"Gateway to Better Health"

Operations Plan

December 28, 2011

Number: 11-W-002050/7

Introduction

On July 28, 2010, Missouri's request for a section 1115 demonstration project, entitled "Gateway to Better Health," was approved. This demonstration project provides financial support to St. Louis ConnectCare, Grace Hill Health Centers (formerly named Grace Hill Neighborhood Health Centers), and Myrtle Hilliard Davis Comprehensive Health Centers for two years until June 30, 2012. Beginning July 1, 2012, a pilot program will be implemented to enroll low-income, uninsured individuals who are not currently eligible for Medicaid into a health care coverage model. Additionally, for all years of the Demonstration, administrative support for the St. Louis Regional Health Commission and the St. Louis Integrated Health Network's Community Referral Coordinator (CRC) program will be provided.

In order to meet the requirements for the demonstration project, the State of Missouri Department of Social Services has asked the St. Louis Regional Health Commission (RHC) to lead planning efforts to determine the pilot program design – subject to the review and approval of the Centers for Medicare and Medicaid Services (CMS) – and to incorporate community input into the planning process. Accordingly, on July 21, 2010, the RHC approved the creation of a "Pilot Program Planning Team." The MO HealthNet Division of the Missouri Department of Social Services is represented on the Planning Team to ensure the RHC and MO HealthNet are working closely to develop the deliverables and to fulfill the milestones of the demonstration project.

Background

"Gateway to Better Health" Demonstration Project

Approved on July 28, 2010, the "Gateway to Better Health" Demonstration Project includes the following main objectives:

I. Preserve the St. Louis City and St. Louis County safety net of health care services available to the uninsured until a transition to health care coverage is available under the Affordable Care Act;
II. Transition the "St. Louis model" to a coverage model as opposed to a direct payment model by July 1, 2012;
III. Connect the uninsured and Medicaid populations to a primary care home which will enhance coordination, quality, and efficiency of health care through patient and provider involvement;
IV. Maintain and enhance quality service delivery strategies to reduce health disparities; and

V. For the first two years of the Demonstration, ensure that there is a 2% increase in the number of uninsured persons receiving services at St. Louis ConnectCare, Grace Hill Health Centers, and Myrtle Hilliard Davis Comprehensive Health Centers.

As mentioned above, by July 1, 2012, the State must implement a pilot program, subject to review and approval by CMS, whereby it will provide a defined health coverage benefit to uninsured individuals residing in St. Louis City and St. Louis County with family income at or below 133% of the Federal Poverty Level (FPL). Only persons who do not meet the eligibility requirements of the Medicaid State plan are eligible for the Demonstration. The goal of the pilot program is to bridge to the implementation of health care reform by preparing the safety net providers and uninsured individuals served by the safety net providers in St. Louis City and St. Louis County for the coverage options available under health reform by January 1, 2014.

As of September 2011, the State of Missouri with the input of the St. Louis community through the St. Louis Regional Health Commission has met all the milestones of the Demonstration. This document is milestone number 6 as detailed in Section XIII, Page 20 of the Special Terms and Conditions. As with all previous deliverables, the Pilot Program Planning Team has been involved in the development of this plan, and approved it on December 14, 2011. The roster of this team is provided in Appendix A. The St. Louis Regional Health Commission approved this document on December 21, 2011.

Please note that the recommendations in this document are based on all the parameters outlined in the Pilot Plan submitted June 30, 2011, to CMS. Because CMS has not provided additional guidance, the planning teams have moved forward under the assumption that the Pilot Plan will be approved as submitted. While operational planning may be adjusted based on the parameters approved by CMS, if CMS does not approve certain key recommendations, it may be difficult to meet the deadlines for enrollment and systems changes.

Situation Analysis

History of the "St. Louis Model"

The current funding provided by this Demonstration Project (Number: 11-W-00250/7) builds on and maintains the success of the "St. Louis Model", which was first implemented through the "Health Care for the Indigent of St. Louis" amendment to the Medicaid Section 1115 Demonstration Project (Number: 11-W00122/7). This amendment authorized the diversion of 6.27 percent of the Statewide DSH cash distributions, previously allocated to St. Louis Regional Hospital, to a "St. Louis Safety Net Funding Pool," which funded primary and specialty care for the uninsured. The downsizing and ultimate closure of St. Louis Regional Hospital in 1997 led to the "St. Louis Model." Under this model, the DSH funds were distributed directly to the legacy clinics of St. Louis Regional Hospital.

The RHC was established under this prior waiver to coordinate, monitor, and report on the safety net network's activities and to make recommendations as to the allocation of these funds. Today, the RHC is charged with improving health care access and delivery to the uninsured and underinsured in the St. Louis region. The Commission works within a large network that includes St. Louis County and its public health department and area Federally Qualified Health Centers (FQHCs) and hospitals. The RHC, St. Louis Integrated Health Network's Community Referral Program and three "Affiliation Partners" are supported with the funds of this Demonstration Project. These "Affiliation Partners" are:

St. Louis ConnectCare, formed in 1997 to provide needed ambulatory services to primarily uninsured and low-income populations who received healthcare through the St. Louis Regional Medical Center integrated health system. In 2005, St. Louis ConnectCare transferred (or "affiliated") its primary care clinics to Grace Hill Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers and focused exclusively on building an accessible specialty and diagnostic care network to support patients who utilize the community-based health centers as their medical home. St. Louis ConnectCare has been transformed to provide specialty health care and urgent care services to the uninsured since St. Louis Regional Medical Center closed.

Primary care physicians from the FQHCs, the St. Louis County primary care clinics, and local community-based volunteer health care clinics refer patients for one or more of thirteen medical and surgical specialties, five radiological modalities, and/or endoscopic procedures in the region's only stand-alone ambulatory surgical center available to all, regardless of ability to pay. If an uninsured patient needs care beyond those that St. Louis ConnectCare directly provides, the Utilization Management Department arranges for advanced diagnostics (MRI, PET, MRA, etc.) procedures and limited hospital services under a voucher system to pay for diagnostic procedures and physician services in a hospital setting.

Grace Hill Health Centers, an FQHC that operates six community health centers strategically located to be accessible to low-income and uninsured residents in St. Louis' medically underserved neighborhoods. The centers are staffed and equipped to provide comprehensive primary and preventive health care. In addition, community health services provided include prenatal and pediatric case management by skilled community health nurses and nurse assistants and an extensive chronic disease management program that uses health coaches to help patients achieve an improved health status. Through health outreach, neighbors are trained to help neighbors access health care services. Two of the Grace Hill Health Centers, formerly ConnectCare primary care clinics, receive funding through the Demonstration

Project. The former ConnectCare primary care clinics transferred to Grace Hill are referred to as "legacy clinics." The legacy clinics operated by Grace Hill are the Murphy O-Fallon Health Center and the Soulard-Benton Health Center.

Myrtle Hilliard Davis Comprehensive Health Centers, an FQHC that operates three community health centers that are located in St. Louis' medically underserved areas. Services are comparable to those offered at other FQHCs. Two of the community health centers, formerly ConnectCare primary care clinics, receive funding through the Demonstration Project. The former ConnectCare primary care clinics transferred to Myrtle Hilliard Davis are referred to as "legacy clinics." The legacy clinics operated by Myrtle Hilliard Davis are the Homer G. Phillips Health Center and the Florence Hill Health Center.

St. Louis Integrated Health Network (IHN), Community Referral Coordinator Program, a 501 c3 comprised of primary and specialty medical care providers in the St. Louis region. The goal of the IHN is to ensure access to health care for uninsured and underinsured through increased integration and coordination of a safety net of health care providers. Members of the IHN include Grace Hill Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, Betty Jean Kerr People's Health Centers, Family Care Health Centers, Saint Louis ConnectCare, St. Louis County and St. Louis City Departments of Health, Washington University School of Medicine and Saint Louis University School of Medicine. The St. Louis Regional Health Commission and Missouri Primary Care Association serve as technical advisors to the IHN. The Community Referral Coordinators employed by the IHN work with uninsured individuals who present at emergency rooms to educate patients on available resources for primary, non-emergent care, to schedule follow up appointments with primary care providers, and arrange transportation to appointments. These services are coordinated with individuals while they are in the emergency room.

As stated in the Special Terms and Conditions of the Demonstration Project, the State of Missouri with the support of the St. Louis Regional Health Commission, is in the process of transitioning the "St. Louis model," which provides funding to the aforementioned "Affiliation Partners," to a coverage model as opposed to a direct payment model by July 1, 2012.

Roles and Responsibilities of Key Partners

Implementation and administration of "Gateway to Better Health" Pilot Program will be integrated within the existing administrative structure of the Missouri Department of Social Services (DSS) and the St. Louis Regional Health Commission (RHC). DSS is the State agency responsible for administering the program. A description of the roles and responsibilities for each of the key organizations involved in the overall implementation of Gateway to Better Health has been provided below.

Missouri Department of Social Services

The MO HealthNet Division (MHD) and Family Support Division (FSD) of the Missouri Department of Social Services will be actively involved in the implementation of the Gateway to Better Health program. The MHD will continue to work closely with the RHC, and will provide policy coordination and support for the Gateway to Better Health Pilot Program, including overseeing all reporting requirements to CMS. In addition, MHD will be involved with the collecting of encounter claims and the processing of fee-for-service (FFS) claims. FSD is a state-administered agency responsible for the eligibility and enrollment process for Medicaid, as well as other state programs. For the purposes of the Gateway to Better Health program, FSD eligibility specialists will screen for Medicaid eligibility and determine eligibility for Gateway. FSD will train key health center staff, who will work with patients to complete applications. FSD will process changes that impact eligibility or service delivery (i.e. address changes) when reported by the consumer.

St. Louis Regional Health Commission

As requested by DSS, the RHC will be responsible for overseeing the day-to-day operations of the pilot program. The RHC is a not-for-profit, public/private partnership created to improve access to health care and to reduce health disparities in St. Louis City and County. The RHC was founded in 2001 in response to a health care crisis precipitated by the closing of the area's last remaining public hospital. The RHC will: manage cross-organizational planning teams to provide ongoing input into the operations of the pilot; develop and manage service level agreements and contracts with the provider network and vendors; oversee the distribution of funds to providers based on enrollment, claims filed with the State and pay for performance criteria; monitor enrollment to ensure enrollment targets are being met; manage the enrollment caps and wait lists based on actual enrollment and utilization; facilitate the outreach and application assistance provided by the health centers; and manage contracts with vendors to provide the information technology, call center, member materials and utilization management services. The RHC will provide monthly updates and reports to its Community Advisory Board, Provider Services Advisory Board, and the members of its Commission, ensuring transparency and accountability to the St. Louis community for the duration of the Demonstration. Each month, members of the Commission, including two appointees from the State, will consider recommendations regarding enrollment caps to ensure financial targets are met.

Grace Hill Health Centers

Two of Grace Hill Health Centers' sites are included in the provider network. They include Murphy O'Fallon Health Center and Soulard-Benton Health Center. Grace Hill is expected to

provide primary care services and serve as a medical home for approximately 11,000 people throughout the 18 months of the pilot program. Grace Hill will be responsible for providing outreach to their uninsured population, assisting eligible patients with the application process and submitting claims data on a monthly basis. In addition, Grace Hill will be expected to meet the identified quality measures to qualify for performance-based incentive payments throughout the pilot.

Myrtle Hilliard Davis Comprehensive Health Centers

Two of Myrtle Hilliard Davis Comprehensive Health Centers' sites are included in the provider network. They include Homer G. Phillips Health Center and Florence Hill Health Center. Myrtle Hilliard Davis is expected to serve as a medical home for approximately 7,000 patients throughout the 18 months of the pilot program. To ensure enrollment targets are met, they will be responsible for outreaching to their uninsured population, assisting eligible patients with the application process and submitting claims data on a monthly basis. Myrtle Hilliard Davis also will be expected to meet the identified quality measures in order to qualify for performance incentive payments.

St. Louis ConnectCare

St. Louis ConnectCare is the specialty, diagnostic and urgent care provider in the Gateway provider network. St. Louis ConnectCare is expected to provide specialty and urgent care to an estimated 24,286 people throughout the 18-month pilot program. ConnectCare will be responsible for ensuring patients eligible for Tier 2 only benefits[1] submit completed applications and that patients who present in the Urgent Care center who may be eligible for Gateway are encouraged to apply. ConnectCare also is expected to meet quality measures in order to qualify for performance incentive payments.

St. Louis Integrated Health Network

St. Louis Integrated Health Network (IHN) is a 501 c3 designed to ensure access to health care for uninsured and underinsured through increased integration and coordination of a safety net of health care providers. Members of the IHN include Grace Hill Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, Betty Jean Kerr People's Health Centers, Family Care Health Centers, Saint Louis ConnectCare, St. Louis County and St. Louis City Departments of Health, Washington University School of Medicine and Saint Louis University School of Medicine. The St. Louis Regional Health Commission and Missouri Primary Care Association serve as technical advisors to the IHN.

The IHN Community Referral Coordinators will assist in the outreach process for the Gateway program. They will provide information about the Gateway program to uninsured individuals without a primary care provider they encounter in the emergency departments and refer the individuals to health centers in the provider network as appropriate.

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[1] In the Pilot Plan submitted by the State to CMS on June 30, 2011, the State recommended that the Pilot Program provide Tier 2 only benefits (specialty and urgent care services) to eligible patients up to 200% of the Federal Poverty Level. Today, these patients receive primary care services at community health centers throughout St. Louis and are referred for services at St. Louis ConnectCare by their primary care physicians as needed.

In addition, all the IHN members with primary care center sites will refer patients for specialty care services at ConnectCare. All of the IHN member organizations also are eligible for consideration as a provider on a contingency basis if one of the providers in the network is unable to provide the services to the patients.

Wakely Consulting Group

Wakely Consulting Group, the actuarial firm contracted to assist in the planning efforts for the Gateway program, will develop the medical services budget and actuarially sound per-member-per-month (PMPM) for the Gateway program. Wakely will continue to be engaged during the program to help adjust projections based on actual utilization and to provide risk adjusted PMPMs for the primary care providers every six months of the Pilot.

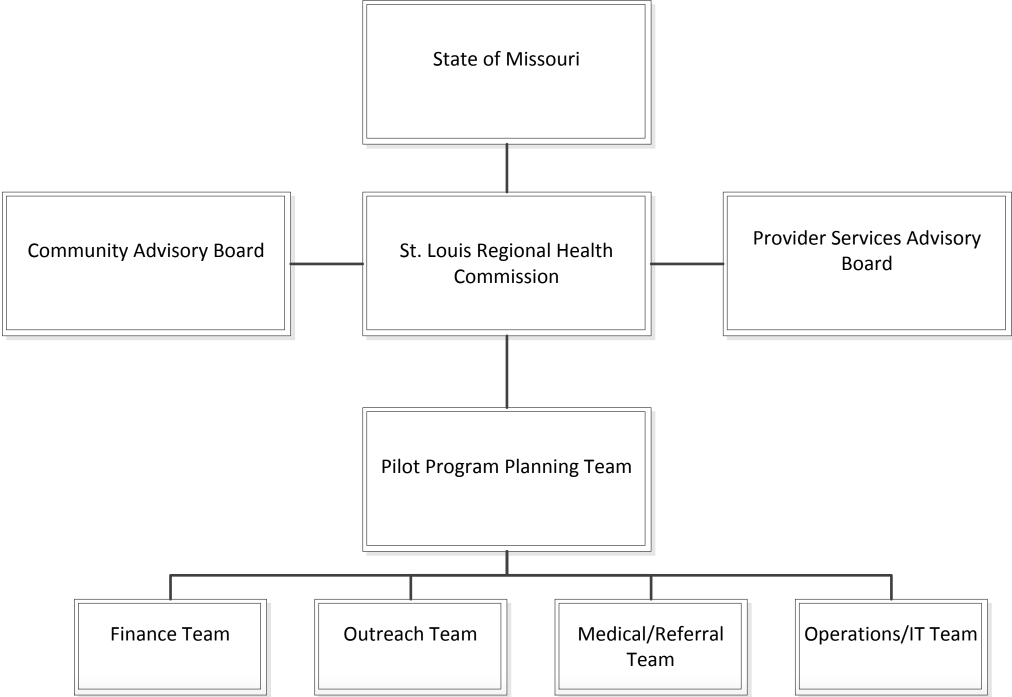
Automated Health Systems

Automated Health Systems (AHS) will provide operational assistance for the pilot program, including staffing a call center to help patients and providers navigate the program through enrollment to ongoing case management, distributing enrollment packets and other information to patients, and providing the technical interface between the Gateway program and the eligibility, enrollment and claims processing systems that will be deployed by the State. AHS will process requests from consumers to change health centers and update MHN Systems' managed care database via online transactions or through a nightly batch file. AHS also has contracted with Permedion to provide utilization management services for the program.

Pilot Program Project Infrastructure

In order to ensure transparency and accountability throughout the Pilot Program, the RHC will implement and manage a team infrastructure. The RHC will perform in this operational capacity at the request of the State of Missouri.

Illustration I: Pilot Program Project Infrastructure



Narrative for Illustration I

In its role as fiscal agent and program manager, the St. Louis Regional Health Commission will manage the interface with both its Community and Provider Services Advisory Boards as well as direct the work of the Pilot Program Planning Team and its sub-teams. All meetings of all teams will be posted on the RHC's web site, and announced at the advisory board and other community meetings. All meetings are open to the public. The output of the teams will be presented and considered by the advisory boards and other public bodies.

The Pilot Program Planning Team will continue to provide input and oversight of the activities of the Pilot. It will review the work of the sub-teams in advance of any recommendations going before the members of the RHC board. Outlined below is the charge and membership of each proposed team:

Charge	Organizations Represented
Pilot Program Planning Team • Develop recommendations for a pilot program to enroll low-income, uninsured individuals who are not currently eligible for Medicaid into a defined health coverage benefit model to operate beginning July 1, 2012; and • Ensure all milestones of the "Gateway to Better Health" Demonstration Project are completed and submitted on time. • Provide operational oversight of the Gateway to Better Health Pilot Program	• Washington University School of Medicine • BJK People's Health Centers • Family Care Health Centers • St. Louis ConnectCare • Grace Hill Health Centers • St. Louis County Department of Health • International Institute of St. Louis • Department of Social Services, State of Missouri • SSM Health Care St. Louis • Places for People (mental health provider)
Outreach Team • Develop an outreach and marketing plan for the Demonstration project • Develop a process for providing and capturing ongoing patient communications	• International Institute of St. Louis • Department of Social Services, State of Missouri • Grace Hill Health Centers • Epworth Children & Family Services • Myrtle Hilliard Davis Comprehensive Health Centers • St. Louis Integrated Health Network • Legal Services of Eastern Missouri • BJK People's Health Centers • St. Louis ConnectCare • St. Louis County Department of Health • St. Louis Diabetes Coalition • Barnes Jewish Hospital • Community members
Finance Team • Monitor financial results of the Pilot Program, and recommend adjustments in order to achieve financial goals • Monitor progress against sustainability benchmarks outlined in sustainability plans submitted to CMS	• Grace Hill Health Centers • Department of Social Services, State of Missouri • Myrtle Hilliard Davis Comprehensive Health Centers • St. Louis ConnectCare • Washington University School of Medicine • St. Louis County Department of Health • BJK People's Health Centers • Family Care Health Centers • St. Louis Integrated Health Network

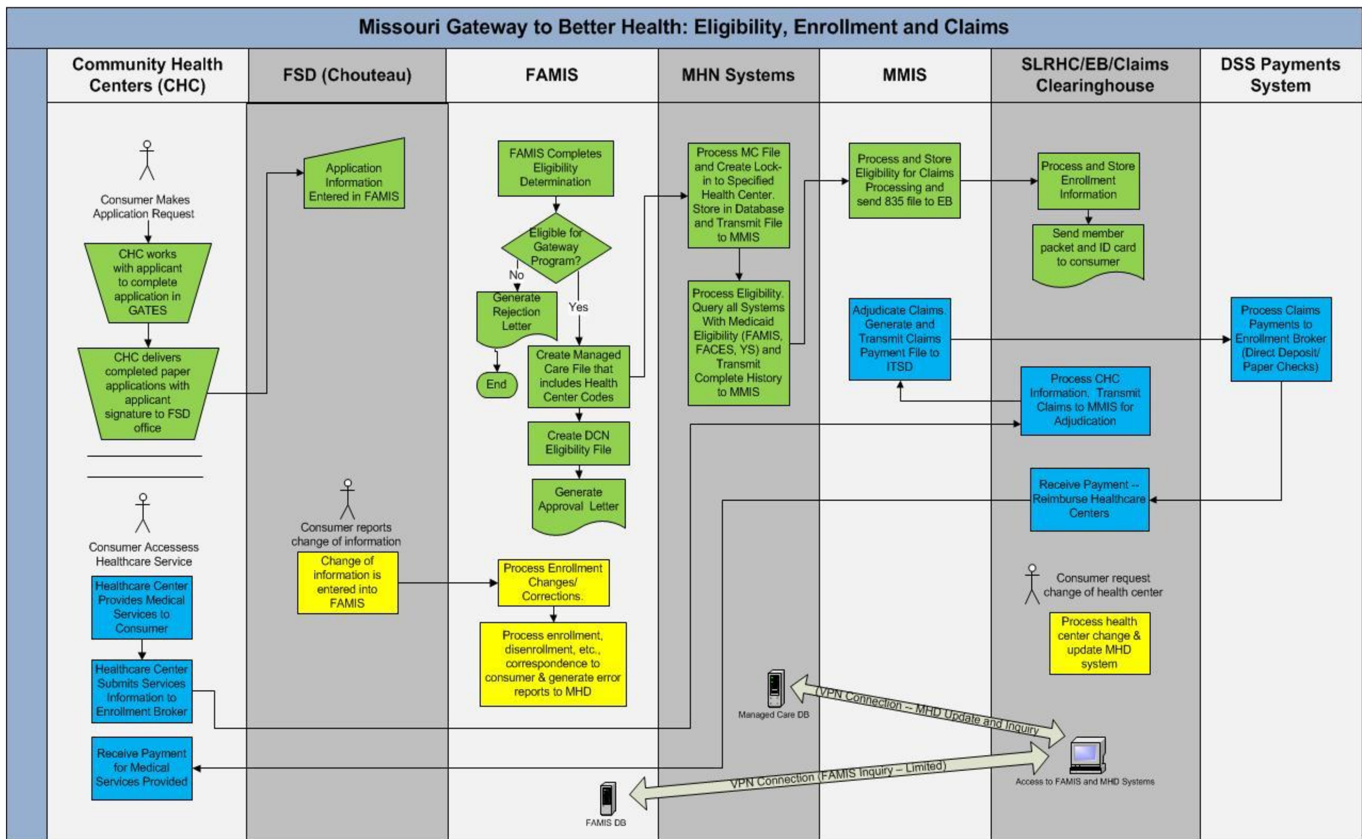
Medical/Referral Team • Develop methodology for effectively implementing/tracking pay-for-performance metrics • Monitor performance data from participating providers, and utilization management data • Monitor specialty care (Tier 2) referral process, and recommend adjustments to process as necessary	• Grace Hill Health Centers • Department of Social Services, State of Missouri • Myrtle Hilliard Davis Comprehensive Health Centers • St. Louis ConnectCare • Washington University School of Medicine • St. Louis County Department of Health • BJK People's Health Centers • Family Care Health Centers • St. Louis Integrated Health Network • Hospital representation • Community members
Operations/IT Team • Monitor performance of system integrations, ensuring implementation deadlines are met • Troubleshoot systems integration issues • Facilitate training/information to be shared with participating providers	• Grace Hill Health Centers • Department of Social Services, State of Missouri • Myrtle Hilliard Davis Comprehensive Health Centers • St. Louis ConnectCare • Washington University School of Medicine • St. Louis County Department of Health • BJK People's Health Centers • Family Care Health Centers • St. Louis Integrated Health Network

Operational and Systems Overview

Each of the involved entities has been meeting on a regular basis to design the operational infrastructure necessary in order to achieve the goals of the Pilot Program.

The process flow outlined below represents the current best thinking of how the plan will be operationalized, including the systems design necessary in order to determine eligibility, complete enrollment and issue payments for services rendered.

Illustration II:



Narrative for Illustration II:

Each entity will assume the following operational roles:

Gateway to Better Health **Entity Roles**	
Entity:	**Roles and Responsibilities:**
Community Health Centers (Grace Hill Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers and St. Louis ConnectCare)	1. Accept and assist consumers residing in St. Louis City and County with application process. Forward paper applications to FSD office on Chouteau Avenue for processing. 2. Provide medical services to consumers via the Gateway program for those that are eligible. 3. Submit services information to claims clearinghouse to initiate claims processing. 4. Receive payment for medical services provided.
Family Support Division(FSD), Chouteau Avenue Office	1. Eligibility Specialists enter the Gateway to Better Health and any other appropriate MO HealthNet applications into the Family Assistance Management Information System. 2. Conduct eligibility determination for the Gateway program. 3. Process changes that impact eligibility or service delivery (i.e. address changes) when reported by the consumer.
Family Assistance Management Information System (FAMIS)	1. Execute eligibility determination process. Assign appropriated Medicaid Eligibility (ME) code for Tier 1 and Tier 2 benefit packages. 2. For eligible consumers, create Managed Care records on nightly file that is picked up for processing by the MO HealthNet System. 3. Include DCN of eligible consumers on eligibility file that is picked up for processing by the MO HealthNet System. 4. Notify consumer of eligibility or ineligibility via letter delivered through postal service.
MO HealthNet Systems (MHN)	1. Managed Care system processes file created by FAMIS and assigns lock-in (i.e. assigns consumer to a specific clinic) based on facility code populated by FAMIS. File with lock-in is transmitted to MMIS and is

Gateway to Better Health Entity Roles	
Entity:	**Roles and Responsibilities:**
	used to adjudicate claims based on lock-in. 2. MO HealthNet Medicaid Eligibility system reads DCN files from FACES (Alternative Care, Adoptions, etc.,), FAMIS, Income Maintenance and Youth Services and builds a complete Medicaid eligibility history record for each consumer. Eligibility history file is transmitted to MMIS and is used to adjudicate claims based on ME codes.
Medicaid Management Information System (MMIS) and Fiscal Agent (WIPRO)	1. Process and store eligibility records transmitted from MHN on a nightly basis. 2. Adjudicate claims based on eligibility history provided by MHN Systems. ME code determines which service claims are covered. 3. Generate and transmit claims payment files to the DSS Payment System maintained by the Department Support Team, Information Technology Services Division.
AHS/SLRHC/Claims Clearinghouse	1. Process and store enrollment information provided on ITSD's managed care file. File is transmitted nightly. 2. Send enrollment packet to eligible consumers via USPS. 3. Issue ID cards to consumers to present at time of service at the appropriate Community Health Centers. 4. Process claims information for health care services provided by the Community Health Care centers (includes combining claims data from all centers). Transmit the claims data to MMIS for adjudication. 5. Receive payment for approved claims from the ITSD DSS Payment System. Disburse funds to the Community Health Centers based on incentive payment criteria being met. 6. Process requests to change health centers. Update MHN Systems' managed care database via online transactions or through a nightly batch file (TBD).

Gateway to Better Health Entity Roles	
Entity:	**Roles and Responsibilities:**
DSS Payment System	1. Process claims payment file provided by MMIS and generate payment to enrollment broker for services covered by the Gateway program.

The following timelines have been developed in order to complete the system implementations:

Gateway to Better Health Timeline for Design, Development and Implementation	
Task	**Date**
Wipro – MMIS Phase I Requirements Amendment Submitted by MHD (amend ST4538)	08/31/2011
Wipro—Business Requirements for MMIS Completed	09/28/2011
MHD approves MMIS Business Requirements	11/21/2011
FSD Approves FAMIS Business Requirements. Design Work Including Design Document and Data Model Changes Begins	12/05/2011
MHD and MHN Systems Completes Business Requirements for MHN Systems	12/06/2011
FSD—Business Requirements Documented and Submitted to ITSD/FAMIS	12/07/2011
Wipro—Submit Functional Design to MHD	12/16/2011
MHD Approves MHN Systems Business Requirements	12/09/2011
MHN Systems Begins Coding and Unit Testing	12/12/2011
MHN Systems Completes Coding and Unit Testing	12/15/2011
FSD Approves FAMIS Design--Coding and Unit Testing Phase Begins on FAMIS	12/19/2011
MHD approves MMIS Functional Design	12/23/2011
Wipro—Coding and Unit Testing Begins on MMIS	01/03/2012
Wipro Completes Coding and Unit Testing on MMIS	01/23/2012
FAMIS Provides Test Data to MHN Systems and Wipro (MMIS)	01/27/2012
Wipro begins testing with FAMIS test data	01/27/2012

Gateway to Better Health Timeline for Design, Development and Implementation	
Wipro completes testing with FAMIS	02/13/2012
Coding and Unit Test Phase Completed on FAMIS	02/13/2012
User Acceptance Testing Begins—Allowing 45 Calendar Days for Complete Test and Customer Sign-off	02/17/2012
Go/No-Go Decision for MMIS Production Release R1204	04/10/2012
Production Implementation – include with MMIS Production Release R1204	04/15/2012

Populations Served

Per the Special Terms and Conditions, the individuals who meet the following criteria will be eligible for Tier 1 and Tier 2 benefits:

- A citizen of the United States; legal immigrant who has met the requirements for the five-year waiting period for Medicaid benefits; refugee or asylee under same immigrant eligibility requirements that apply to the Medicaid program
- A resident of St. Louis City or St. Louis County
- Ages 19 through 64
- Uninsured
- At or below the federal poverty level of 133 percent
- Not eligible for coverage under the federal Medicare program or Missouri Medicaid
- Patients with a primary care home at one of the four legacy sites (former ConnectCare clinics) that are now operated by Grace Hill or Myrtle Hilliard Davis.

In addition to these eligibility terms, the Pilot Program will specifically target: a) young adults who are aging out of Medicaid and are at risk of losing healthcare coverage and b) patients with chronic illness who may significantly benefit from coverage.

The State recommends the Pilot Program provide specialty and urgent care benefits (Tier 2 only benefits) to those individuals who meet the following criteria:

- Citizens of the United States; legal immigrants who have met the requirements for the five-year waiting period for Medicaid benefits; refugees or asylees under same immigrant eligibility requirements that apply to the Medicaid program
- A resident of St. Louis City or St. Louis County
- Ages 19 through 64
- Uninsured
- At or below the Federal Poverty Level of 200 percent
- Not eligible for coverage under the federal Medicare program or Missouri Medicaid

Patients receiving Tier 2 benefits are referred to ConnectCare, one of St. Louis Regional Hospital's "legacy" sites, from primary care providers. More than 95% of these referrals come from members of the St. Louis Integrated Health Network. About 4% of the referrals for specialty care come from other primary care providers in the region. Members of the St. Louis Integrated Health Network include:

- Betty Jean Kerr People's Health Centers
- Family Care Health Centers
- Grace Hill Health Centers
- Myrtle Hilliard Davis Comprehensive Health Centers
- Saint Louis County Department of Health

Defining a "Legacy" Patient

To ensure patients whose healthcare is currently funded through the Demonstration continue to receive this support during the Pilot Program, the health centers will attempt to first enroll existing patients (those patients who have received services at one of the legacy sites within the last twelve months). Enrollment caps are projected to begin at 14,500 for people receiving Tier 1 and Tier 2 benefits and 18,000 for people receiving Tier 2 only benefits, based on current actuarial analysis. These enrollment caps are expected to increase over the life of the program as the reimbursement rate for St. Louis ConnectCare decreases.[2] At this time, enrollment caps at the end of the program are projected to be 17,300 for Tier 1 and Tier 2 beneficiaries and 21,000 for Tier 2 only beneficiaries. It is estimated that a total of 18,631 unique individuals would receive Tier 1 and Tier 2 benefits during the life of the program, and that 24,286 unique individuals would receive Tier 2 only benefits during the entire program. The enrollment cap projections are subject to change as actuarial analysis is finalized. In addition, the maximum enrollment numbers may change throughout the program based on the actual utilization of services for Gateway enrollees.

[2] In the Final Pilot Plan submitted in June 2011, the State proposed a graduated fee schedule for St. Louis ConnectCare, which started at 167% of Medicare for four quarters, stepped down to 150% of Medicare for one quarter and 100% of Medicare for the final quarter of the Pilot Program.

Eligibility and Enrollment Plan

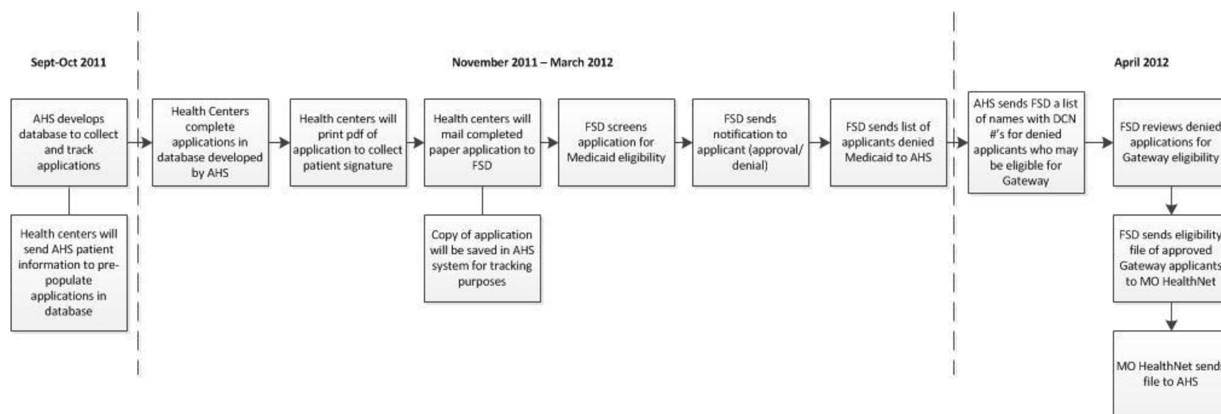
Outreach and Application Assistance

Grace Hill and Myrtle Hilliard Davis have been charged with developing an outreach plan for how they plan to reach their enrollment targets by July 1, 2012. Below is summary of the activities included in their outreach plan. A copy of each health center's outreach plan has been provided in Appendix B, Page 3.

Grace Hill and Myrtle Hilliard Davis started raising the awareness of the Gateway program within their health center sites in November 2011. Flyers and posters were placed throughout the health centers. AHS sent targeted mailings to people potentially eligible for the program on behalf of the health centers. Sample outreach materials have been provided in Appendix C, Page 10.

On July 1, 2012, ConnectCare will begin accepting applications for eligible patients who present at the Smiley Urgent Care Center. St. Louis ConnectCare will maintain its policies that encourage patients to establish primary care homes at one of the community health centers in the St. Louis area. To ensure patients of the Pilot Program do not begin to use urgent care services in place of a primary care home, Gateway patients will be eligible for up to a maximum of three urgent care visits throughout the program. (If patients utilize all three visits, they may access additional urgent care services from ConnectCare. Patients will pay for those services based on ConnectCare's sliding fee scale.)

Illustration III: Application Assistance Process/Timeline



Narrative for Illustration III

To assist with the management of enrollment targets, AHS developed a web-based, application database for health centers to collect Gateway applications during the application assistance period. This database is called GATES, Gateway Application Tracking and Eligibility System. GATES allows health centers to collect applications electronically, store completed applications and verification documents in one place and track enrollment progress. The web-based application follows the same design and content as the application developed by FSD provided in Appendix D, page 14. Using GATES, the health centers collect patient information and attach verification documents. Once applications have been

completed in GATES, the health centers print the completed applications, collect the patient's signature and send the paper applications and verification documents to FSD, which screens for Medicaid eligibility and determines Gateway eligibility.

For individuals applying for Tier 1 and Tier 2 benefits, the application process will take place at the health center sites of Grace Hill and Myrtle Hilliard Davis. To assist in the application process, FSD has trained workers at Grace Hill and Myrtle Hilliard Davis as Authorized Representatives of FSD to collect completed applications, thereby minimizing the need for eligibility specialists to contact patients to collect additional information. Each application will be accompanied by an IM Authorized Representative form (provided Appendix E, Page 19).

During the initial application assistance period, which started in November 2011, Grace Hill and Myrtle Hilliard Davis will collect applications from patients of legacy sites eligible for Tier 1 and 2 benefits. If enrollment targets are not met or close to being met by April 2012, the first phase of the contingency network will be activated. Grace Hill and Myrtle Hilliard Davis will begin enrolling eligible uninsured patients at their non-legacy sites. If by May 30, 2012, enrollment targets have not been attained, enrollment for Gateway will be opened to the remaining members of the contingency network[3]. These dates may be adjusted by the Pilot Program Planning Team if it appears enrollment targets may not be achieved.

Because there is no way to predict when or if a person will need specialty and/or urgent care services, the pre-enrollment period for people applying for Tier 2 only benefits will begin in June 2012 and will target those patients with specialty care appointments scheduled for July 1 or later. For individuals applying for Tier 2 only benefits, staff at referring health centers will assist patients with their applications. St. Louis ConnectCare will provide further application assistance as needed. Workers at ConnectCare will receive the application assistance training in April 2012.

Application assistance will continue to be provided throughout the 18-month program.

[3] In the Pilot Plan submitted by the State to CMS on June 30, 2011, the State recommended adding to the provider network, on a contingency basis, members of the IHN that provide health care services in St. Louis City and St. Louis County. The first two entities that would qualify as contingency providers are the non-legacy clinics operated by Grace Hill Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers. Other organizations that would qualify as contingency providers, if the need would arise, include Betty Jean Kerr People's Health Centers, Family Care Health Centers, Saint Louis County Department of Health, Saint Louis University School of Medicine and Washington University School of Medicine.

Gateway to Better Health Demonstration Project
Enrollment Timeline

	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012
Materials Development											
FSD approves Gateway application											
FSD develops training manual for health center staff											
AHS develops marketing materials											
Training											
FSD trains health center staff on application process											
Information on pilot program is sent to providers outside of the provider network											
Outreach/Enrollment Process											
Outreach and Enrollment for Tier 1 and 2 applicants begin											
– Grace Hill and Myrtle Hilliard Davis outreach and enroll at legacy sites											
– If targets are not met, outreach and enrollment opens at Grace Hill and Myrtle Hilliard Davis non-legacy sites											
– If enrollment targets still are not met, outreach and enrollment opens at other IHN primary care non-legacy sites											
Outreach and enrollment for Tier 2 only applicants											

Eligibility Determination and Enrollment Process

Using the Missouri Medicaid application as a basis, FSD developed an application for the Gateway to Better Health Program to be used to screen for Medicaid eligibility and determine Gateway eligibility (Appendix D, Page 14). Gateway applications will be available at Grace Hill, Myrtle Hilliard Davis, ConnectCare, and other health center sites, as needed. The same application will be used for individuals applying for Tier 1 and 2 benefits and Tier 2 only benefits. To streamline the application process for the Gateway program, self-declaration of Medicaid eligibility requirements[4] that do not apply to Gateway will be allowed. For the Gateway program, income for the last 30 days will be verified. Applicants also will provide identification, proof of residency, and information to confirm citizenship and immigration status to apply for the Gateway program.

FSD will program their eligibility determination system, FAMIS, to screen for Medicaid eligibility and to determine eligibility for the Gateway program. Once the applicants are determined to be eligible for Gateway, the data entered in FAMIS will be sent to the MHN system, where it is "locked in" for the management of claims and capitation payments. Once the MHN system has "locked in" the Gateway enrollees, eligibility files will be sent to AHS, who will issue the Gateway enrollment packet and card to members upon approval. The MHN system will send an eligibility and enrollment file to the MMIS for claims payment processing and reporting.

Once FSD receives completed applications, they will enter the applicant's information in FAMIS and screen for Medicaid eligibility and determine Gateway eligibility.

- If the person is potentially eligible for Medicaid, FSD will contact the patient and the health center that submitted the application to collect the appropriate verification documents needed for a complete Medicaid application. Individuals deemed eligible for Medicaid will be enrolled in the Medicaid program.
- If the person is not eligible for Medicaid, the FSD worker will review the application for Gateway eligibility. If the person is eligible for Gateway, FSD will send the applicant an acceptance letter for Gateway that includes information on their denial for Medicaid and the appeals process. FSD will also send the applicant's information to the MHN system. The MHN system will "lock-in" the patient information, and will then send an enrollment file to AHS. AHS will distribute the member's enrollment packet and card within 5 days of approval notification. If the person is not eligible for Medicaid or Gateway, the individual will receive a denial letter from FSD and continue to be eligible for services under the health center's sliding fee scale.

A flow chart of the eligibility and enrollment process has been provided in Appendix F, Page 21. Patients who apply for Gateway before the program is implemented on July 1, 2012, will continue to be eligible for services at the health centers on a sliding fee basis. If an individual may be eligible for Medicaid as determined by the person's self-declarations, the individual will have to complete Medicaid's eligibility process, and decisions will be made within Medicaid timeframes.

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[4] Medicaid requires verification of resources, assets, disability status, income/employment, and citizenship and immigration status.

FSD will verify submitted information against social security, food stamps, employment and other databases they are able to access. If the information submitted by the applicant does not support the information FSD finds in their databases, FSD will work with the respective health center to provide additional follow-up with the applicant. All applicants will be screened for and enrolled in other State programs as appropriate.

AHS will be notified of the status of all applications submitted as they will update the GATES systems, and run a call center for health centers, applicants and/or members to call to check enrollment status, ask questions,inquire about eligibility decisions or file complaints. AHS will also provide regular enrollment reports to the RHC and health centers.

Members Communications and Materials Distribution Process

AHS will be responsible for distributing enrollment materials to members. Once FSD has enrolled a person into Gateway, the individual's enrollment information will be sent to AHS. AHS will identify which benefits package (Tier 1 and 2 or Tier 2 only) the person has been enrolled into and distribute the appropriate enrollment materials. All Gateway enrollees will receive the following materials:

- Welcome Letter
- Benefits Summary
- Membership Card
- General Health and Wellness Information

The welcome letter will provide an overview of the Gateway to Better Health program, the patient's medical home, brief description of benefits and a number to call for more information.

For Tier 1 and 2 members, the benefits summary will be a membership handbook that describes the services covered and not covered under Gateway, instructions on how to use the membership card and list of co-pays by services (sample handbook provided in Appendix I). The benefits summary for Tier 2 members will describe the specialty and urgent care services available under Gateway and the co-pays associated with them. It also will describe the process for accessing specialty care services. All benefits summaries will include patient's rights and responsibilities, appeals/grievance policy and a HIPAA overview.

Membership cards will include patient's name, benefits tier, primary medical home, number to call for questions and other information as appropriate.

All enrollees will receive general health information throughout their enrollment in the program. Some of the information provided will include: the importance of a medical home, preventive health care and how to access the appropriate levels of care (when to and when not to use the emergency department).

AHS will distribute materials within five business days of receiving the enrollment notification from FSD. AHS will distribute replacement membership cards within three business days of request.

Once enrolled into the Gateway program, members will be instructed to contact AHS' customer call center for Gateway to file complaints or appeals, ask questions, request a change of provider or request a replacement membership card. To report changes to information or eligibility status, Gateway members will be asked to contact FSD directly. AHS will establish a toll-free number for members to

utilize. AHS will have a designated point-of-contact at the health centers, FSD and RHC to contact for any questions or concerns they are unable to address directly. The RHC will receive a report on the types of calls received by the AHS call center and a description of how each call was resolved, including the timeframe in which the call was answered and addressed.

Member Enrollment and Disenrollment Policy

Individuals who are approved for the Gateway program are enrolled in the program from the date of the application or the start of the pilot program (July 1, 2012), depending on enrollment timeframe, until the end of the pilot program (December 31, 2013).

Members will be asked to notify FSD if there are any changes in the information they submitted. Members will be disenrolled from the Gateway program if they submit information that demonstrates they are no longer eligible for the Gateway program.

Members will report changes to patient information (i.e. residence, pregnancy status, disability, etc.) to FSD. Once FSD receives the new information, they will determine if the enrollee is still eligible for the Gateway program.

- If the enrollee is no longer eligible for Gateway, FSD will take the appropriate action to close Gateway eligibility in FAMIS, which will send a record to MHN to close the "lock-in". FSD will screen the applicant for other State programs based on the new information.
- If the enrollee is now eligible for Medicaid or other State programs, FSD will collect verification documents as needed and enroll the patient in Medicaid and/or other State programs. FSD will notify the patient of their new benefits and disenrollment from Gateway, including information on the appeals process. AHS will be notified of the patient's disenrollment status and will notify the health center in its enrollment reports.
- If the patient is no longer eligible for Gateway and is not eligible for other State programs, FSD will send a letter to the patient notifying them that they are no longer eligible for the Gateway program and do not qualify for other State benefits. The letter will also explain the appeals process and that the patient will be able to receive services at their health center under the health center's sliding fee scale. AHS will be notified of the patient's disenrollment from Gateway, and will notify the respective health center.

Enrollees will continue to receive coverage under the Gateway program until it has been determined that they are no longer eligible for Gateway and/or have enrolled into another State program.

If the program achieves a wait list, patients who have not used any service within the first six months of enrollment will be contacted by AHS. They will be required to submit information indicating they want to remain enrolled in the program. If they do not submit the requested information, they will be disenrolled from the Gateway program.

Enrollees also will have the option to change primary care homes within the provider network under the Gateway program. If an enrollee would like to change health centers to another one in the provider network, the enrollee must contact the Gateway customer call center to request change and provide a reason for change. AHS will note the new provider under the patient files and send the updated enrollment information to the MHN system. AHS will also notify the health centers in its enrollment files.

Member Wait List Policy

To ensure the sustainability of Gateway to Better Health, enrollment caps are projected to begin at 14,500 for people receiving Tier 1 and Tier 2 benefits and 18,000 for people receiving Tier 2 only benefits, based on current actuarial analysis. These enrollment caps are expected to increase over the life of the program as the reimbursement rate for St. Louis ConnectCare decreases.[5] At this time, enrollment caps at the end of the program are projected to be 17,300 for Tier 1 and Tier 2 beneficiaries and 21,000 for Tier 2 only beneficiaries. It is estimated that a total of 18,631 unique individuals would receive Tier 1 and Tier 2 benefits during the life of the program, and that 24,286 unique individuals would receive Tier 2 only benefits during the entire program. The enrollment cap projections are subject to change as actuarial analysis is finalized. In addition, the maximum enrollment numbers may change throughout the program based on the actual utilization of services for Gateway enrollees. Details about the management of the enrollment caps are on Page 41.

Once the Gateway program achieves membership at its current enrollment cap, a waiting list will be established for individuals applying to the Gateway program, but are unable to be considered for enrollment at the time of application submission.

At a minimum, enrollment will be monitored on a weekly basis. Enrollment sites, MHD and FSD will be notified by AHS when 75% of the projected enrollment of either cap has been achieved. They will be notified again at increments of 85% and 95%. At 95%, the enrollment sites will be asked to notify patients who complete applications that they may be put on a wait list. Individuals will be enrolled in the Pilot Program from the wait list as room becomes available in the program due to either disenrollment or because more budget has become available due to the declining reimbursement rate for St. Louis ConnectCare. Based on current projections, up to 2000 applications will be received and processed for each wait list. This number is subject to change based on actuarial projections. After the maximum number of individuals is on either waiting list, no additional applications will be received for that level of benefit until at least 50 patient slots open up. FSD will screen all applications on the waiting list for Medicaid eligibility. A flowchart of this process has been provided in Appendix G, Page 23.

In addition to monitoring enrollment targets, for the Tier 2 only benefits paid on a fee-for-service basis, Gateway expenditures will be monitored by the RHC and State to ensure funding remains within budget targets. Enrollment targets and wait lists will be adjusted accordingly.

The waiting list will be maintained by AHS. When disenrollment has opened up room for additional enrollment, individuals will be enrolled in the order of the date of the application as received by FSD.

If individuals on the waiting list become eligible for enrollment, and if their application is older than 30 days, AHS will contact the health center and patient to determine if any information has changed. The application will be amended as needed and reviewed by an FSD eligibility specialist.

[5] In the Final Pilot Plan submitted in June 2011, the State proposed a graduated fee schedule for St. Louis ConnectCare, which started at 167% of Medicare for four quarters, stepped down to 150% of Medicare for one quarter and 100% of Medicare for the final quarter of the Pilot Program.

Individuals on the waiting list will still be able to receive primary and specialty care services under the health centers' sliding fee scale as they had before the implementation of the pilot program and as there is capacity for service in the community.

Provider Communications and Training Plan

Staff at each of the health centers in the provider network will receive information describing the Gateway to Better Health program along with an overview of the services covered and not covered, a picture of the membership card and a number to call for more information. This information also will be distributed to health centers outside of the provider network and emergency departments so that they are aware of the new program and are able to address members that show up at their centers/departments trying to use their cards.

Training on how to complete the application will be provided by FSD to registration and outreach staff at the health centers in the provider network. Health center staff will be responsible for ensuring complete applications are submitted to FSD to prevent a delay in processing the application. Training will also be provided to the billing department at the health centers to ensure claims are coded and submitted in the appropriate format. This training will be provided by the claims processing vendor.

Provider Network

Per the Special Terms and Conditions of the Gateway to Better Health Demonstration, the provider network will be:

- St. Louis ConnectCare
- Two legacy clinics operated by Myrtle Hilliard Davis Comprehensive Health Centers:
    - Homer G. Phillips Health Center
    - Florence Hill Health Center
- Two legacy clinics operated by Grace Hill Health Centers:
    - Murphy O'Fallon Health Center
    - Soulard-Benton Health Center

The St. Louis Regional Health Commission will establish contracts with the members of the provider network. These contracts will be established for the time period of July 2011 – March 2014, to allow for the runout of claims and to ensure all reporting requirements are met.

Pending successful contracting with AHS, they will secure contracts with the providers serving patients through the voucher program.

It is anticipated that components of the service agreements with the providers will include but not necessarily be limited to:

- Credentialing and licensure
- Retention of records
- Provider responsibility to collect co-payments
- Prior authorization guidelines
- Patient rights
- Timely filing of claims
- Over/underpayment guidelines
- Appeals process
- Reporting/monitoring requirements
- Appointment wait times
- Minimum enrollment targets
- Maximum enrollment caps

In order to maintain budget neutrality, the RHC will incur no more than a total of $30 million per federal fiscal year, or $7.5 million per quarter, for program expenses, including administrative expenses.

Capacity

If it is determined by the St. Louis Regional Health Commission that one of the providers is unable to fulfill the terms of the service agreements, the RHC will establish contracts with one or more of the

providers in the contingency network[6]. Those providers would be subject to the same contract terms as those in the minimum provider network.

The RHC will monitor contract compliance, including requiring providers to self-report on a quarterly basis on appointment wait times, in order to evaluate capacity of the providers. The RHC also will conduct patient satisfaction surveys, which will ask about appointment wait times.
Based on similar guidance for Missouri Medicaid plans, the health providers shall have the capacity to ensure that the time elapsed between the request for appointments and the scheduled appointments do not exceed the following:

1) Urgent care appointments for illness/injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): appointments within twenty-four (24) hours.

2) Routine care with symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): appointments within one (1) week or five (5) business days whichever is earlier.

3) Routine care without symptoms (e.g. well child exams, routine physical exams): appointments within thirty (30) calendar days.

4) Specialty care appointment wait time guidelines will be determined in the Spring of 2012 by the Pilot Program Planning Team based on capacity in the marketplace.

Gateway to Better Health Providers will be required to notify the RHC immediately if an Act of God or other unforeseen circumstance makes it impossible to continue to provide the contracted services. At such time, the RHC will seek services from providers in the contingency network.

Voucher Services

Patients with Tier 1 and Tier 2 benefits and Tier 2 only benefits also will be eligible for limited benefits administered through a “voucher” program as funding allows. All voucher services will be reimbursed on a fee-for-service basis based on contracts established with the RHC. Current actuarial projections include an average reimbursement rate for voucher services of 85 percent of Medicare.

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[6] In the Pilot Plan submitted by the State to CMS on June 30, 2011, the State recommended adding to the provider network, on a contingency basis, members of the IHN that provide health care services in St. Louis City and St. Louis County. The first two entities that would qualify as contingency providers are the non-legacy clinics operated by Grace Hill Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers. Other organizations that would qualify as contingency providers, if the need would arise, include Betty Jean Kerr People’s Health Centers, Family Care Health Centers, Saint Louis County Department of Health, Saint Louis University School of Medicine and Washington University School of Medicine.

Benefits

Medical Services Covered

Eligible patients who choose a medical home at one of the primary care clinics in the provider network will receive Tier 1 and Tier 2 benefits. Eligible patients referred by other primary care providers for specialty care, or eligible patients who self-refer to the Smiley Urgent Care Center at ConnectCare will receive Tier 2 benefits.

Patients enrolled with Tier 1 benefits will have access to the following services:

> Preventative; wellcare; dental (diagnostic, periodontal, preventive, prosthodontics and the removal of erupted teeth); internal and family practice medicine; gynecology; podiatry, generic prescriptions dispensed at primary care clinics

Patients enrolled with Tier 2 benefits will have access to the following services:

> Cardiology; DME (on a limited basis); endocrinology; ENT; gastroenterology; neurology; oncology, radiation therapy, rheumatology, laboratory/pathology services; ophthalmology; orthopedics; outpatient surgery; physical, occupational or speech therapy (on a limited basis); pulmonology; radiology (x-ray, MRI, PET/CT scans); renal; urology; urgent care (up to a maximum of 3 visits during the program); non-emergency medical transportation; and generic prescriptions dispensed at an urgent care or specialty care clinic in the network

See Appendix J for a comparison of procedure codes offered by Gateway to Better Health compared to MO HealthNet Medicaid.

Pharmacy Coverage

Generic prescriptions dispensed at the health center chosen as a primary care home by the patient or at St. Louis ConnectCare are covered under this plan.

In-Network Pharmacies

- Myrtle Hilliard Davis Homer G. Phillips Health Center
  2425 N. Whittier
  St. Louis, MO 63113
  (314) 371-3100
- Myrtle Hilliard Davis Florence Hill Health Center
  5541 Riverview Blvd.
  St. Louis, MO 63120
  (314) 389-4566
- Grace Hill Soulard-Benton Health Center
  2220 Lemp Ave.
  St. Louis, MO 63104
  Automated refill pharmacy line number: (314) 898-1063

- Grace Hill Murphy O'Fallon Health Center
  1717 Biddle Street
  St. Louis, MO 63106
  Automated refill pharmacy line number: (314) 898-1061
- St. Louis ConnectCare Pharmacy
  5535 Delmar Blvd
  St. Louis, MO 63112
  Pharmacy Phone: (314) 879-6208
  Pharmacy Refill Line: (314) 879-6332

Out-of-Network Policy

The Gateway to Better Health program will only cover primary care services provided by the health centers in the provider network. The program also will only cover specialty care provided by in network providers.

In-network providers include:

- For primary care, or the receipt of Tier 1 benefits:
  - Two legacy clinics operated by Myrtle Hilliard Davis Comprehensive Health Centers
    - Homer G. Phillips Health Center
    - Florence Hill Health Center
  - Two legacy clinics operated by Grace Hill Health Centers:
    - Murphy O'Fallon Health Center
    - Soulard-Benton Health Center
- For specialty care, or the receipt of Tier 2 benefits:
  - St. Louis Connect Care
  - Services not available at St. Louis ConnectCare will be available at other locations administered through a voucher program. These will require prior authorization.

In the event enrollment targets are not reached and members of the contingency network are activated, services at those network providers will be covered.

> *In the Pilot Plan submitted by the State to CMS on June 30, 2011, the State recommended adding to the provider network, on a contingency basis, members of the IHN that provide health care services in St. Louis City and St. Louis County. The first two entities that would qualify as contingency providers are the non-legacy clinics operated by Grace Hill Health Centers and Myrtle Hilliard Davis Comprehensive Health Centers. Other organizations that would qualify as contingency providers, if the need would arise, include Betty Jean Kerr People's Health Centers, Family Care Health Centers, Saint Louis County Department of Health, Saint Louis University School of Medicine and Washington University School of Medicine.*

Services sought outside of in-network primary care providers are not covered by the Gateway program.

Cost Sharing Strategies

The Special Terms and Conditions outline that co-pays for the Pilot Project should be the same as those for patients of Missouri Medicaid, MO HealthNet. The following details the current co-pays for enrollees of the Missouri Medicaid Fee for Service plan:

$10.00 Inpatient Hospital per Hospitalization
$ 3.00 Outpatient Services
$ 1.00 Physician Services
$ .50 Clinic Services
$ 1.00 X-ray and Laboratory Services
$ 1.00 Nurse Practitioner Services
$ .50 CRNA Services
$ 2.00 Rural Health Clinic Services
$ 1.00 Case Management Services
$ 2.00 Federally Qualified Health Center Services
$ 2.00 Psychology Services

For Dental, Optical and Podiatry services, the following co-payments apply based on the provider's billed amount:

$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

Exemptions to Co-pay Requirements include:

- Emergency admissions or transfer inpatient admissions;
- Emergency services provided in an outpatient clinic or emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
    - Placing the patient's health in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part;
- Certain therapies - chronic renal dialysis, physical, radiation, and chemotherapy;
- Mental Health services provided by community mental health facilities operated by the Department of Mental Health or designated by the Department of Mental Health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system;
- Family planning services;
- Hospice services;
- NEMT public transit and gas reimbursement modes of transportation.

Under current pharmacy dispensing fee policy all Missouri Medicaid eligible participants are subject to the fee requirement when provided covered pharmacy services, with the exception of the following, which are excluded:

- Participants under age 19;
- Institutionalized participants who are residing in a skilled nursing facility, a psychiatric hospital, a residential care facility or an adult boarding home;
- Foster care children up to 21 years of age;
- All Medicare/Medicaid crossover claims as primary coverage;
- Those drugs specifically identified as relating to family planning services;
- Emergency services; and
- Services provided to pregnant women, which are directly related to the pregnancy or complication of the pregnancy

Pharmacy Dispensing Fees

The Missouri Medicaid pharmacy fee requirement is considered a portion of the professional dispensing fee and is *not* deducted from reimbursement to providers.

Ingredient Cost for Each Prescription	Member Fee Amount
0 - $10.00	$0.50
$10.01 - $25.00	$1.00
$25.01 – higher	$2.00

The co-pays listed above represent the entire proposed cost for patients of the Pilot Program. These thresholds will ensure the total annual aggregate amount of Demonstration cost sharing, Medicaid cost sharing, and CHIP premiums and cost sharing do not exceed 5 percent of family income for the year involved. Family income is determined under the methodology applicable to the group under the state's Medicaid plan.

Providers of service *must* charge and collect the copay or coinsurance amount. Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the participant's inability to pay the fee when charged. A participant's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the participant's liability to pay the amount due.

As a basis for determining whether a participant is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the participant's statement of inability to pay at the time the charge is imposed.

Specialty Care Referral Process

Patients eligible for Tier 1 and Tier 2 benefits, and those eligible for Tier 2 only benefits will be referred for specialty care from their primary care providers. Most of this specialty care will be provided at St. Louis ConnectCare. Some services are not offered by St. Louis ConnectCare. These covered benefits will be provided by other providers and funded through vouchers issued after the Gateway Utilization Management (UM) Department determines medical necessity.

Services covered through vouchers, which are subject to change include but are not limited to: allergy tests and treatment; cardiac diagnostics (e.g., EKG, stress test); chemotherapy; consultation with a specialist not available at ConnectCare (neurologist, ophthalmologist, pulmonologist, etc.); physician fees for ED visit or inpatient; labs, radiology and injectibles ordered by voucher-covered physicians; physical therapy (as needed post-surgery); advanced imaging (e.g., MRI); and surgeries other than those offered at ConnectCare's ambulatory surgery center.

Patients Eligible for Tier 1 and Tier 2 Benefits

After a primary care provider at one of the four primary care clinics in the Gateway provider network determines a patient needs specialty care available at St. Louis ConnectCare, the physician/care team will provide the patient with directions about how to schedule an appointment. After services are provided, the St. Louis ConnectCare physician will provide consultation notes to the referring physician who made the referral within a time to be determined.

For those patients who are referred to services provided through the voucher program, the referring physician/care team will:

1. Submit a prior authorization form for review to the Utilization Management Department.
    a. The Utilization Management Department shall notify the referring physician's office and specialty physician's office of its determination within 72 hours (non-emergency)/24 hours (emergency) of receipt of the prior authorization request.
    b. In cases where the Utilization Management Department determines a lack of medical necessity, the UM Department will notify the referring physician's office and recommended specialty physician's office of the determination within 24 hours of receipt.
2. Instruct patients that they should contact the recommended specialist's office to schedule an appointment. In the case of emergency referrals, the referring physician/staff may provide assistance in scheduling the appointment.

If patients have trouble scheduling an appointment, they will be instructed to call the Gateway call center. After services are provided, the specialist will provide consultation notes to the physician who made the referral within a time to be determined.

Patients Eligible for Tier 2 Only Benefits

Non-Urgent Referrals to St. Louis ConnectCare:

After a primary care provider at a community health center determines an uninsured patient needs specialty care available at St. Louis ConnectCare, the physician/care team will:

1. Notify the patient he/she may be eligible for assistance with their specialty care through the Gateway to Better Health Specialty Care Program.
2. Complete the application for the patient in GATES or provide the patient with a 1-800 number to call for assistance with completing the application.
    a. Completed applications are to be mailed/delivered to the local FSD office for processing, if collected prior to patient's appointment.
    b. Coverage determinations shall be communicated by AHS to the primary care physician's office and ConnectCare via the provider portal.
3. Instruct patients that upon completion and submission of the Gateway to Better Health eligibility application, they should contact St. Louis ConnectCare to schedule an appointment.

If patients have trouble scheduling an appointment, they will be instructed to call the Gateway call center. If patients provide applications at the time of appointment, St. Louis ConnectCare will fax a copy of the application to FSD, and then send the original copy of the application to the FSD local offices.

After services are provided, the specialist will provide consultation notes to the physician who made the referral within a timeframe to be determined.

Urgent Referrals to St. Louis ConnectCare:

After a primary care provider at a community health center determines an uninsured patient needs urgent specialty care available at St. Louis ConnectCare, the physician/care team will:

1. Instruct the patient he/she may be eligible for assistance with their specialty care through the Gateway to Better Health Specialty Care Program.
2. Complete the application for the patient in GATES or provide the patient with a 1-800 number to call for assistance with completing the application.
    a. Completed applications are to be mailed/delivered to the local FSD office for processing, if collected prior to patient's appointment.
    b. Coverage determinations shall be communicated by AHS to the primary care physician's office and ConnectCare via the provider portal.
3. Assist the patient with securing an appointment at St. Louis ConnectCare.

After services are provided, the specialist will provide consultation notes to the physician who made the referral within a timeframe to be determined.

Non-Urgent Referrals for Voucher Services:

After a physician determines an uninsured patient needs non-urgent specialty care available through the voucher program, the physician/care team will:

1. Submit a prior authorization form for review to the Utilization Management Department.
    a. The Utilization Management Department shall notify the referring and specialty physician's office of its determination within 72 hours of receipt of the prior authorization request.
    b. In cases where the Utilization Management Department determines a lack of medical necessity, the UM Department shall notify the referring physician's office and the recommended specialty physician's office of the determination within 24 hours of receipt.
2. Instruct the patient he/she may be eligible for assistance with their specialty care through the Gateway to Better Health Specialty Care Program.
3. Complete the application for the patient in GATES or provide the patient with a 1-800 number to call for assistance with completing the application.
    a. Completed applications are to be mailed/delivered to the local FSD office for processing, if collected prior to patient's appointment.
    b. Coverage determinations shall be communicated by AHS to the primary care and referring physicians' office via the provider portal.
4. Instruct patients that upon completion and submission of the Gateway to Better Health eligibility application, they should contact the recommended specialist's/provider's office to schedule an appointment.

If patients have trouble scheduling an appointment, they will be instructed to call the Gateway call center. If patients provide applications at the time of appointment, the physicians' office will fax a copy of the completed application to the local FSD office, and then have the original copy of the application delivered.

After services are provided, the specialist will provide consultation notes to the physician who made the referral within a timeframe to be determined.

Urgent Referrals for Voucher Services:

After a physician determines an uninsured patient needs urgent specialty care available through the voucher program, the physician/care team will:

1. Submit a prior authorization form for review to the Utilization Management Department:
    a. The Utilization Management Department shall notify the referring and specialty physician's office of its determination within 24 hours of receipt of the prior authorization request.
    b. In cases where the Utilization Management Department determines a lack of medical necessity, the UM Department will notify the referring physician's office and the recommended specialty physician's office of the determination within 24 hours of receipt.
2. Instruct the patient he/she may be eligible for assistance with their specialty care through the Gateway to Better Health Specialty Care Program.

3. Complete the application for the patient in GATES or provide the patient with a 1-800 number to call for assistance with completing the application.
    a. Completed applications are to be mailed/delivered to the local FSD office for processing, if collected prior to patient's appointment.
    b. Coverage determinations shall be communicated by AHS to the primary care physician's office and referring physician via the provider portal.
4. Assist the patient with securing an appointment with the recommended specialist's/provider's office.

After services are provided, the specialist will provide consultation notes to the physician who made the referral within a timeframe to be determined.

Necessary Forms and Documentation (Other than Application and Gateway Patient Information):

- Referral form
- Prior authorization forms to be completed by physicians
- Communications from UM to referring physicians
- Other UM forms

Utilization Management

For the utilization management component, AHS will subcontract with Permedion to provide all related services. All voucher services will be subject to pre-authorization by Permedion with exceptions for emergency services.

The Project team for RHC will be comprised of utilization management experts, led by Permedion's Medical Director, David Sand, MD, MBA, FACS, CHCQM and Sue Butterfield, RN, CCM, CPHQ Review Manager. In addition, Permedion will assign registered nurses, intake specialists and board-certified physician reviewers experienced in pre-certification. Their operations core team has expert knowledge of associated business processes and rules, best practices, and federal and state regulations that pertain to prior authorization projects.

Permedion's existing staff has completed the necessary core training for this engagement; upon award of business, their staff will receive contract-specific training. New project staff will participate in their training program, and all training will be completed prior to contract launch. For the Gateway to Better Health Demonstration Project, the initial training will employ a combination of classroom lecture, hands-on practice, skill strengthening exercises, and one-on-one mentoring so that assigned staff will:

- Understand privacy and confidentiality, including HIPAA regulations as they relate to the utilization control process;
- Understand and adhere to the requirements of the contractual relationship with the RHC;
- Follow applicable state and federal laws without exception;
- Understand the responsibilities of his or her position within the RHC's program;
- Be knowledgeable regarding operations of the RHC's program; and
- Understand the requirements of the Utilization Management program.

Reviewers will be equipped with criteria and reference material to ensure accurate decisions and citations:

- Coding Clinic, DRG, ICD-9-CM, CPT, HCPCS, AMA, CCI reference;
- Covered services and limitations, and prior authorization requirements;
- Milliman Care Guidelines.

Clinical Care Criteria

As part of the review process, Permedion provides access to and hard-copy versions of a variety of clinical care guidelines. These are available to all staff through Permedion's online reference portal, which also contains links to and copies of state provider manuals, regulations, and other criteria necessary for accurate review.

Evidence-based criteria and/or nationally recognized guidelines predicate the team's decisions.

Permedion staff maintains deep experience using national criteria, including Milliman Care Guidelines and InterQual Care Planning and InterQual Level of Care Criteria, along with specialized criteria, such as guidelines supplemented or modified by clients. Permedion has found the Milliman Care Guidelines ® to

be the most appropriate and highly referenced nationally-recognized criteria source for similar populations in their work on multiple contracts.

Permedion reviews and updates the selected criteria source annually, and have that source evaluated and approved by the Medical Director. This is a requirement to receive URAC accreditation, which Permedion holds in Health Utilization Management and Independent Medical Review. Information publicized within the provider community includes this set of criteria along with the rationale for each decision in case documentation.

As with any national criteria, these are open to interpretation to some extent, requiring modification of the application to conform to local practice and/or payor policy. Working together with AHS, Permedion will work closely with RHC to identify, apply, and modify any criteria that may fall into this category.

Proprietary Prior Authorization/Concurrent Review Software:
Gemini System Application for Prior Authorization

Gemini provides a structured environment for tracking prior authorization activity, ensuring that all required information associated with prior authorization requests is obtained and input in a consistent manner. Inconsistent data entries are flagged as they are being made to again allow correction at the error source.

Gemini also allows Permedion staff to produce letters and reports associated with the prior authorization activity accurately as needed, and helps staff monitor the progress of prior authorization requests to confirm that they are completed within required contract time periods. Permedion modifies their review applications (on an ongoing basis) as needed to meet any unique characteristics of their prior authorization activity for clients. Gemini provides Permedion staff an easy way to access a specific case and to enter or examine overview, notes, and decision information.

Permedion's experienced staff work closely with providers to obtain as much information as possible during the pre-certification process. Ultimately, Permedion refers 1.5% of outpatient specialty services and diagnostic imaging exam pre-certification requests to physician advisors for review and determination.

Consistent with Permedion's URAC accreditation, nurses cannot make a denial determination. If a nurse reviewer cannot approve **any** request for service, the case is forwarded to a physician reviewer for determination.

Permedion's panel of nearly 700 physicians/specialists represents more than 70 specialties, including every specialty recognized by the American Board of Medical Specialties (ABMS). Upon award, together with AHS, Permedion will recruit, credential and educate Missouri-licensed physicians in the necessary specialties. Permedion currently has eight board certified physicians who are licensed in Missouri. As needed, they will recruit, credential, and train physician reviewers, all of whom will possess a valid and unrestricted license to practice medicine in Missouri and conform with all requirements for membership on the reviewer panel.

Prior Authorization Review Process

Permedion maintains a tested, successful system that clients use to communicate, track, receive, and respond to information and requests for review for medical necessity of clinical services. The following steps are used in the review process:

Prior Authorization Requests. Gateway providers can call Permedion's designated toll-free number, fax a prior authorization form to the toll-free fax number, or submit a request though our secure web-based prior authorization application. The intake coordinator or nurse reviewer enters demographic and other data into the Gemini system from faxed or telephoned requests. Requests made via the web portal require requestors to enter information, which the prior authorization system automatically captures.

Once this information is entered, the request goes into the queue of reviews based on the time the requests received and the expected date of service. If a provider submits a request at least one working day in advance of the service, Permedion will be able to issue a determination prior to the scheduled service date. Requests for Emergency Room care will be given priority and addressed urgently.

Nurse Reviewer Inputs Clinical Data and Determines if Case Meets Criteria. The nurse reviewer assesses the provided clinical information using nationally recognized evidenced based medical criteria to determine the medical necessity of the requested service. The nurse reviewers use software applications specifically designed for prior authorization of healthcare services. Nurse reviewers are experienced in utilizing nationally recognized evidenced based criteria sources. Permedion currently uses the *MillimanCare Guidelines*™, or InterQual Criteria, in addition to state regulations or client directives to make timely decisions. The nurse reviewer determines whether the clinical information presented supports the medical necessity of the requested service, based upon the application of these criteria.

If the information received meets criteria, the nurse reviewer notes an approved response in the prior authorization application, and enters an approved transaction into the system. If the clinical information is insufficient to make a determination, the nurse reviewer calls or faxes the requesting provider to request additional information. If the information is not available at the time of the call, the nurse reviewer places the case in a pending status within the system. The case is entered as a denial if no additional information is received prior to the date of service.

Nurse Reviewer Refers Case to Peer Matched Physician Reviewer. If the nurse reviewer cannot approve the request for service, the case is forwarded to a physician reviewer for a determination. A physician reviewer with no conflict of interest in reviewing the case is selected. Permedion provides all clinical information received for review along with any nurse reviewer notes to the physician reviewer via secure e-mail, secure fax, or scanned materials and provided via Permedion's secure website. The physician reviewer makes the decision of medical necessity based on clinical judgment, standards of care, and or pertinent guidelines/criteria.

Assign Approved Request Number. Determinations are usually made within one business day and providers are notified by phone or fax of the results of the determination. Determination letters to the requesting provider and/or facility are sent within three business days. Letters are sent via fax followed by a hard copy by mail. Providers may also view the status of their request 24/7 via the website; the pre-certification activity status report is updated daily. A daily report identifies all cases that require a

determination on that day. This activity assures timely review of all requests received. A daily case determinations report is also generated and posted to the website for client access.

Request for Reconsideration. When a request from a provider for reconsideration is received within 30 days or fewer (from date on denial letter), all case information is sent to a specialty matched physician for review. If a reconsideration request is received past 30 days of the date on the denial letter, a notification is sent to the provider that the request is late and cannot be considered; the system is updated and no further action is taken on the case.

Physician Review. Permedion conducts reconsiderations as a “de novo” review by a second, board-certified specialty matched physician. The physician reviewer reviews the case in its entirety and makes a determination.

Determination. If the physician reviewer approves the case and the initial denial is overturned, a retrospective Determination Re-Review Approval Letter is generated and sent to the provider. If the physician review upholds the initial denial, the second denial letter contains instructions on any next steps that may be available.

Cash Flow and Budget Management

Enrollment Cap

To account for variations in actual experience versus what is projected, the State proposes the following procedures for managing its enrollment cap:

1. The RHC will monitor financial and utilization results on a monthly basis to calculate appropriate enrollment caps. When it is determined necessary to adjust the enrollment caps, the RHC will adjust them as needed to maintain budget neutrality.
2. On a monthly basis, RHC will share financial results, including adjustments to the enrollment cap, with its board.
3. If the enrollment caps are changed, all health centers, FSD county offices, vendors, and partners will be notified.
4. The enrollment caps will be adjusted based on two factors:
    a. The actual expenditures for fee-for-service claims compared to projections
    b. The amount of funds in the pay-for-performance incentive pools that remain unused
5. The goal in adjusting the enrollment caps will be to fund the service where the demand exists and to utilize as much of the medical services budget as possible during a federal fiscal year.
6. If specialty care costs are under projection, the enrollment cap for Tier 1 and Tier 2 eligibles will be raised to serve more people.
7. If specialty care costs are over projections, both enrollment caps will be lowered.

In order to maintain budget neutrality, the RHC will pay no more than a total of $30 million per federal fiscal year, or $7.5 million per quarter, for program expenses, including administrative expenses.

Provider Payment Strategies

To determine the appropriate payment methodologies that will meet the objectives of the Demonstration Project and the Pilot Plan as outlined in both the Special Terms and Conditions as well as the Evaluation design, the Pilot Program Planning Team evaluated a spectrum of methodologies from capitation to fee-for-service based on the following criteria:

I. Align payment model to goals of the demonstration project
    a. Services to be obtained in appropriate setting (Community Health Center vs. ConnectCare vs. Hospital ED)
    b. Maintain and enhance quality service delivery to target population
    c. Transition current block-grant reimbursement to coverage model
II. Ensure access is maintained or enhanced for uninsured patients
III. Provide ability to remain within programmatic budget parameters
IV. Relatively easy to implement and administer
V. Cost-effective to implement and maintain
VI. Create “glidepath” to stakeholders to the implementation of PPACA in 2014

Primary Care Provider Organizations

The Pilot Program Planning Team has determined that for primary care provider organizations, in this case the community health centers, a capitated model with potential for pay-for-performance incentive payments best meets the objectives of the Demonstration Project and the Pilot Program. The per-member-per month rate will be paid to the health center where the member enrolls. The rate will be set based on historic utilization and risk adjusted based on age and sex of current eligible patients. The rate will cover services provided at the community health centers or currently contracted out, such as laboratory services.

The RHC will pay health centers 93% of their total per-member-per month rate, and 7% will be withheld and paid out in whole or part every six months of the pilot when certain clinical measures are attained. In addition, the health centers will be required to submit utilization data on a monthly basis. Paying the primary care provider organizations on a capitated basis will minimize the administrative cost of the program, making more funds available for direct patient care, while incenting the health centers to provide quality care and to transition to a model where they are reimbursed for services rendered rather than by direct block grant funding.

Based on current system design, capitation payments will be made to health centers a month in arrears based on enrollment the preceding month. The State will issue a global PMPM to the RHC based on enrollment the prior month. This PMPM will be inclusive of capitation payments to the health centers and administrative costs. The RHC will in turn issue payments to the health centers based on enrollment, adjusting for withholds, performance against quality measures and risk (budget-neutral risk adjustment between primary care provider organizations).

On a monthly basis, as near as practical to the fifth day of the calendar month following the month for which services have been performed and for which payment is being made, the State shall make payments to the RHC via electronic funds transfer in accordance with the following:

For each member enrolled on the first of the month, the state shall pay the RHC the firm, fixed per-member-per-month amount.

i. For members enrolled at any time after the beginning of the month's payment cycle, the state shall pro-rate the net capitation amount for the first partial month.
ii. For members whose enrollment lapses for any period of a month in which a capitation payment was made due to loss of eligibility, death, or other circumstance, the state shall adjust its next monthly capitation payment to recoup the portion of the capitation payment to which it is due a refund.
iii. Any payment pro-rations shall be on a daily basis.

Each month, the health centers paid on a capitated basis will provide utilization claims to a claims clearinghouse, which will then prepare them and upload them into the state's MMIS. The MMIS will be prepared to accept these claims by July 1, 2012.

The capitation payments will be generated based on enrollment files in the MHD system.

Specialty Care Provider Organizations

For those claims paid on a fee-for-service basis (Tier 2 only benefits), providers will upload their claims to an identified claims clearinghouse, so that the State's MMIS will adjudicate the claims and issue payments to the Regional Health Commission, which will issue payments to the health centers.

Due to the complexity and cost of developing a claims payment system for pharmacy claims, the State will pay St. Louis ConnectCare an actuarially sound capitation rate for the pharmacy services they are anticipated to provide throughout the program. St. Louis ConnectCare will submit pharmacy utilization claims to a claims clearinghouse, which will then prepare them and upload them into the state's MMIS. The MMIS will be prepared to accept these claims by July 1, 2012. The capitation payments will be generated based on enrollment files in the MHD system.

Pay for Performance Incentive Withholds and Payments

The RHC will be responsible for monitoring the health center's performance against the pay-for-performance metrics outlined below and will manage the withholds and payments.

Community Health Center Pay-for-Performance Incentive Eligibility

It is anticipated that pay-for-performance incentive payments will be paid out at six-month intervals of the Pilot Program. It is recommended that the withholds are 7% of cap payments. Following are the proposed criteria for the community health center's first incentive payments (anticipated to be paid within 30 days of receipt of data for the period of July 1, 2012 – December 31, 2012):

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
All Patients Enrolled As of 7/1/2012 - Minimum of at least 1 office visit (including a health risk assessment and health and wellness counseling) within the first 6 months following enrollment	80%	20%	Claims Data
Patients with Diabetes, Hypertension, CHF or COPD – 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	80%	20%	Claims Data
Patients with Diabetes - HgbA1c and LDL testing performed within the first 4 months following the latter of either: a) initial enrollment, or b) initial diagnosis	85%	20%	Claims Data
Patients with Diabetes – percentage of diabetics who have a HgbA1c <8% within six months following the latter of either: a) initial enrollment, or b) initial diagnosis	60%	20%	Self-Reported by Health Centers
Hospitalized Patients - percentage of enrollees with select conditions who are admitted through ED who have a follow-up primary care encounter w/i 14 days of hospital discharge*	60%	20%	Prior authorization data and claims data
TOTAL POSSIBLE SCORE		**100%**	

***This assumes an operational process is implemented by which the health centers are informed that their patient has been admitted to the hospital.**

Specialty Care Provider Pay for Performance Eligibility

In evaluating potential payment methodologies, the Pilot Program Planning Team has determined that for those patients with Tier 1 and Tier 2 benefits, specialty and urgent care will be based on a capitation model which will include a base cap rate combined with a pay-for-performance incentive payment opportunity. It is recommended that the withhold be 7% of cap payments. The pay-for-performance incentive payment will be based on achieving specified goals for the following:

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
Timely Patient Access as Measured by Appointment Wait Times - Benchmarked against capacity in the marketplace; benchmarks to be established in Spring 2012	80%	50%	Semi-Annual Self Reporting
Coordination of Care – (a)Timely receipt of consultation documentation*; (b) completion of a primary care – specialist physician compact of collaborative guideline**s	(a) 90% (b) 100%	(a) 15% (b) 10%	AHS/RHC
Timely, Accurate Filing of Patient Encounters and Claims Data – Utilization data for patients covered by cap payments and claims data all submitted within 60 days of date of service	90%	25%	Claims Processing Vendor
TOTAL POSSIBLE SCORE		**100%**	

*Assumes an operational process is implemented by which AHS tracks the exchange of consultation documentation.
**Additional objective measures may be added upon completion of the compact of collaborative guidelines.

For those patients with Tier 2 benefits only, specialty and urgent care reimbursement will be based on a fee-for-service methodology at a percentage of Medicare with a base payment combined with a pay-for-performance incentive payment opportunity. The pay-for-performance incentive payment will be based on achieving specified goals for the following:

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
Timely Patient Access as Measured by Appointment Wait Times - Benchmarked against capacity in the marketplace; benchmarks to be established in Spring 2012	80%	50%	Semi-Annual Self Reporting
Coordination of Care – (a)Timely receipt of consultation documentation*; (b) completion of a primary care – specialist physician compact of collaborative guideline**	(a) 90% (b) 100%	(a) 15% (b) 10%	AHS/RHC
TOTAL POSSIBLE SCORE		**100%**	

*Assumes an operational process is implemented by which AHS tracks the exchange of consultation documentation.
**Additional objective measures may be added upon completion of the compact of collaborative guidelines.

Additional Provider Incentives

Any remaining funds in either the community health center pay-for-performance incentive pools or the specialty care pools will flow to a Global Incentive pool. All the providers will be eligible for these funds based on the following criteria:

Community health center criteria –

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
Emergency Department Utilization among Tier 1/Tier 2 Enrollees	TBD pending final actuarial analysis	30%	Claims data
Rate of Referral to Specialist among Tier 1/Tier 2 Enrollees	TBD pending final actuarial analysis	70%	Claims data

Specialist criteria –

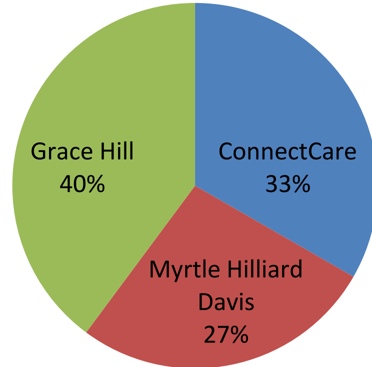
Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
Timely Patient Access as Measured by Appointment Wait Times - Benchmarked against capacity in the marketplace; benchmarks to be established in Spring 2012	80%	50%	Semi-Annual Self Reporting
Coordination of Care – (a)Timely receipt of consultation documentation*; (b) completion of a primary care – specialist physician compact of collaborative guideline**	(a) 90% (b) 100%	(a) 15% (b) 10%	AHS/RHC

*Assumes an operational process is implemented by which AHS tracks the exchange of consultation documentation.

**Additional objective measures may be added upon completion of the compact of collaborative guidelines.

If ConnectCare qualifies for additional provider incentives in the Global Incentive Pool, the organization will be eligible for up to one-third of the total funds in the Global Incentive Pool. The primary care providers will be eligible for the remaining funds based on the percentage of Tier 1 and Tier 2 patients enrolled at their health centers. For example, if Grace Hill has 60% of the primary care patients and Myrtle Hilliard Davis 40%, they would each qualify up to that percentage of the remaining funds. For the purposes of this illustration, that would mean Grace Hill would qualify for up to 40% of the total funds, and Myrtle Hilliard Davis would qualify for up to 27% of the total funds. Funds not distributed will be used to create additional slots where demand and capacity exist.

Example Distribution: Global Incentive Pool



Program Administration and State/Health Center Enrollment Budgets

The State of Missouri Department of Social Services, St. Louis Regional Health Commission and its vendors are partnering to provide the operational components of the Gateway to Better Health Pilot Program.

The State and RHC have identified strategies for managing the program within $6.5 million, or 15 percent of the total budget for the Pilot Program, with the exception of certain State of Missouri incurred expenses. These additional expenses, estimated at $1.3 million, are for systems work and eligibility specialists. Based on Section XI "General Financing Requirements" in the Standard Terms & Conditions, it is believed that these expenses are not subject to the Waiver's budget neutrality requirements, and should not be treated as waiver expenses because they are part of the preparation for transitioning the safety net population in St. Louis to Medicaid coverage in 2014. The St. Louis Regional Health Commission will transfer funds – not related to the Demonstration – to cover the non-federal share of the $1.3 million in anticipated expenses for systems work and eligibility specialists. The funds will come from operating funds that the Commission had in hand prior to the commencement of the Waiver.

Approximately 30% of the total estimated non-medical costs, or approximately $1,950,000, is projected to be expended prior to the coverage model becoming operational. The State and RHC are identifying sources for upfront working capital and are negotiating with vendors to begin receiving payments after administrative funds become available through the Pilot Program.

The following items are included in the administrative budget:

- Automated Health Systems will provide the administrative services for the program, accounting for approximately $3 million of the total budget. These services include:
    - Customer service (with full call center support)
    - Enrollment services
    - Member materials distribution
    - Utilization management
    - Claims clearinghouse services
    - Capitation management
    - Reporting and technology support
- Salaries and benefits for those individuals anticipated to be employed by the St. Louis Regional Health Commission in order to oversee and manage the program. Details of the proposed staffing are provided in Appendix H.
- Claims processing to be provided by the State's fiscal agent.