Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • RONALD J. LEVY, DIRECTOR

MO HEALTHNET DIVISION
P.O. BOX 6500 • JEFFERSON CITY, MO 65102-6500
WWW.DSS.MO.GOV • 573-751-3425

March 31, 2010

Julie Sharp
Centers for Medicare and Medicaid Services
7500 Security Blvd., Mailstop S2-01-16
Baltimore, MD 21244

Via email

Dear ~~Ms. Sharp~~: Julie -

Attached you will find Missouri's response to the March 15, 2010 questions from the Centers for Medicare and Medicaid Services regarding the Missouri Gateway to Better Health Section 1115 demonstration proposal. Please do not hesitate to contact this office if further clarification is needed.

Also provided is a letter of support from the Missouri Congressional delegation.

Thank you for your assistance.

Sincerely,

Ian McCaslin, M.D., M.P.H.
Director

IM:kp

Attachment

cc: James G. Scott (via email)

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Original signed by

Ian McCaslin, M.D., M.P.H.
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Attachment

cc: James G. Scott (via email)

United States Senate
WASHINGTON, DC 20510

March 16, 2010

Ms. Victoria Wachino, Director
Family and Children's Health Program Group
Centers for Medicare & Medicaid Services
7500 Security Blvd., S2-01-16
Baltimore, MD 21244

Dear Ms. Wachino:

We fully support the Missouri Department of Social Services Section 1115 waiver application for operation of the St. Louis Regional Health Commission (SLRHC) entitled "Gateway to Better Health: Preserving and Strengthening Primary and Specialty Care Services for Medicaid and the Uninsured in the St. Louis Region." We urge you to grant this waiver in order to enable the continued provision of vital health care services to the St. Louis community by the SLHRC.

As you may know, the St. Louis healthcare community has developed a widely acclaimed model for providing care to needy citizens. Disproportionate share hospital (DSH) payments from the Center for Medicaid and Medicare Services (CMS) are designed to reimburse hospitals for the cost of caring for uninsured people in their emergency rooms, but by design these payments must go to hospitals rather than primary care clinics which are often more appropriate for the type of care being delivered. The "St. Louis Model" is built around the idea of moving indigent care out of hospital emergency rooms and into neighborhood clinics and it has been recognized as one of the most effective and efficient ways to deliver health services to uninsured and underinsured populations. To continue its clinic-based work however, the SLHRC finds itself in need of a Section 1115 waiver from the CMS in order to allow non-hospital based DSH reimbursement. The St. Louis model has a proven track record and should be embraced. In short, an excessively rigid regulatory structure does not clearly accommodate the innovative care model developed in St. Louis

In light of the success of the St. Louis Model and the fact that the exact services CMS funding mechanisms are designed to support are in fact occurring, just not where the regulations necessarily envisioned them, a Section 1115 waiver should be granted to enable to continuation of the SLRHC indigent care delivery model. Any other result would be step backwards for those who have benefited from SLRHC innovations.

Congress has been working toward comprehensive health reform in the hope of reducing the number of uninsured Americans and improving access to care. While that work in Washington remains unfinished, the SLRHC continues its own efforts on the front lines

working to improve access to care. Until national efforts to reduce the number of uninsured populations are successful, the need for more local models like the SLRHC will continue. We are proud of the efforts made toward improving care for the uninsured people and Medicaid recipients in the St. Louis region and do not want to see the years of work lost due to a loss of funding. Again, we endorse their efforts and urge your approval of their waiver request.

Sincerely,

Claire McCaskill
U.S. Senator

Christopher Bond
U.S. Senator

Wm. Lacy Clay
U.S. Representative

Todd Akin
U.S. Representative

Russ Carnahan
U.S. Representative

Text Document of Letter from United States Senate

March 16, 2010

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U.S. Senator Christopher Bond
U.S. Representative William Lacy Clay
U.S. Representative Todd Akin
U.S. Representative Russ Carnahan

Missouri Responses to March 15, 2010, Questions From Centers for Medicare and Medicaid Services Regarding Missouri Gateway to Better Health Section 1115 Demonstration Proposal

General/ Background Questions

1. How does this Demonstration request differ from the similar component that was in operation between 2002-2007 under the Missouri Managed Care Plus (MC+) section 1115 demonstration that expired in October 2007?

   Response: The current waiver submission is different from the component in place from 2002-2007 in that it is providing a bridge to coverage under national health care reform. Until coverage begins in 2014, maintaining access to quality care in the neighborhoods of St. Louis that are traditionally underserved will help to make the costs of covering this new population more affordable by keeping patients healthier. Over the last ten years, both under the prior waiver and through other efforts, there has been a significant strengthening of ambulatory care services for the uninsured in St. Louis City. The primary care services provided by the affiliated federally qualified health centers (FQHC) partners and the specialty care services provided by ConnectCare will be an important cornerstone as the uninsured become newly insured under health care reform. For the most part, these are the only ambulatory care providers in the neighborhoods they serve. The current demonstration proposal will also seek to establish medical homes that will ease the transition into expanded health care coverage. The St. Louis Regional Health Commission (SLRHC) will be working with the affiliated partners to ensure that they are developing systems that will enable them to succeed in a coverage environment. The State and SLRHC will spend the first 18 months of the waiver collecting data and developing a transition plan for providers and patients to ensure that they are prepared for the advent of national health coverage.

2. In our letter dated April 27, 2004, in which CMS approved an extension of the "Health Care for the Indigent of St. Louis" amendment to the State's MC+ Demonstration, we specify: "The purpose of this amendment is to enable the St. Louis Community to transition its 'safety net' system of care for the medically indigent to a viable, self-sustaining model . . . As [the State] indicates in [its] March 1, 2004 letter, the State agrees not to seek an extension of this amendment beyond the 3 years." (A copy of our April 27, 2004 letter is attached for your reference.)

   Please explain in more detail why the "safety net" system of care for the uninsured could not be transitioned to a "viable, self-sustaining model."

   Response: When the statement was made in 2004, there were initiatives at the state level to facilitate coverage for the indigent uninsured which would have enabled the system of care to become self-sustaining. For various reasons, those initiatives did not come to pass. Because of the large number of uninsured patients that are served by the affiliated partners, it was not feasible to become self-sustaining in the absence of a coverage expansion. Missouri

hospitals were able to provide continued funding for several years but this, too, was not a self-sustaining model.

The advent of national health reform may enable the system to become self-sustaining, and it is in the interest of the state and federal government that the indigent uninsured of St. Louis continue to have access to quality care in the interim. It is also in the interest of the state and federal government to ensure that the underserved areas of the city have a robust health infrastructure to serve the newly covered. Because the system has developed substantially since the old waiver was renewed in 2004, and because it is critically important to provide a "bridge" to national health reform, the State believes that the change in circumstances makes the prior commitment no longer applicable.

Programmatic Questions

3. Do individuals generally need referrals to receive specialty care from St. Louis ConnectCare? Under the Demonstration, will individuals from the Grace Hill and Myrtle Hilliard Davis Health Centers need referrals to receive specialty care from St. Louis ConnectCare?

   Response: In order to promote primary care homes and ensure appropriate use of limited specialty care resources, individuals do need a referral from one of the St. Louis region's primary care community health centers to receive specialty care from St. Louis ConnectCare.

   Under the Demonstration, individuals from the Grace Hill and Myrtle Hilliard Davis Health Centers will continue to need referrals from a primary care physician to receive specialty care from St. Louis ConnectCare. The referral from a primary care physician is important in establishing and strengthening medical homes.

4. Does the State screen and enroll individuals for Medicaid who come in contact with the safety net providers? If so, please describe this process.

   Response: As part of the registration process, patients are asked about insurance status, income, and family size. Registration staff actively screen for patients who may meet Medicaid eligibility requirements. Patients thought to meet eligibility requirements are referred to an appropriate staff member – each clinic site employs an outreach/eligibility staff member. Separately, the State of Missouri also places Family Support Division staff within clinic sites to assist health center staff in this process. If the patient meets Medicaid eligibility requirements, the staff member assists with completing the Medicaid enrollment forms prior to the patient's visit with the provider.

Questions Specific to Page Numbers in the Proposal

5. On **page 2** of the proposal, the State indicates that the Demonstration would allow St. Louis ConnectCare, Grace Hill, and Myrtle Hilliard Davis Health Centers to provide services to an "additional 2,200 additional individuals." Please provide explain how the State arrived at this estimate. Please explain the assumptions the State used to arrive at this estimate.

   Response: It is estimated that the universe of uninsured individuals in St. Louis City and St. Louis County is at least 155,000. Grace Hill and Myrtle Davis currently provide services to 22,000 uninsured individuals in the underserved neighborhood clinic sites supported by the proposed demonstration funds. The assumption was made that an additional 10% of the uninsured population could be added to the demonstration. The expanded population would total 2,200. The assumptions are simple and based on the Commission's experience and efforts with medical homes which should facilitate the identification of an additional 10% of the targeted population and help transition them into the active service population. We believe that we can identify and serve these 2,200 individuals before 2014.

   With the enactment of national health care reform legislation, SLRHC and the State will focus their outreach and education efforts on childless adults and young adults aging out of Medicaid to help preserve their health care status and link them to a medical home until health care coverage is available through health care reform. It is believed that the SLRHC will be able to utilize its experience with these populations to refine outreach efforts and develop best practices which can then be replicated by the State in reaching out to the uninsured populations utilizing highly articulated processes and materials to assist in linking the uninsured to health care coverage when available under health care reform.

   In addition, the State proposes to conduct a pilot outreach program to this targeted population and other uninsured individuals in the region. After collecting data and designing the outreach pilot the effort will be evaluated to determine if it has maintained access and provider availability for this population in the region. This will be part of our over-all evaluation and transition effort to be conducted during the third year of the waiver.

6. On **page 3** of the proposal, the State indicates that St. Louis ConnectCare, *two* of Grace Hill Neighborhood Health Centers, and *two* of Myrtle Hilliard Davis Comprehensive Health Centers would receive funding through the Demonstration.

   - Please explain the relationship between St. Louis ConnectCare and the Grace Hill and Myrtle Hilliard Davis Health Centers. Please feel free to use a diagram to illustrate the relationship.

     Response: St. Louis ConnectCare (ConnectCare), the two sites operated by Grace Hill Neighborhood Health Centers (Grace Hill), and the two sites operated by Myrtle Hilliard Davis Comprehensive Health Centers (Myrtle Davis) are all located in the outpatient clinics previously operated by St. Louis Regional Medical Center, St. Louis' last public hospital (which closed in 1997). Originally, ConnectCare was the principal legacy provider to St. Louis Regional, providing both specialty and primary care services. In the

final years of the prior waiver, primary care services were transferred from ConnectCare to Grace Hill and Myrtle Davis. ConnectCare now focuses its services on specialty, diagnostic, and urgent care for the uninsured and underinsured. These mergers were recommended to (1) improve efficiency, (2) leverage benefits under Section 330, and (3) allow ConnectCare to strategically focus its services.

The four primary care sites previously operated by St. Louis Regional, then ConnectCare, and now Grace Hill and Myrtle Davis, are located in St. Louis' areas of highest need. No other providers operate health centers or medical facilities in these challenged neighborhoods.

The FQHCs refer their patients needing specialty care to ConnectCare. ConnectCare also takes referrals from non-affiliated FQHCs in the St. Louis area.

- Please indicate whether St. Louis ConnectCare, the two Grace Hill Neighborhood Health Centers, and the two Myrtle Hilliard Davis Comprehensive Health Centers are providers within the managed care organizations (MCOs) that deliver services to Medicaid beneficiaries in the St. Louis region under the State's 1915(b) managed care waiver.

Response: Yes. All are participating providers in the MC+ managed care program.

- Please explain why only two of Grace Hill's six community health centers and only two of Myrtle Hilliard Davis' three community health centers would receive funding under the Demonstration.

    - How do the health centers that would receive funding compare/contrast with the health centers that would *not* receive funding? Are the centers that would not receive funding under the Demonstration solvent?
    - Are there differences in payer-mix (Medicaid, Medicare, private insurance, or uninsured) and/or in the severity of needs of the populations at the health centers that would receive funding versus those health centers that would not receive funding? If so, please provide details regarding these differences in payer-mix and/or in the severity of needs of the populations.

    Response: The sites that receive funding are located in the legacy clinics of St. Louis Regional Hospital, serving the city's poorest and historically underserved neighborhoods. Because Grace Hill and Myrtle Davis expanded their operations to take over the sites previously operated by ConnectCare, the SLRHC sought to ensure that the funds distributed from the Regional DSH pool were available to continue services for the patients living and being served within the legacy clinics.

    Grace Hill and Myrtle Davis see a disproportionate share of the uninsured in the St. Louis region and serve more uninsured patients (each approximately 55% of total patients) than the other community health centers in the region where approximately 43-49% of total patients are uninsured.

    It is not possible to accurately compare patient populations across health centers at Grace Hill and Myrtle Davis for multiple reasons. Patients may be seen at different locations within the same organization, and providers may practice at more than one clinic location. Additionally, Grace Hill and Myrtle Davis each consolidated clinic sites when ConnectCare's clinics were transferred to increase efficiencies and to leverage physical plant capacity.

7. On **page 5** of the proposal, the State notes that "lower income standards for Medicaid eligibility in 2004 . . . resulted in over 100,000 individuals losing Medicaid coverage [which in addition to a loss in employer-sponsored insurance] ha[s] resulted in a dramatic rise in the uninsured population in Missouri."

    - Has the State considered increasing the income standards in the Medicaid program?

    Response: Yes, it was seriously considered in 2008, but it was ultimately determined not to be feasible.

- Does the State expect that increases in the income standards in the Medicaid program would reduce the level of uncompensated care at St. Louis ConnectCare, the two Grace Hill health centers, and the two Myrtle Hilliard Davis health centers?

  Response: The State is not aware of how to increase the income standards in the Medicaid program for those just uninsured utilizing St. Louis ConnectCare, the two Grace Hill health centers, and the two Myrtle Hilliard Davis centers.

  The increase in the Medicaid income standards authorized in health care reform should reduce uncompensated care in 2014.

8. On **page 7** of the proposal, the State indicates that the following amounts were distributed in SFY 2008 and SFY 2009 to the following entities:

   - $13,800,000 to St. Louis ConnectCare
   - $5,600,600 to Grace Hill Neighborhood Health Centers
   - $3,599,500 to Myrtle Davis Comprehensive Health Centers
   - $300,000 to the [St. Louis Regional Hospital] Commission (SLRHC) for administrative costs
   - $510,980 to the St. Louis Regional Integrated Health Network for the Community Referral Coordinator Program

   - Does the State expect that the allocation of funds during the Demonstration period to be close to the amounts above?

     Response: Yes. As long as access is maintained in these sites at current levels, with an increase in access for the uninsured by 2% annually as committed to in the waiver proposal, it is anticipated that the funds will continue to flow from the "St. Louis Safety Net Funding Pool" as they have in the following amounts, with a modest one-time adjustment of 4.35% for a inflation adjustment and to finance the 2% annual increase in access for the uninsured, as follows:

     - $14,400,000 to St. Louis ConnectCare
     - $5,850,000 to Grace Hill Neighborhood Health Centers
     - $3,750,000 to Myrtle Davis Comprehensive Health Centers

     This process will allow the current providers to plan for a stable base of funding for providing essential services to the uninsured in St. Louis' areas of highest need, while maintaining the oversight and community input process necessary to ensure the system continues to positively mature, grow, and improve.

   - Please describe the methodology used to determine the amount of funding to be given to each clinic in more detail.

     Response: The funds were initially allocated based on agreement among the affiliated partners, with community input, as to the optimal distribution to meet the primary and

specialty needs for the uninsured in St. Louis City. Those amounts are reviewed annually based on reporting from the affiliated partners. As long as affiliated partners continue to expand their reach while meeting quality goals, the allocation is likely to remain the same. However, the SLRHC will continue to collect comprehensive data from the affiliated partners and to solicit community input to assure that the distribution is appropriate to ensure maximum access to needed health care service. In the event there is a change in the distribution, the State will provide SLRHC's recommendation to CMS in advance of any change.

- How much funding does the State expect will go toward the administration costs for the Commission for each year of the Demonstration?

  - How much did the SLRHC expend in administrative costs in SFY 2009 and SFY 2010?
  - Please define what makes up an administrative cost (description of FTEs, overhead, etc.).

  Response: The SLRHC expends approximately $670,000 annually in "core expenses" to support its mission to improve access to health care and reduce health disparities. The funding sources for the SLRHC include:

  $300,000 - St. Louis Safety Net Funding Pool (for oversight, coordination of community input, data collection and management, and public reporting)

  $135,000 - City of St. Louis
  $135,000 - St. Louis County
  $100,000 - Civic Progress
  $670,000

  These amounts have been constant over the past five years.

  This core budget supports staffing, as follows: one Chief Executive Officer, one Director of Strategic Planning, one Director of Community Engagement, and one support staff (four FTEs) with salary and related benefits. Other administrative costs include rent and rent-related expenses, postage, insurance, supplies, website development and hosting, printing and outreach activities, and bookkeeping/accounting services.

  The State expects that $300,000 annually will continue to be made available to the SLRHC for its operations.

- How much funding does the State expect will go toward the Community Referral Coordinator Program for each year of the Demonstration?

  Response: The Community Referral Coordinator Program is an essential component of the Demonstration intended to ensure that access to community health centers are enhanced and that emergency departments are not utilized for costly, unnecessary visits

better handled by community health centers. This model has proven effective to date and is an emerging national best practice.

The State expects $700,000 will be allocated to the Community Referral Coordinator program each year of the Demonstration. A detailed explanation of the program and costs is provided in Answer #13 to these questions.

- Please submit revised budget neutrality worksheets which show the specific amounts going to each entity/program listed below for each year of the Demonstration.
  - St. Louis ConnectCare
  - Two Grace Hill Neighborhood Health Centers
  - Two Myrtle Hilliard Davis Comprehensive Health Centers
  - Administrative costs for the SLRHC
  - Community Referral Coordinator Program

  Response: See attached. The amounts reflected are subject to change based on SLRHC's review of the reports of the affiliated partners and community input. In the event of a change, the State will provide CMS with SLRHC's recommendation prior to implementation.

9. Besides the clinics, Community Referral Coordinator Program, and SLRHC administrative costs, are there any additional entities that would receive funding under the Demonstration? If so, please describe these entities and explain the amount of funding that the State estimates would go to these entities.

   Response: Additional entities are not anticipated at this time. However, if the reports from the affiliated partners, or community input, indicate that the funds should be reallocated and distributed to a new entity, the State will forward the SLRHC recommendation to CMS prior to implementation.

10. On **page 9** of the proposal, the State notes that "a limited number of vouchers for inpatient and outpatient hospital services not available through the safety net providers are available to uninsured patients of the affiliated partners [St. Louis ConnectCare, Grace Hill Neighborhood Health Centers, and Myrtle Hilliard Davis Comprehensive Health Centers] who are residents of St. Louis City."

    - Please provide an overview of the voucher system.
    - Which hospitals would the patient go to for service?
    - How is the voucher amount determined?
    - Does the voucher amount generally cover the full cost of the services?
    - Is the State proposing to use funding under the Demonstration to cover these inpatient and outpatient services?
    - If so, please provide estimates of "voucher services" for each year of the Demonstration. Please provide separate estimates for inpatient and outpatient services.

Response: Primary care physicians from the FQHCs, the St. Louis County primary care clinics, and local community based volunteer health clinics refer patients to ConnectCare for one or more of 13 medicine and surgical specialties, five radiological modalities, and or endoscopic procedures in the region's only stand alone ambulatory surgical center serving all regardless of the ability to pay. If the patient needs care beyond those that ConnectCare directly provides, ConnectCare, through its Utilization Management department, arranges for advanced diagnostic (MRI, PET, MRA, etc.) procedures and outpatient surgeries.

In order to qualify for ConnectCare authorization and payment of a "voucher," the patient must live in Missouri, be uninsured or under-insured, seen by a ConnectCare physician, and have a referral from an FQHC or St. Louis County Clinic authorizing the service, within the past 12 months from the date of the request. The service requested must be deemed medically necessary by ConnectCare's Utilization Management processes. In order to qualify for sliding scale coverage, patients must provide appropriate documentation of income and/or employment status.

Barnes-Jewish Hospital and St. Louis University Hospital, the two major academic medical centers in the St. Louis region, are the major providers of voucher services, providing approximately 80% of the voucher services in 2008. Some services are provided at St. Mary's, St. John's, and St. Alexius hospitals.

Payments to hospitals for inpatient services are based upon 70% of Medicaid per diem rates. For outpatient services, payment is calculated based on a percentage of Ambulatory Payment Classifications (APC) rates. This formula results in payments that are less than the cost of care.

Total voucher services in State Fiscal Year 2009 was $3,356,818, inclusive of $1,074,563 in total inpatient services, $748,671 in total outpatient/diagnostic services paid to hospitals, and $1,533,584 paid for professional fees for outpatient services not directly provided by ConnectCare.

The State is amending the proposed 1115 Demonstration project by not covering traditional inpatient hospitalizations through the voucher program. ConnectCare will issue hospital vouchers for outpatient hospital services and professional fees not offered by ConnectCare and will no longer issue any vouchers for inpatient hospitalizations. This will allow ConnectCare to provide more specialty care and continue to enhance specialty care services to uninsured individuals in a cost effective manner. The vouchers will be issued only for outpatient specialty services not offered by ConnectCare, e.g., kidney dialysis, oncology services, etc. The following highlights the projected voucher payments over the life of the proposed demonstration:

	2011	2012	2013	2014	2015
Vouchers to Hospitals					
Outpatient Voucher Estimate - # Issued	1,816	1,834	1,853	1,871	1,871
Outpatient Voucher Estimate - $ Issued	650,000	663,000	676,260	689,785	703,581
Emergency Department Voucher Estimate - # Issued					
Emergency Department Voucher Estimate - $ Issued					
Vouchers to Physicians and Others					
Professional Fees for Outpatient - # Issued	1,816	1,834	1,853	1,871	1,871
Professional Fees for Outpatient - $ Issued	420,000	432,646	445,871	459,206	468,390
Professional Fees for Emergency Department - # Issued	586	586	586	586	586
Professional Fees for Emergency Department - $ Issued	161,000	164,220	167,504	170,854	174,272
Professional Fees for Office Visits - # Issued	2,036	2,077	2,118	2,161	2,204
Professional Fees for Office Visits - $ Issued	419,000	435,928	453,539	471,862	490,925
Other Non Hospital Based Voucher Services					
Home Health - # Issued	37	40	42	45	45
Home Health - $ Issued	4,608	5,081	5,442	5,947	6,066
Ambulance - # Issued	67	70	70	70	70
Ambulance - $ Issued	13,597	14,490	14,780	15,075	15,377
Lab - # Issued	41	41	41	41	41
Lab - $ Issued	48,277	49,243	50,227	51,232	52,257
IDF - # Issued	20	20	20	20	20
IDF - $ Issued	6,207	6,331	6,458	6,587	6,719

As calculated, less than 3% of the total funds that the State is proposing to be used under the Demonstration Project would be devoted to voucher payments for outpatient hospital services annually.

11. On **page 13** of the proposal, the State provides some information regarding the demographics of the people seen at the clinics, such as the number of Medicaid, Medicare, private insurance, and uninsured.

    - Please provide estimates regarding the number of non-Medicaid eligible pregnant women, non-Medicaid eligible children, non-Medicaid eligible parents/caretakers, and uninsured childless adults that receive services at St. Louis ConnectCare, Grace Hill health centers, and Myrtle Hilliard Davis health centers.

Response: The health centers provided the following *estimates* for their non-Medicaid eligible patients:

	ConnectCare	Grace Hill	Myrtle Hilliard Davis	Total Estimates
Non-Medicaid Eligible Pregnant Women	0	41	49	90
Non-Medicaid Eligible Children	794	3,509	743	5,046
Non-Medicaid Eligible Parents/Caretakers*	Data not available	Data not available	Data not available	Data not available
Uninsured Childless Adults*	Data not available	Data not available	Data not available	Data not available

*The health centers do not collect data on whether patients have children; therefore, these estimates are not available.

- Which specific populations within St. Louis ConnectCare, Grace Hill health centers, and Myrtle Hilliard Davis health centers would the $30 million in diverted DSH be used to pay for?

  Response: The funding requested under this Demonstration Project would pay for care to uninsured patients not eligible for Medicaid coverage.

12. On **page 13**, the State provides the number of total number of users seen at each of the clinics during calendar year 2008. A copy of the chart appears below.

	Grace Hill	**Myrtle Hilliard Davis**	**Connect Care**
Medicaid	14,625	11,980	4,939
Medicare	2,495	2,519	2,430
Uninsured	22,431 (21,569 below 100% FPL)	21,264 (19,648 under 100% FPL)	23,305 (16,069 under 100% FPL)
Other Insurance	1,495	2,634	4,051
Total No. of Users	41,046	38,397	34,725

- Please confirm whether these are unduplicated numbers.

  Response: The numbers provided are unduplicated for each organization. ConnectCare's numbers do include patients from Grace Hill and Myrtle Hilliard Davis, which account for approximately 53% of specialty care referrals to ConnectCare.

- How many of the 41,046 persons served in CY 2008 at the Grace Hill health centers were seen at the two clinics that the State is proposing would receive funding under the Demonstration?

  Response: In CY2008, 25,663 patients were seen at the two Grace Hill clinics proposed to receive funding under the Demonstration.

- How many of the 38,397 persons served in CY 2008 at the Myrtle Hilliard Davis health centers were seen at the two clinics the State proposes would receive funding under the Demonstration?

  Response: In CY2008, 16,894 patients were seen at the two Myrtle Hilliard Davis clinics proposed to receive funding under the Demonstration.

13. On **page 19**, the State provides some information regarding the Community Referral Coordinator Program.

- How is the funding for the Community Referral Coordinator Program allocated within the program (i.e., FTEs, administration costs, etc.)?
- Which hospitals currently have Referral Coordinators working in the ER?
- Please confirm whether any aspects of the Community Referral Coordinator Program are currently being funded under the CMS Medicaid Emergency Room Diversion Grant.

  Response: Currently, the Community Referral Coordinator (CRC) program operates in three hospitals: Barnes/Jewish Medical Center, St. Louis University Medical Center, and St. Mary's (SSM) Medical Center. Based on the success of the program to date, the St. Louis community plans to expand this model to four additional hospitals in the areas of highest need in St. Louis, including: DePaul (SSM) Medical Center, Christian Northeast Medical Center, St. Louis Children's Hospital, and Cardinal Glennon Children's Hospital.

  Operating in these seven hospitals, the annual cost of the program is $700,000 annually. This amount includes nine FTEs (one program director, and eight Community Referral Coordinators) at a cost of $640,000 per year inclusive of salary and benefits, and $60,000 of non-personnel costs including postage, information technology support, printing and copies, supplies, telephone, and training costs.

  The CMS Emergency Room Diversion Grant has provided support for two FTEs in the initial pilot phase of the project, at a total expenditure of $193,175. The funding from the CMS Emergency Room Diversion Grant will expire on April 14, 2010, and no additional funding from CMS is anticipated for this program after that time period, other than the funds requested under the proposed Demonstration.

14. On **page 22** (last full paragraph) of the proposal, the State explains that "MO HealthNet Division (MHD), SLRHC, and the IHN will work . . . to do a pilot program to transition and educate individuals relative to health care coverage."

    - Please explain in more detail what this pilot program would be.
    - Is the State proposing to receive Federal matching funds for this pilot program?
    - If so, what types of services/ activities is the State proposing to receive Federal matching funds for under this pilot program?
    - Is the State considering increasing coverage under the Medicaid State plan or by using section 1115 demonstration authority to cover persons who would otherwise not be eligible under the Medicaid State plan?

    Response: The State is not considering increasing coverage under the Medicaid State Plan or by using section 1115 demonstration authority. Instead, the pilot program will pave the way for the transition to coverage under national health reform. The program will operate within the $30 million dedicated to the demonstration project and will be eligible for Federal matching funds. The State and SLRHC will work together to provide a proposal to CMS within 18 months after waiver approval as to how to structure payments in the remaining years of the demonstration to ensure that providers are prepared for operating in a coverage environment. The State also believes that it will be necessary to help educate the patients served by the affiliated partners as to how access and care will change in a coverage environment.

Evaluation Questions

15. On **page 23**, the State lists three evaluation questions. Please provide additional information as to how the State expects to evaluate the demonstration. Please clarify what the goals are of the Demonstration and how the State expects it will evaluate the Demonstration to measure whether the goals were achieved.

    - For example, on **page 6** (second paragraph), the State indicates that "each year, the SLRHC collects a comprehensive data set from all community health centers and hospitals in the St. Louis region concerning access to care for the uninsured and Medicaid populations."

        - What elements are included in the comprehensive data set?
        - Will this data set be used to evaluate the Demonstration?
        - If so, would the State please provide specific health outcomes that would be measured to determine whether improvement has occurred?

    Response: We believe with the passage of health care reform we have a unique opportunity to re-orient the focus of the effort in the St. Louis region on providing a transition for impacted providers/affiliated partners from a subsidy model to a health care coverage model; and, also provide the State an opportunity to inform its efforts in educating and outreaching

to uninsured populations with a particular emphasis on childless adults and young adults aging out of Medicaid while maintaining access to providers when transitioning to health care coverage in 2014 as contemplated under the health care reform legislation.

We want to collect data(financial and programmatic) over the next 12 months; and, evaluate the data to develop a transition plan for uninsured individuals to health care coverage targeting individuals aging out of Medicaid and other childless adults into coverage and assign a medical home in the St. Louis region. This will not only provide insight to the covered population but assist the SLRHC's affiliated partners in transitioning to a coverage model as opposed to operating with financial subsidies. We believe this approach will be beneficial not only to the State but to CMS. The St. Louis model will have lessons learned to be shared with other large urban areas. We will work closely with CMS in developing the data collection effort and will also solicit consumer stakeholder input on the development of the transition plan. We will develop a transition timeline with key milestone/benchmark dates including the evaluation efforts at the end of the first quarter of the approved waiver.

The goals of the proposed waiver are to maintain access for the uninsured until coverage is available under health care reform in a cost effective manner and to conduct outreach to link childless adults with medical homes to reduce the cost of health care. We will share the data elements prior to actual data collection with CMS.

The evaluation questions may need to be refined or changed and we will not know this until the data collection is completed during the first year of the waiver. This may be necessary to frame the questions in a manner to solicit the best information for the SLRHC and the State to assist in health care reform transition efforts. The timeline for the data collection activities are as follows:

- The first eighteen months we will collect information on the costs of care and characteristics (including health status) of the uninsured populations served.
- Evaluate the data collected during the first eighteen months to support the development of a plan to transition the targeted uninsured populations during waiver months nineteen through twenty four. We would also reframe or refine the evaluation questions at this point if necessary.
- Implement the coverage pilot beginning in waiver month twenty five.

Program Integrity Questions

16. How does the State propose to ensure that there is no duplication of Federal funding under the Demonstration?

Response: The State will review the reports provided by the affiliated partners to ensure that the funding under the Demonstration does not exceed the clinics' uncompensated costs, which will ensure that there is no duplication of Federal funding. If an entity is reimbursed in excess of its costs, the funding allocation will be changed. With respect to hospital

payments, the State will ensure that voucher payments for outpatient services are included as revenue in calculating uncompensated costs for DSH purposes.

17. How will the State ensure that St. Louis ConnectCare, the two Grace Hill Neighborhood Health Centers, the two Myrtle Hilliard Davis Comprehensive Health Centers, the Community Referral Coordinator Program, and administrative costs for the SLRHC will be financially self-sustaining after the Demonstration expires?

    Response: The State, working with SLRHC, will propose a concrete plan for providers and patients to transition to the health care coverage that will be implemented through health care reform.

18. What types of milestones/ benchmarks would the State consider meeting to ensure that the entities/ programs listed above are financially self-sustaining?

    Response: The first benchmark will be the development of a transition plan. The plan itself will contain further benchmarks to complete the transition to a coverage model of care. We will submit the transition plan at the end of the first quarter after the waiver is approved.

Standard Funding Questions

Please answer these questions in terms of how the proposed section 1115 demonstration would be funded.

1. Section 1903(a) (1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan.

    a. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

        Response: No MO HealthNet payments made under the proposed 1115 Demonstration will be returned to the State, local government entities, or any other organizations during the Demonstration period.

    b. Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?

        Response: No providers participate in IGTs or CPE payments. There will be $5 million in public funds from the City of St. Louis that will be paid directly to ConnectCare. No

payment is returned to the State, local governmental entity, or any other intermediary organization.

c. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Response: No providers are required to return any portion of any payment.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

Response: The NFS will come from state revenue derived from the Federal Reimbursement Allowance Fund. In addition, $5 million will be paid by the City of St. Louis directly to ConnectCare.

b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Response: See above answer to (a).

c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

Response: The demonstration project will use $30 million (total computable) of the State's Medicaid Disproportionate Share Hospital (DSH) allotment. The non-federal share for the payments will come from an appropriation of $5 million made by the City of St. Louis to St. Louis ConnectCare. The remaining non-federal share will be provided by the State from revenues received from the hospital provider tax.

d. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Response: There will not be an IGT or CPE. The City of St. Louis will contribute $5 million to ConnectCare.

e. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Response: Not applicable.

f. For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority; and
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Not applicable.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: No supplemental or enhanced payments are involved.

4. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Response: Not applicable.

5. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

Response: No.

a. In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Response: Not applicable.

b. If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

Response: Not applicable.

c. If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response: Not applicable.

Budget Neutrality

St. Louis Safety Net (Total Computable)

HISTORICAL DATA: 5 PRIOR YEARS

	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	Total - 5 years
Total Expenditures						
Total Disproportionate Share Hospital Expenditures	**$717,222,170**	**$717,154,705**	**$703,597,719**	**$733,288,726**	**$179,518,534**	**$3,050,781,854**

* SFY 2010 only includes quarter ending 9/30/09

** Amounts could change due to prior year adjustments reported on CMS 64.

Budget Neutrality

St. Louis Safety Net (Total Computable)

	DY 1 SFY 2011	DY 2 SFY 2012	DY 3 SFY 2013	DY 4 SFY 2014	DY 5 SFY 2015	Total - 5 year demonstration SFY 2011- SFY 2015
Without Waiver Projections						
Hospital DSH Expenditure*	$732,605,968	$732,605,968	$732,605,968	$732,605,968	$732,605,968	**$3,663,029,840**
Without Waiver Total	**$732,605,968**	**$732,605,968**	**$732,605,968**	**$732,605,968**	**$732,605,968**	**$3,663,029,840**
With Waiver Projections						
Hospital DSH	$702,605,968	$702,605,968	$702,605,968	$702,605,968	$702,605,968	*$3,513,029,840*
St. Louis ConnectCare	$19,400,000	$19,400,000	$19,400,000	$19,400,000	$19,400,000	*$97,000,000*
Grace Hill Neighborhood Health Centers	$5,850,000	$5,850,000	$5,850,000	$5,850,000	$5,850,000	*$29,250,000*
Myrtle Davis Comprehensive Health Centers	$3,750,000	$3,750,000	$3,750,000	$3,750,000	$3,750,000	*$18,750,000*
Administrative costs for SLRHC	$300,000	$300,000	$300,000	$300,000	$300,000	*$1,500,000*
Community Referral Coordinator Program	$700,000	$700,000	$700,000	$700,000	$700,000	*$3,500,000*
Total With Waiver Expenditures	**$732,605,968**	**$732,605,968**	**$732,605,968**	**$732,605,968**	**$732,605,968**	*$3,663,029,840*
Amount under (over) the annual waiver cap	$0	$0	$0	$0	$0	*$0*
Amount under (over) 5 year cap	$2,930,423,872	$2,197,817,904	$1,465,211,936	$732,605,968	$0	***$0***

*Calculation does not assume any future growth in the Hospital DSH Allotment. State assumes any future growth in the Hospital DSH allotment would increase the amount available for Hospital DSH expenditures.

**$732 million was derived as follows:

		Jul-Sep 2010 Quarter	Oct-Dec 2010 Quarter	Jan-Mar 2011 Quarter	Apr-Jun 2011 Quarter
Federal DSH Allotment for FFY 2009 *	$ 465,868,922	$ 116,467,231	$ 116,467,231	$ 116,467,231	$ 116,467,231
Federal Match Rate		64.51%	63.29%	63.29%	63.29%
DSH Allotment - Total Computable	$ 732,605,968	$ 180,541,359	$ 184,021,537	$ 184,021,537	$ 184,021,537

* Best number available at this time.

Reconciles to CMS 64 Reports

Quarter Ended	DSH - Reg	DSH - IMD	Connectcare	Prior Period	Total	Ties to CMS 64	
9/30/2005	89,189,456	51,690,025	9,595,000	29,274,999	179,749,480		
12/31/2005	92,276,808	51,195,176	9,676,466	26,106,181	179,254,631		
3/31/2006	89,203,789	51,195,176	9,626,466	29,051,468	179,076,899		
6/30/2006	118,223,126	51,195,176	9,626,466	96,392	179,141,160		
SFY 2006	**388,893,179**	**205,275,553**	**38,524,398**	**84,529,040**	**717,222,170**		
9/30/2006	112,422,198	51,195,178	9,676,369	7,441,594	180,735,339	FFY 2006	718,208,029
12/31/2006	115,145,240	51,469,437	9,676,369	4,718,544	181,009,590		
3/31/2007	114,722,977	51,469,437	9,676,369	4,845,155	180,713,938		
6/30/2007	119,955,944	51,469,437	3,225,455	45,002	174,695,838		
SFY 2007	**462,246,359**	**205,603,489**	**32,254,562**	**17,050,295**	**717,154,705**		
9/30/2007	123,042,061	50,793,291	-	116,978	173,952,330	FFY 2007	710,371,696
12/31/2007	125,597,245	50,793,291	-	116,978	176,507,514		
3/31/2008	123,276,077	50,793,291	-	2,413,633	176,483,001		
6/30/2008	125,602,203	50,793,291	-	259,380	176,654,874		
SFY 2008	**497,517,586**	**203,173,164**	**-**	**2,906,969**	**703,597,719**		
9/30/2008	124,720,448	50,793,292	-	8,166,393	183,680,133	FFY 2008	713,325,522
12/31/2008	124,720,448	50,174,352	-	8,215,021	183,109,821		
3/31/2009	124,720,448	50,174,352	-	8,284,678	183,179,478		
6/30/2009	130,542,579	50,174,352	-	2,602,363	183,319,294		
SFY 2009	**504,703,923**	**201,316,348**	**-**	**27,268,455**	**733,288,726**		
9/30/2009	131,278,236	48,240,298	-		179,518,534	FFY 2009	729,127,127
12/31/2009			-		-		
3/31/2010			-		-		
6/30/2010			-		-		
SFY 2010	**131,278,236**	**48,240,298**	**-**	**-**	**179,518,534**		