter DATE as of):	**New Patient**	**Established Patient**
Pediatric		
Obstetrical		
Adult		
Dental		
Number of Clinical FTEs* by Provider Type	**Non-Resident**	**Residents & Students**
Family Practicioner		
General Practicioner		
General Internist**		
General Internist (with subspecialties)*** <please specify which subspecialties>		
Obstetrician/Gynocologist		
Pediatrician		
Registered Nurse		
Nurse Practicioner		
Physician Assistant		
Certified Nurse Midwife		
Dentist		
Dental Hygienist		
Psychiatrist		
Psychologist		
Other Licensed Mental Health Provider (e.g., LCSW, LPC, etc.)		
Other Mental Health/Substance Use Staff		
Podiatrist		
Optometrist		
Pharmacist		
Chiropractor/Pain Management		
All Other		
What positions have been the most difficult to fill?		
How long have these positions been open?		

*Please provide method used to calculate FTE count.

**May be board certified in other subspecialties but only practice as an internist.

***Practices both subspecialty and as an internist.

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Users by Payor Category:	Hispanic							Non-Hispanic							Unknown/ Refused Race and Ethnicity	Clinical Total
	White	Black/ African American	Asian	American Indian/Alaska Native	Native Hawaiian/ Other Pacific Islander	More than one race	Unknown Race	White	Black/ African American	Asian	American Indian/Alaska Native	Hawaiian/ Other Pacific	More than one race	Unknown Race		
Medicare (including Dual Eligibles)																-
Medicaid (Traditional FFS/Managed Medicaid)																-
Private/Commerical																-
Uninsured																
Gateway to Better Health																-
All Other Uninsured																-
Total Uninsured																-
Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number of Babies Delivered* *This data is only required of the community health centers and RHC QIs/GPIs	Hispanic							Non-Hispanic							Unknown/ Refused Race and Ethnicity	Clinical Total
	White	Black/ African American	Asian	American Indian/Alaska Native	Native Hawaiian/ Other Pacific Islander	More than one race	Unknown Race	White	Black/ African American	Asian	American Indian/Alaska Native	Hawaiian/ Other Pacific	More than one race	Unknown Race		
Number of live births																-
Very Low Birth Weight (<1500 grams)																-
Low Birth Weight (1500 - 2499 grams)																-
Normal Birth Weight (>2499)																-
Number of non-live births																-
Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

*This data is only required for Myrtle Hilliard Davis, Affinia Healthcare and SSM Urgent Care.

	Hispanic							Non-Hispanic								
	White	Black/ African American	Asian	American Indian/Alaska Native	Native Hawaiian/Other Pacific Islander	More than one race	Unknown Race	White	Black/ African American	Asian	American Indian/Alaska Native	Native Hawaiian/ Other Pacific Islander	More than one race	Unknown Race	Unknown/ Refused Race and Ethnicity	Clinical Total
Number of URGENT CARE Users by Type:																
Pediatric (0-17)																
Adult																
Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of total existing health center medical users who've used urgent care at least once during 2016 calendar year																
URGENT CARE Users by Payor Category:																
Medicare (including Dual Eligibles)																
Medicaid (Traditional FFS/Managed Medicaid)																
Private/Commerical																
Uninsured																
Gateway to Better Health																
All Other																
Total Uninsured																
Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number of URGENT CARE Encounters by Type:	
Urgent	
Non-Urgent (Preventative Care) (see table 2 below for codes)	
STI Screening	
Immunizations	
Physical Exams	
Other, please specify	
Total	-

URGENT CARE Encounters by Payor Category:	
Medicare (including Dual Eligibles)	
Medicaid (Traditional FFS/Managed Medicaid)	
Private/Commerical	
Uninsured	
Gateway to Better Health	
All Other	
Total Uninsured	
Total	-

URGENT CARE Left Without Being Seen Rates by Payor	**Total**
Medicare (including Dual Eligibles)	
Medicaid (Traditional FFS/Managed Medicaid)	
Private/Commerical	
Uninsured	
Gateway to Better Health	
All Other	
Total Uninsured	
Unknown Payor	
Total	-

URGENT CARE Fees	
Do you advertise your urgent care prices?	__ Y or __ N
What is your base rate for urgent care services for those patients who are uninsured (self-pay) or with high deductible plans?	

Hours of Operation:	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	
What day/time of day is the busiest (in terms of patient volume) for your urgent care site?	

Table 2. Codes for Preventative Visits

Preventative	CPT
Immunizations	90281, 90283,
Physical Exams	99381–99429
STI Screening	ICD9: V74, V73.8, V73.9; ICD10: Z11.3, Z11.4, Z11.5

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Policies		
	In dollars, how much medical care did your organization write off as "bad debt" (see definition below) in 2016?	
	In dollars, how much medical care did your organization write off as "charity care"/"sliding fee scale" (see definition below) in 2016?	
Scheduling		
	Do you require payor information to schedule an appointment?	__Y or __N
	What is the policy for scheduling appointments for patients with an outstanding balance? (Attach separate document, if necessary)	
	Do you have a missed appointment/no-show policy?	__Y or __N
	If yes, what is your missed appointment/no-show policy? (Attach separate document, if necessary)	
Financial Assistance		
	What is the process for applying for financial assistance and/or sliding fee schedule, including documentation requirements? (Attach separate document, if necessary)	
	What documents do you require?	
	Do you require uninsured/self pay patients to apply for finanical assistance and/or coverage?	__Y or __N
	Does your institution require a patient receive an invoice for services before applying for financial assistance?	__Y or __N
	Does the application for financia assistance include information on the patient's medical condition?	__Y or __N
	Is financial assistance and/or sliding fee scale schedule available to individuals with high deductible insurance plans?	__Y or __N
	If yes, what is the policy for accessing this assistance? (Attach separate document, if necessary)	
	How many applications were collected in CY2016 for financial assistance, charity care and/or sliding fee schedule?	
	How many were approved for charity care or financial assisstance?	
	Is staff available assist patients with completing applications for coverage (Medicaid, Marketplace, Gateway to Better Health)?	__Y or __N
	If so, how many patients did you assist in applying for coverage during CY2016?	
	Is staff available to assist patients in completing financial assistance applications?	__Y or __N
Interpreter Use		
	Do you have a written policy around language access?	__Y or __N
	If yes, what is your language access policy? (Attach separate document, if necessary)	
	Interpreter services available for limited English proficient (LEP) or Deaf/Hard of Hearing (DHH) patients (Enter "X" next to YES or NO)	__Y or __N
	Contracted	__Y or __N
	If contracted, please list organization.	
	How much notice is needed to acquire interpreter services?	
	Employed In-House	__Y or __N
	How many FTE in-house interpreters available?	
	Number of clinical staff with non-English language skills	
	Written materials available for non-English speakers (Enter "X" next to YES or NO)	__Y or __N
	Are financial assistance policies and/or sliding fee schedules available in languages other than English?	__Y or __N
	Are interpreters available to explain financial assistance policies and assisst patients in completing financial assistance applications?	__Y or __N
	Total number of interpreter encounters	
	Phone Encounters	
	Video Ecnounters	
	In Person Encounters	
Pharmacy Services		
	Do you have an on-site pharmacy?	__Y or __N
	If multiple locations, which of your locations have pharmacies on-site?	
	Number of UNIQUE customers at your pharmacy	
	Number of prescriptions filled during the calendar year at your pharmacy	
	Do you have a retail pharmacy partner that offers your patients 340B pricing?	__Y or __N
	If so, who and where are they located? (e.g., Walgreens)	
	Do you assist patients in completing applications for prescription assistance programs?	__Y or __N
	If yes, number of patients assisted?	

Charity Care and/or sliding fee
Charges for supplies and/or services that a healthcare provider or institution would normally expect collection, but due to an individual's indigent status (per the institution's charity care/sliding fee scale policy) the provider or institution has voluntarily chosen to write off. The organization has deemed that the patient meets certain financial criteria and is unable to pay for all or a portion of the services. Services that were written off during the reporting year (CY2016), regardless of when the service was provided, should be included. In addition, any automatic discounts applied to uninsured patients (self-pay discount), regardless of meeting certain charity care criteria, may be included. Also, include non-reimbursable expenses that are deemed as eligible for coverage by the organization's charity care policy.

Bad debt
Charges for supplies and/or services that a healthcare provider or institution would normally expect to collect from the patient, but was unable to collect, and as a result had to write off, either in part or in its entirety. Services that were written off during the reporting year (CY2016), regardless of when the service was provided, should be included. This includes unpaid non-reimbursable expenses, for which the patient was responsible (excluding those services eligible for charity care coverage). Bad debt expenses should be net of any recoveries received to date for debt written off during CY2016.

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

For community health centers only, please duplicate this exhibit and complete a table for each individual site within your organization.

Safety Net Users by Zip Code and Payor* (to be reported in aggregate across all reporting organizations)

Zip Code of Residence (please list all St. Louis City and County zip codes)	Medicare	Private/Commerical	Medicaid	Uninsured		Total
				Gateway to Better Health	All Other Uninsured	
63001						-
63005						-
63006						-
63011						-
63017						-
63021						-
63022						-
63024						-
63025						-
63026						-
63031						-
63032						-
63033						-
63034						-
63038						-
63040						-
63042						-
63043						-
63044						-
63045						-
63074						-
63088						-
63099						-
63101						-
63102						-
63103						-
63104						-
63105						-
63106						-
63107						-
63108						-
63109						-
63110						-
63111						-
63112						-
63113						-
63114						-
63115						-
63116						-
63117						-
63118						-
63119						-
63120						-
63121						-
63122						-
63123						-
63124						-
63125						-
63126						-
63127						-
63128						-
63129						-
63130						-
63131						-
63132						-
63133						-
63134						-
63135						-
63136						-
63137						-
63138						-
63139						-
63140						-
63141						-

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

For community health centers only, please duplicate this exhibit and complete a table for each individual site within your organization.

Safety Net Users by Zip Code and Payor* (to be reported in aggregate across all reporting organizations)

63143						-
63144						-
63145						-
63146						-
63147						-
63150						-
63151						-
63155						-
63156						-
63157						-
63158						-
63160						-
63163						-
63164						-
63166						-
63167						-
63169						-
63171						-
63177						-
63178						-
63179						-
63180						-
63182						-
63188						-
63190						-
63195						-
63196						-
63197						-
63198						-
63199						-
All Other MO Zip Codes						-
All IL Zip Codes						-
All Other Zip Codes						-
TOTAL			-	-	-	-

**This data should only include those patients seen within the calendar year using their last known address as of December 31, 2016 or the time of their last encounter.*
Add additional rows as necessary or attach a separate document.

Primary Care Data Request
EXHIBIT B - REVENUE AND EXPENSES

Reporting for RHC
<Insert Institution Name>
Statement of Revenue and Expense for the year ending December 31, 2016

**This data is only required of the community health centers.*

			Clinical Operations Total Clinical	Other Programs (optional) [Name]	Total
Revenues					
	HRSA Grants				
	Other Federal Revenue				
	Medicaid/Medicare				
	Other Patient Revenue				
	Gateway to Better Health				
	Other Funding				
	Contributed Services				
Total Revenues					
Expenses					
	Salaries, employee benefits and payroll taxes				
	Professional and contractual services				
	Supplies				
	Insurance				
	Pharmaceuticals				
	Occupancy				
	Depreciation				
	Contributed services				
	Other				
Total Expenses					
Surplus / (Deficit)					

Specialty Care Template

Specialty Care Data Request

Please provide the information requested for your institution for **calendar year 2016**. Please submit your responses electronically to mjohns@stlrhc.org by **July 31, 2017**. For questions, contact Marquisha Johns at 314-446-6454 x 1103 or mjohns@stlrhc.org.

Organization Information	
Name:	
Site	
Street:	
City:	
Zip:	

Survey Contact Person	
Name:	
Title:	
Phone/Ext.:	
Email:	

Key Definitions & Guidelines

When completing this survey, please follow the definitions and guidelines outlined below:

- **Encounter:** Encounters (or "visits") are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgement in the provision of services to the patient.
- **User:** Users (or "patients") are individuals who have had at least one encounter during the reporting year. Within a service category (i.e. medical, dental, etc.), an individual can only be counted once as a user. A person who received multiple types of services should be counted once (and only once) for each service.
- The number of encounters should be greated than or equal to the number of users.
- Volumes provided should be unduplicated counts. If duplication exists, please note this for each line affected.

Specialty Data Request

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2026

	Hispanic							Non-Hispanic								
All Users by Payor Category and Race:	White	Black/ African American	Asian	American Indian/Alaska Native	Native Hawaiian/ Other Pacific Islander	More than one race	Unknown Race	White	Black/ African American	Asian	American Indian/Alaska Native	Native Hawaiian/ Other Pacific Islander	More than one race	Unknown Race	Unknown/ Refused Race and Ethnicity	Clinical Total
Medicare (including Dual Eligibles)																-
Medicaid (Traditional FFS/Managed Care Medicaid)																-
Private/Commerical																-
Uninsured																
Gateway to Better Health																-
All Other																-
Total Uninsured																-
Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

All Encounters by Payor Category	Total
Medicare (including Dual Eligibles)	
Medicaid (Traditional FFS/Managed Care Medicaid)	
Private/Commerical	
Uninsured	
Gateway to Better Health	
All Other	
Total Uninsured	
Total	-

STANDARD Hours of Operation:	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Do some specialties consistently offer evening hours for appointments?	
If so, which specialties?	
Are these appointments available for safety net patients (Medicaid, Uninsured, Gateway to Better Health)?	
Do some specialties consistently offer ~~week~~end hours for appointments?	
If so, which specialties?	
Are these appointments available for safety net patients (Medicaid, Uninsured, Gateway to Better Health)?	

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Number of Clinical FTE's by Specialty:	Non-Resident	Resident
Cardiology		
Dermatology		
Endocrinology		
Endoscopy		
ENT/Otolaryngology		
Gastroenterology (GI)		
Gynecology ONLY		
Obstetrics/Prenatal Care ONLY		
Obstetrics/Gynecology		
Hematology		
Hepatology		
Infectious Disease		
Mental/Behavioral Health		
Nephrology		
Neurology		
Neurosurgery		
Oncology		
Ophthalmology/Eye Care		
Orthopedics		
Pain Management		
Physical Therapy		
Podiatry		
Pulmonology		
Rheumatology		
Surgery -- General		
Urology		
All Other		

*Please limit to those providers geographically located in St. Louis City and County AND provide method used to calculate FTE count.

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Please complete wait time data as close to July 1, 2017 as possible.

Days until THIRD next available appointment as of DATE (please enter DATE as of):	New Patient	Returning Patient	Urgent Patient*
Cardiology			
Dermatology			
Endocrinology			
Endoscopy			
ENT/Otolaryngology			
Gastroenterology (GI)			
Gynecology ONLY			
Obstetrics/Prenatal Care ONLY			
Obstetrics/Gynecology			
Hematology			
Hepatology			
Infectious Disease			
Adult Psychiatry			
Pediatric/Youth Psychiatry			
Nephrology			
Neurology			
Neurosurgery			
Oncology			
Ophthalmology/Eye Care			
Orthopedics			
Pain Management			
Physical Therapy			
Podiatry			
Pulmonology			
Rheumatology			
Surgery -- General			
Urology			
All Other			

*Patients who need immediate access to assistance due to medical necessity, not urgent care or emergency dept.

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Policies, as of TODAY		
	In dollars, how much medical care did your organization write off as "bad debt" (see definition below) in 2016?	
	In dollars, how much medical care did your organization write off as "charity care"/"sliding fee scale" (see definition below) in 2016?	
Scheduling		
	Do you require payor information to schedule an appointment?	__Y or __N
	Do any of your specialty departments require uninsured patients to pay a deposit or upfront fee prior to or during check in for their appointment?	__Y or __N
	If yes, which departments and how much is the standard fee?	
	Are different appointments available to safety net patients -- defined as uninsured, Medicaid or Gateway patients -- compared to commercially insured patients?	__Y or __N
	What is the policy for scheduling appointments for patients with an outstanding balance? (Attach separate document, if necessary)	
	Do you have a missed appointment/no-show policy?	__Y or __N
	If yes, what is your missed appointment/no-show policy? (Attach separate document, if necessary)	
	If yes, does it vary by specialty?	__Y or __N
Financial Assistance (discounted fee structure)/Charity Care Policies (payment slides to zero dollars)		
	What is the process for applying for financial assistance and/or sliding fee schedule, including documentation requirements? (Attach separate document, if necessary)	
	What documents do you require for financial assistance?	
	Are patients applying for financial assistance required to receive a bill before applying?	__Y or __N
	What is the process for applying for charity care, if different from financial assistance, including documentation requirements? (Attach separate document, if necessary)	
	What documents do you require for charity care?	
	Are patients applying for charity care required to receive a bill before applying?	__Y or __N
	Do individual departments have the ability to establish their own patient financial policies or opt out of institutional charity care/financial assistance policies?	__Y or __N
	Does the application for financial assistance and/or charity care include information about the applicant's medical condition?	__Y or __N
	Is financial assistance available to individuals with high deductible insurance plans?	__Y or __N
	If yes, what is the policy for accessing this assistance? (Attach separate document, if necessary)	
	Do "self pay" patients receive an automatic discount from billed charges?	__Y or __N
	If yes, is there a standard discount for all "self pay" patients who do not receive financial assistance?	__Y or __N
	If yes, what percentage of billed charges is the a standard discount for all "self pay" patients who do not receive financial assistance?	
	If a patient qualifies for financial assistance with your institution, do your facility partners require additional documentation to qualify for their financial assistance?	__Y or __N
	Do partnering providers (e.g. physician groups, lab services, radiology, etc.) offer financial assistance?	__Y or __N or __N/A
	Are your partnering providers (e.g. lab, radiology) obligated to honor your financial assistance program for the services they provide to qualifying patients?	__Y or __N
	Do you provide cost estimates to patients in advance of delivering care?	__Y or __N
	How many applications were collected in CY2016 for financial assistance, charity care and/or sliding fee schedule?	
	How many were approved for charity care?	
	How many were approved for financial assistance (including sliding fee scale)?	
Patient Navigation		
	Are financial assistance policies publically available online?	__Y or __N
	Do ALL patients receive basic information about financial assistance?	__Y or __N
	Is staff available to assist patients in understanding financial assistance policies?	__Y or __N
	Is staff available to assist patients in completing financial assistance applications?	__Y or __N
	Is staff available to assist patients in applying for insurance coverage?	__Y or __N
	If so, how many patients did you assist in applying for coverage during CY2016?	
	Do you inform patients about the availability of prescription assistance programs?	__Y or __N
	If yes, do you assist patients in completing applications for prescription assistance programs?	__Y or __N
	How many people did you assist in CY 2016?	
Interpreter Use		
	Do you have a written policy around language access?	__Y or __N
	If yes, what is your language access policy? (Attach separate document, if necessary)	
	Interpreter services available for limited English proficient (LEP) or Deaf/Hard of Hearing (DHH) patients (Enter "X" next to YES or NO)	__Y or __N
	Contracted (Enter "X" next to the appropiate option)	
	if contracted, please list organization.	
	Employed In-House (Enter "X" next to the appropiate option)	
	How many FTEs in-house interpreters available?	
	Written materials available for non-English speakers (Enter "X" next to YES or NO)	__Y or __N
	Are financial assistance policies available in languages other than English?	__Y or __N
	Are interpreters available to explain financial assistance policies and assist patients in completing financial assistance applications?	__Y or __N
	Total number of interpreter encounters	
	Phone Encounters	
	Video Ecnounters	
	In Person Encounters	

Charity Care and/or sliding fee

Charges for supplies and/or services that a healthcare provider or institution would normally expect collection, but due to an individual's indigent status (per the institution's charity care/sliding fee scale policy) the provider or institution has voluntarily chosen to write off. The organization has deemed that the patient meets certain financial criteria and is unable to pay for all or a portion of the services. Services that were written off during the reporting year (CY2016), regardless of when the service was provided, should be included. In addition, any automatic discounts applied to uninsured patients (self-pay discount), regardless of meeting certain charity care criteria, may be included. Also, include non-reimbursable expenses that are deemed as eligible for coverage by the organization's charity care policy.

Bad debt

Charges for supplies and/or services that a healthcare provider or institution would normally expect to collect from the patient, but was unable to collect, and as a result had to write off, either in part or in its entirety. Services that were written off during the reporting year (CY2016), regardless of when the service was provided, should be included. This includes unpaid non-reimbursable expenses, for which the patient was responsible (excluding those services eligible for charity care coverage). Bad debt expenses should be net of any recoveries received to date for debt written off during CY2016.

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Safety Net Users by Zip Code and Payor* (to be reported in aggregate across all reporting organizations)

Zip Code of Residence (please list all St. Louis City and County zip codes)	Medicare	Private/Commerical	Uninsured			
			Medicaid	Gateway to Better Health	All Other Uninsured	Total
63001						-
63005						-
63006						-
63011						-
63017						-
63021						-
63022						-
63024						-
63025						-
63026						-
63031						-
63032						-
63033						-
63034						-
63038						-
63040						-
63042						-
63043						-
63044						-
63045						-
63074						-
63088						-
63099						-
63101						-
63102						-
63103						-
63104						-
63105						-
63106						-
63107						-
63108						-
63109						-
63110						-
63111						-
63112						-
63113						-
63114						-
63115						-
63116						-
63117						-
63118						-
63119						-
63120						-
63121						-
63122						-
63123						-
63124						-
63125						-
63126						-
63127						-
63128						-
63129						-
63130						-
63131						-
63132						-
63133						-
63134						-
63135						-
63136						-
63137						-
63138						-
63139						-
63140						-
63141						-

Reporting for RHC
<Insert Institution Name>
Statistical Information for the 12 Months Ending December 31, 2016

Safety Net Users by Zip Code and Payor* (to be reported in aggregate across all reporting organizations)

63143						-
63144						-
63145						-
63146						-
63147						-
63150						-
63151						-
63155						-
63156						-
63157						-
63158						-
63160						-
63163						-
63164						-
63166						-
63167						-
63169						-
63171						-
63177						-
63178						-
63179						-
63180						-
63182						-
63188						-
63190						-
63195						-
63196						-
63197						-
63198						-
63199						-
All Other MO Zip Codes						-
All IL Zip Codes						-
All Other Zip Codes						-
TOTAL	-	-	-	-	-	-

**This data should only include those patients seen within the calendar year using their last known address as of December 31, 2016 or the time of their last encounter.*
Add additional rows as necessary or attach a separate document.

B. Measure Specifications

MEASURE	MEASURE SPECIFICATION
Gateway provider revenue	Total amount of claims-based revenue for all primary care services received across all Gateway providers from January 1 through December 31.
Primary clinic business hours/week	[Sum of open clinic hours between 8:00 a.m. and 5:00 p.m. Monday-Friday] / [Total number of clinic locations across all Gateway providers].
Primary clinic non business hours/week	[Sum of clinic hours before 8:00 a.m. and after 5:00 p.m. Monday-Friday] + [Sum of open clinic hours on Saturday and Sunday]
Total primary clinic hours/week	[Total number of primary clinic business hours open clinic hours] + [Total number of primary clinic non-business hours]
Available primary care services[14]	Sum [Number of "core" primary care services X number of clinics] + Sum [Number of "additional" primary care services X number of clinics]
Primary care non-urgent wait times new patients	[Sum of all non-urgent wait times for new patients for primary care services in one quarter] / [Total number of clinics]
Primary care non-urgent wait times established patients	[Sum of all non-urgent wait times for established patients for primary care services in one quarter] / [Total number of clinics]
Primary care urgent wait times new patients	[Sum of all urgent wait times for new patients for primary care services in one quarter] / [Total number of clinics]
Primary care urgent wait times established patients	[Sum of all urgent wait times for established patients for primary care services in one quarter] / [Total number of clinics]
Specialty care wait times for patients	[Sum of all urgent wait times for patients for specialty services reported annually] / [Total number of clinics]
Specialty care referrals	Total number of specialty referrals made by primary care providers in one year
Number of uninsured adults newly enrolled in Gateway	Total number of uninsured adults newly enrolled in Gateway program in one year
Percent uninsured unique users	[Total number of unique users who received at least one primary care service in the Gateway program between January 1 and December 31] / [Total number of uninsured adults between 19 and 64 years of age in St. Louis County between January 1 and December 31]
Percent uninsured adults enrolled in Gateway	[Total number of adults enrolled in the Gateway program between January 1 and December 31] / [Total number of uninsured adults between 19 and 64 years of age in St. Louis County between January 1 and December 31]
Barrier to healthcare	[Total number of responses that endorse "not at all confident" and "not too

[14] See full service array options below

MEASURE	MEASURE SPECIFICATION
self-report	confident" on each components of item five of the Enrollee Satisfaction survey] / [Total number of responses on each component of item five on the Enrollee Satisfaction survey]
Barrier to healthcare provider report	[Total number of responses that endorse "not at all confident" and "not too confident" on each component of item two of the Provider survey] / [Total number of responses on each component of Provider survey]
Engagement self-report	[Total number of responses that endorse "good" and "very good" on each components of item four of the Enrollee Satisfaction survey] / [Total number of responses on each component of item four on the Enrollee Satisfaction survey]
Newly Enrolled Office Visit	[Number of newly enrolled Gateway members who receive at least one office visit, within one year (6 months before or after reporting period start date)] / [Total number of newly enrolled Gateway members]
Medical service line average utilization	[Number of medical service line encounters for Gateway members for services received between January 1 and December 31] / [Total number of medical service line unique users between January 1 and December 31]
Medical service line unique users penetration	[Number of medical service line unique users between January 1 and December 31]/ [Number of Gateway enrollees between January 1 and December 31]
Substance use service line unique users penetration	[Number of substance use service line unique users between January 1 and December 31]/ [Number of Gateway enrollees between January 1 and December 31]
Alcohol withdrawal medication management	[Number of enrollees prescribed at least one medication[15] to manage withdrawal from alcohol between January 1 and December 31]/ [Number of enrollees with AUD diagnosis between January 1 and December 31]
Opioid withdrawal medication management	[Number of enrollees prescribed at least one medication[16] to manage withdrawal from opioids between January 1 and December 31]/ [Number of enrollees with OUD diagnosis between January 1 and December 31]
AUD medication maintenance	[Number of enrollees prescribed Disulfiram or Naltrexone HCL between January 1 and December 31]/ [Number of enrollees with AUD diagnosis between January 1 and December 31]
OUD medication maintenance	[Number of enrollees prescribed Buprenorphine HCl or Naltrexone HCL between January 1 and December 31]/ [Number of enrollees with AUD diagnosis between January 1 and December 31]
Primary care provider incentive payments	Total amount of revenue from incentive payment received across all Gateway providers from January 1 through December 31.
P4P incentive criteria	[Sum of all criteria met by Gateway providers across one year]/ [Total number

[15] Baclofen, Desipramine HCL, Mirtazapine, Paroxetine CR, Paroxetine ER, Paroxetine HCL, and Gabapentin.
[16] Baclofen, Desipramine HCL, Mirtazapine, Paroxetine CR, Paroxetine ER, and Paroxetine HCL.

MEASURE	MEASURE SPECIFICATION
scores	of providers]
Wellness self-report	[Total number of responses that endorse "better" on item six of the Enrollee Satisfaction survey] / [Total number of responses on each component of item six on the Enrollee Satisfaction survey]
Wellness provider report	[Total number of responses that endorse "improved" on item one of the Provider survey] / [Total number of responses on each component of item one on the Provider Satisfaction survey]
Tobacco use assessment and cessation intervention	[Number of enrollees 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 Gateway enrollees during the measurement year with at least one medical visit during the reporting year, and with at least two medical visits ever]
Hypertension: Blood Pressure Control	[Number of enrollees whose last systolic blood pressure measurement was less than 140 mm Hg and whose diastolic blood pressure was less than 90 mm Hg] / [Number of enrollees 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.
Diabetes: HbA1c control	[Number of enrollees with a diagnosis of Type I or Type II diabetes whose most recent hemoglobin A1c level during the measurement year is less than or equal to 9%]/ [Number of enrollees 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]
Adult weight screening and follow-up	[Number of enrollees 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 enrollees who had at least one medical visit during the reporting year]
Flu Shot for adult patients	[Number of enrollees who received an influenza immunization OR who reported previous receipt of an influenza immunization]/ [Number of enrollees seen for a visit between October 1 and March 31 of the measurement year]
Use of appropriate medications for asthma	[Number of enrollees with asthma diagnosis who were ordered at least one prescription for a preferred therapy during the measurement period] / [Number of Gateway enrollees with persistent asthma and a visit during the measurement period EXCEPT enrollees with a diagnosis of emphysema, COPD, obstructive chronic bronchitis, cystic fibrosis or acute respiratory failure that overlaps the measurement period]

Service Array

Core Services
Primary Medical Care
Dental Care
Mental Health Services, *(please specify types of services available)*
Substance Abuse Services, *(please specify types of services available)*
Podiatry
Optometry
Enabling Services
Pharmacy
Chronic Disease Management
Ophthalmology
Case Management
Social Services
Referral to Specialty Care
Eligibility assistance services
Radiology
Clinical Laboratory Services, *(please indicate whether in-house or contracted)*

Additional Services
Nutrition
Youth Behavioral Health Services, *(please specify types of services available)*
WIC
Community Health Homeless Services
Prenatal classes/Centering Pregnancy
HIV Counseling
Urgent Care
Specialty Care, *(please specify specialties available)*
STD Clinic Services
Social Services
Other not listed, *(please specify)*

C. Enrollee Satisfation Survey

GATEWAY to Better Health

2018 Patient Satisfaction Survey

Date:

As you think about your visit today, how would you rate the following:

1. How well the staff and doctor listened to your needs and explained things in a way that was easy to understand	Very Poor	Poor	Fair	Good	Very Good
2. The quality of services received	Very Poor	Poor	Fair	Good	Very Good

3. Would you recommend [insert health center] to a family member or friend? Yes/No

In an effort to better understand your Gateway experience and health center relationship, we want to know how you would answer the following:

4. Please rate your health center's communication with you:

a. How promptly we answer your phone calls	Very Poor	Poor	Fair	Good	Very Good
b. Information from our website and other materials to help you get the healthcare you need	Very Poor	Poor	Fair	Good	Very Good
c. Getting advice or help from the clinic when needed during office hours	Very Poor	Poor	Fair	Good	Very Good
d. Helpfulness of our health information materials	Very Poor	Poor	Fair	Good	Very Good

5. If the Gateway program ended, how confident are you that you could:

a. Afford to see a doctor	Not at all confident	Not too confident	Somewhat confident	Very confident
b. Afford prescription medicines	Not at all confident	Not too confident	Somewhat confident	Very confident
c. Coordinate all of your health care needs	Not at all confident	Not too confident	Somewhat confident	Very confident
d. Get necessary medical tests	Not at all confident	Not too confident	Somewhat confident	Very confident
e. Follow the treatments your doctor recommends	Not at all confident	Not too confident	Somewhat confident	Very confident

6. Since you have been enrolled in the Gateway program, do you think your overall physical health is?

   a) Better

   b) Worse

   c) Stayed the same

In an effort to better understand chronic pain in our community, we want to know how you would answer the following:

1. Do you have chronic pain (pain in your body that has lasted for at least 3 months)?

   Yes/No

   IF YOU ANSWERED NO, you can skip the remaining questions.

2. Which of these bests describe the area that hurts you the most?

   - o Head
   - o Neck
   - o Back
   - o Abdomen or Pelvis (Belly)
   - o Shoulders, Arms, or Hands
   - o Hips, Legs, or Feet
   - o Multiple Locations
   - o Other:

3. Does your pain affect your ability to seek or maintain employment? Yes/No

4. Which of the following methods <u>have helped you</u> cope with pain? Check all that apply:

   - o Physical Therapy
   - o Exercise Program
   - o Pain Injection
   - o Prescription Medication
   - o Family/Friend/Community Support
   - o Other (Ex: Chiropractor, Weight Loss, Acupuncture):

5. Which of the following methods do you <u>wish you had</u> to cope with pain? Choose your top 3:

   - o Physical Therapy
   - o Exercise Program
   - o Pain Injection
   - o Prescription Medication
   - o Family/Friend/Community Support
   - o Other (Ex: Chiropractor, Weight Loss, Acupuncture):

D. Provider Survey

GATEWAY to Better Health

2018 Patient Satisfaction Survey

Date:

As you think about your visit today, how would you rate the following:

1. How well the staff and doctor listened to your needs and explained things in a way that was easy to understand	Very Poor	Poor	Fair	Good	Very Good
2. The quality of services received	Very Poor	Poor	Fair	Good	Very Good

3. Would you recommend [insert health center] to a family member or friend? Yes/No

In an effort to better understand your Gateway experience and health center relationship, we want to know how you would answer the following:

4. Please rate your health center's communication with you:

a. How promptly we answer your phone calls	Very Poor	Poor	Fair	Good	Very Good
b. Information from our website and other materials to help you get the healthcare you need	Very Poor	Poor	Fair	Good	Very Good
c. Getting advice or help from the clinic when needed during office hours	Very Poor	Poor	Fair	Good	Very Good
d. Helpfulness of our health information materials	Very Poor	Poor	Fair	Good	Very Good

5. If the Gateway program ended, how confident are you that you could:

a. Afford to see a doctor	Not at all confident	Not too confident	Somewhat confident	Very confident
b. Afford prescription medicines	Not at all confident	Not too confident	Somewhat confident	Very confident
c. Coordinate all of your health care needs	Not at all confident	Not too confident	Somewhat confident	Very confident
d. Get necessary medical tests	Not at all confident	Not too confident	Somewhat confident	Very confident
e. Follow the treatments your doctor recommends	Not at all confident	Not too confident	Somewhat confident	Very confident

6. Since you have been enrolled in the Gateway program, do you think your overall physical health is?

   a) Better

   b) Worse

   c) Stayed the same

In an effort to better understand chronic pain in our community, we want to know how you would answer the following:

1. Do you have chronic pain (pain in your body that has lasted for at least 3 months)?

   Yes/No

   IF YOU ANSWERED NO, you can skip the remaining questions.

2. Which of these bests describe the area that hurts you the most?

   - o Head
   - o Neck
   - o Back
   - o Abdomen or Pelvis (Belly)
   - o Shoulders, Arms, or Hands
   - o Hips, Legs, or Feet
   - o Multiple Locations
   - o Other:

3. Does your pain affect your ability to seek or maintain employment? Yes/No

4. Which of the following methods <u>have helped you</u> cope with pain? Check all that apply:

   - o Physical Therapy
   - o Exercise Program
   - o Pain Injection
   - o Prescription Medication
   - o Family/Friend/Community Support
   - o Other (Ex: Chiropractor, Weight Loss, Acupuncture):

5. Which of the following methods do you <u>wish you had</u> to cope with pain? Choose your top 3:

   - o Physical Therapy
   - o Exercise Program
   - o Pain Injection
   - o Prescription Medication
   - o Family/Friend/Community Support
   - o Other (Ex: Chiropractor, Weight Loss, Acupuncture):

GBH 2018 Referring Provider Survey

Medical Provider Survey Changes:

Continue prompting for written feedback when a provider is rated as "Poor" or "Needs Improvement".

Change the provider rating scale to the following:

Poor	Needs Improvement	Average	Above Average	Excellent	N/A

Add Mercy cardiology and GI/hepatology to the list of providers.

Move Eye Associates to the first provider slot on the survey.

Remove Dr. Theordore Otti from the list of providers.

Add the following questions to address Gateway's impact on patient health and access to care:

1. Do you think the overall health of your patients has improved, worsened or stayed the same after enrolling in Gateway?
    - Improved
    - Worsened
    - Stayed the same

2. If the Gateway program ended, how confident are you that current Gateway enrollees could:

a. Could keep their overall health the same	Not at all confident	Not too confident	Somewhat confident	Very confident
b. Could access quality medical care	Not at all confident	Not too confident	Somewhat confident	Very confident
c. Could afford to see a primary care provider	Not at all confident	Not too confident	Somewhat confident	Very confident
d. Could afford prescription medicines	Not at all confident	Not too confident	Somewhat confident	Very confident
e. Could afford to see a specialist doctor	Not at all confident	Not too confident	Somewhat confident	Very confident

Add the following questions to better understand the provider's perspective on chronic pain in our community:

1. Approximate the percentage of your adult encounters in which chronic pain (pain persisting for at least 3 months) is a major focus of the visit?
    - 0-25%
    - 26-50%
    - 51-75%
    - 75-100%
2. Which of the following methods do your patients utilize, in order to manage chronic pain and increase function? Choose any/all that apply:

- Primary Care Encounters
- Behavioral Health Consultant Encounters
- Prescription Medication
- Physical Therapy
- Exercise Program with Trainer
- Pain Doctor for Injection Therapies
- Orthopedist or Physical Medicine
- Chronic Pain Therapy & Support Group
- Comprehensive Multidisciplinary Pain Management Program
- Other (Ex: Rheumatologist, Chiropractic, Acupuncture, Massage, Weight Loss Management, Family/Friend/Community Support/Counseling/Validation)
  - Open Text Box for Comments

3. What else do you still need to help your patients in chronic pain? Choose the top 3:
   - Physical Therapy
   - Exercise Program with Trainer
   - Pain Doctor for Injection Therapies
   - Orthopedist or Physical Medicine
   - Chronic Pain Therapy & Support Group
   - Comprehensive Multidisciplinary Pain Management Program
   - Other (Ex: Massage, Rheumatologist, Chiropractic, Acupuncture, Weight Loss Management, Family/Friend/Community Support/Counseling/Validation)
     - Open Text Box for Comments
4. If you could integrate one more professional (ex: physical therapist, chiropractor, etc.) in your health home model in order to help with chronic pain, what would be your top priority?
5. If your patients had greater access to services you prioritized in questions 3 and 4, would this result in you prescribing fewer controlled substances for pain such as opioids?

Support Staff Survey Changes:

Continue prompting for written feedback when a provider is rated as "Poor" or "Needs Improvement".

Change the provider rating scale to the following:

Poor	Needs Improvement	Average	Above Average	Excellent	N/A

For Washington University, notate that we are asking for feedback on the Streamlined Referrals Department for two questions: overall ease of scheduling and helpfulness and courtesy of staff when scheduling.

Move Eye Associates to the first provider slot on the survey.

Remove Dr. Theodore Otti from the list of providers.

Medical Providers

NOTE: Only answer questions about providers that you actively use for GBH patient referrals.

For questions contact us at GBHISSUES@stlrhc.org.

1. BJC Medical Group (ENT, cardiology & orthopedics) @ Christian NE Hospital

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○
Report from consultation provider, did you receive it?	○	○	○	○	○
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

2. Washington University

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○
Report from consultation provider, did you receive it?	○	○	○	○	○
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

3. Barnes-Jewish Hospital Resident Clinic

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○
Report from consultation provider, did you receive it?	○	○	○	○	○

	N/A	Needs Improvement	Average	Above Average	Excellent
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

4. Saint Louis University (SLU) Care

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○
Report from consultation provider, did you receive it?	○	○	○	○	○
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

5. Eye Associates

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○
Report from consultation provider, did you receive it?	○	○	○	○	○
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

6. Dr. Mwintshi (nephrology) @ Nephrology & Hypertension Associates, LLC

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○

	N/A	Needs Improvement	Average	Above Average	Excellent
Report from consultation provider, did you receive it?	○	○	○	○	○
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

7. SSM (cardiology & GI) @ St. Mary's & DePaul

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○
Report from consultation provider, did you receive it?	○	○	○	○	○
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

8. Dr. Theodore Otti (nephrology) @ St. Mary's & St. Alexius

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○
Report from consultation provider, did you receive it?	○	○	○	○	○
Report from consultation provider, was it meaningful?	○	○	○	○	○
Rendering specialist, available to speak with you?	○	○	○	○	○

9. Other Comments:

Submit

Support Staff

NOTE: Only answer questions about providers that you actively use for GBH patient referrals.

For questions contact us at GBHISSUES@stlrhc.org.

1. BJC Medical Group (ENT, cardiology & orthopedics) @ Christian NE Hospital

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

2. Washington University

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

3. Barnes-Jewish Hospital Resident Clinic

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○

	N/A	Needs Improvement	Average	Above Average	Excellent
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

4. Saint Louis University (SLU) Care

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

5. Eye Associates

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

6. Dr. Mwintshi (nephrology) @ Nephrology & Hypertension Associates, LLC

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

7. Mercy (cardiology & GI/hepatology)

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

8. SSM (cardiology & GI) @ St. Mary's & DePaul

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○

	N/A	Needs Improvement	Average	Above Average	Excellent
Timeliness of available appointments	○	○	○	○	○

9. Dr. Theodore Otti (nephrology) @ St. Mary's & St. Alexius

	N/A	Needs Improvement	Average	Above Average	Excellent
Overall ease of scheduling a consultation	○	○	○	○	○
Ease of contacting the rendering provider	○	○	○	○	○
Helpfulness and courtesy of staff when scheduling	○	○	○	○	○
Timeliness of available appointments	○	○	○	○	○

10. On the following scale, how would you rate Logisticare's scheduling process?

	1	2	3	4	5	
Very difficult	○	○	○	○	○	Not difficult

11. On the following scale, how would you rate your overall satisfaction with Logisticare's services?

	1	2	3	4	5	
Not satisfied	○	○	○	○	○	Very satisfied

12. Other Comments:

Next

E. Pay for Performance Criteria and Benchmarks

PERFORMANCE CRITERIA	BENCHMARK
All Newly Enrolled Patients – Minimum of at least 1 office visit within 1 year (6 months before/after enrollment date).	80%
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%
Patients with Diabetes – Have one HgbA1c test within 6 months of reporting period start date.	85%
Patients with Diabetes – Have a HgbA1c less than or equal to 9% on most recent HgbA1c test within the reporting period.	60%
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%
Rate of Referral to Specialist among Tier 1/Tier 2 Enrollees	680/1000

F. 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 SLRHC released a request for proposals (RFP) on August 23, 2017. Proposals were due back to the SLRHC 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 developed the final evaluation design for the 2018-2022 approval period. SLRHC staff will implement the research design, calculate the results of the study, evaluate the results for conclusions, and write the Interim and Summative Evaluation Reports. Mercer will review the research, results and report for its alignment with the research design and verify the appropriateness of the reported results.

Mercer has over 25 years assisting state governments with the design, implementation and evaluation of publicly sponsored health care programs. Mercer currently has over 25 states under contract and has 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 work 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

G. Conflict of Interest Statement

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."

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.

G. Conflict of Interest Statement

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."

H. Evaluation Budget

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

I. 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