Gateway to Better Health Demonstration

Demonstration Extension Application Appendices

December 31, 2015

Number: 11-W-00250/7

Appendix I

Quality Measures

Baselines are provided using data from calendar year 2011. These quality measures will be reviewed for evaluation purposes.

Quality Measures

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
1. Tobacco Use Assessment[1] Percentage of patients aged 18 and over who were queried about any and all forms of tobacco use at least once within 24 months	Number of patients for whom documentation demonstrates that patients were queried about their tobacco use one or more times during their most recent visit or within 24 months of their most recent visit	Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least two medical visits ever, or a sample of these patients.	82%	82%	73%	84%	76%	86%	NA	NA	87%	UDS
2. Tobacco Cessation Intervention[1] Percentage of patients aged 18 and over who were identified as users of any and all forms of tobacco during the program year or the prior year who received tobacco use intervention (cessation counseling and/or pharmacological intervention)	Number of patients who received tobacco cessation counseling or smoking cessation agents during their most recent visit or within 24 months of the most recent visit	Number of patient who were 18 years of age or older during the measurement year, seen after their 18th birthday, who were identified as a tobacco user at some point during the prior twenty-four months who had at least one medical visit during the reporting period, and at least two medical visits ever, or a sample of these patients	57%	42%	63%	53%	66%	60%	NA	NA	62%	UDS

[1] As of 2014, this metric is no longer measured by UDS. Data for this metric will not be captured going forward.

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
3. Tobacco Use Assessment & Cessation Intervention[2] Percentage of adults age 18 and older assessed for tobacco use and, if identified as a tobacco user, received cessation counseling and/or pharmacotherapy	Number of patients for whom documentation demonstrates that patients were queried about their tobacco use at least once within 24 months of their last visit (during measurement year) about any and all forms of tobacco use AND received tobacco cessation counseling intervention and/or Pharmaco-therapy if identified as a tobacco user	Number of patients who were 18 years of age or older during the measurement year, seen after 18th birthday, with at least one medical visit during the reporting year, and with at least two medical visits ever, or a sample of these patients.	-	-	-	-	-	-	72%	77%	TBD	UDS

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

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
2. Hypertension: Controlling High Blood Pressure Proportion of patients aged 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 (adequate control) at the time of the last reading	Number of patients whose last systolic blood pressure measurement was less than 140 mm Hg and whose diastolic blood pressure was less than 90 mm Hg	All patients 18 to 85 years of age as of December 31 of the measurement year: -with a diagnosis of hypertension (HTN), and -who were first diagnosed by the health center as hypertensive at some point before June 30 of the measurement year, and -who have been seen for medical services at least twice during the reporting year -or a statistically valid sample of 70 of these patients	59%	61%	62%	61%	56%	59%	76%	59%	64%	UDS
3. Hypertension: Blood Pressure Measurement Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded	Number of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits	54%	NA	NA	NA	99%	NA	97%	NA	59%	HITECH Meaningful Use / MPCA

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
4. Cervical Cancer Screening Percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer	Number of female patients 24-64 years of age receiving one or more documented Pap tests during the measurement year or during the two years prior to the measurement year	Number of all female patient 24-64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sampling of these women	61%	52%	51%	48%	49%	49%	66%	47%	66%	UDS
5. Diabetes: HbA1c Control Proportion of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes whose hemoglobin A1c (HbA1c) was less than 9% at the time of the last reading in the measurement year. Results are reported in four categories: less than 7%; greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9%	Number of adult patients whose most recent hemoglobin A1c level during the measurement year is less than or equal to 9%	Number of adult patients aged 18 to 75 as of December 31 of the measurement year: -with a diagnosis of Type I or II diabetes and, -who have been seen in the clinic for medical services at least twice during the reporting year, -or a statistically valid sample of 70 of these patients	70%	73%	68%	70%	69%	71%	69%	72%	75%	UDS

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
6. Adult Weight Screening and Follow-Up Percentage of patients aged 18 and over who had documentation of a calculated BMI during the most recent visit or within the 6 months prior to that visit	Number of patients who had their BMI (not just height and weight) documented during their most recent visit or within 6 months of the most recent visit and if the most recent BMI is outside parameters, a follow-up plan is documented	Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, or a sample of those patients	19%	31%	47%	44%	53%	53%	46%	55%	24%	UDS
9. Primary Care Visits for Patients with Chronic Diseases Percentage of enrolled patients with diabetes, hypertension, CHF or COPD with 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	Number of enrollees with diabetes, hypertension, CHF or COPD with 2 office visits within the first 6 months following the latter of either: a) initial enrollment, or b) initial diagnosis	Number of enrollees with diabetes, hypertension, CHF or COPD	NA	NA	73%	NA	71%	NA	78%	NA	80%	Claims data
10. Primary Care Follow-Up After Hospitalization Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff	Number of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days of hospital discharge.	Number of enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center during the measurement year.	NA	NA	79%	NA	66%	NA	65%	NA	50%	Claims data

Metric	Numerator	Denominator	2011		2012		2013		2014		Goal	Data Source
			Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State	Gateway CHCs	State		
member from the primary care home within 7 days of hospital discharge												

APPENDIX II

Incentive Payment Protocol

Incentive Payments

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

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

Reporting Periods:

- July 1, 2012 – December 31, 2012
- January 1, 2013 – June 30, 2013
- July 1, 2013 – December 31, 2013
- January 1, 2014 – June 30, 2014
- July 1, 2014 – December 31, 2015
- January 1, 2016 – June 30, 2016
- July 1, 2016 – December 31, 2016
- January 1, 2017 – June 30, 2017
- July 1, 2017 – December 31, 2017

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

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

TABLE 1

Pay-for-Performance Incentive Criteria	Threshold	Weighting	Source
All Newly Enrolled Patients- Minimum of at least 1 office visit within 1 year (6 months before/after enrollment date)	80%	20%	EHR Data
Patients with Diabetes, Hypertension, CHF or COPD – Minimum of at least 2 office visits within 1 year (6 months before/after reporting period start date)	80%	20%	EHR Data
Patients with Diabetes - Have one HgbA1c test within 6 months of reporting period start date	85%	20%	EHR Data
Patients with Diabetes – Have a HgbA1c less than or equal to 9% on most recent HgbA1c test within the reporting period	60%	20%	EHR Data

Hospitalized Patients - Among enrollees whose primary care home was notified of their hospitalization by the Gateway Call Center, the percentage of patients who have been contacted (i.e. visit or phone call for status/triage, medical reconciliation, prescription follow up, etc.) by a clinical staff member from the primary care home within 7 days after hospital discharge.	50%	20%	Self-reported by health centers and AHS Call Center Data
TOTAL POSSIBLE SCORE		**100%**	

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

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

TABLE 2

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

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

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

Primary Care Health Center (PCHC) Calculations:

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

- IP = PCHC Payments Earned x 7%

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

- Identify which performance metrics were achieved
- Determine the total Incentive Pool Weights (IPW) by adding the weights of each performance metric achieved

- *Example:* If the PCHC achieves 3 of the 5 performance metrics, then: IPW = 20% + 20% + 20% = 60%
- IPEP = IP x IPW

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

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

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

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

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

- PS = RPCIF x (CMM/TMM)

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

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

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

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

- RPCIFP = PS x IPW

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

SCENARIO 1

Key assumptions:

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

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

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

Remaining Primary Care Incentive Funds

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

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

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

Step 6

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

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

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

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

SCENARIO 2

Key assumptions:

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

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

STEP 3

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

Remaining Primary Care Incentive Funds

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

STEP 4 ***STEP 5***

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

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

Step 6

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

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

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

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

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

APPENDIX III

Pay-for-Performance Incentive Payment Results
Reporting Period: January – June 2015

Background

The State withholds 7% from payments made to the primary care health centers. The amount withheld is tracked on a monthly basis. Primary care health centers provided self-reported data to SLRHC within 30 days of the end of the reporting period for those patients who were enrolled for the entire reporting period. SLRHC validated the data by taking a random sample of the self-reported data and comparing it to the claims data. SLRHC has calculated the funds due to the providers based on the criteria and methodologies described in the Incentive Protocol, approved by CMS. Results for the sixth reporting period, January – June 2015, are summarized below.

Primary Care Health Center Pay-for-Performance Results

The potential incentive payment amount totaled $475,659.97 and 100% will be paid to primary care providers. The following table outlines the pay-for-performance thresholds in comparison to the actual results of each metric.

Table 1 Pay-for-Performance Criteria	Threshold	*Actual Outcomes Achieved*					
		GH	MHD	FC	BJKP	County	Total
1 - All Patients (1 visit)	80%	74%	83%	78%	58%	89%	74%
2 - Patients with Chronic Disease (2 visits)	80%	86%	94%	85%	90%	97%	90%
3 - Patients with Diabetes HgbA1c Tested	85%	92%	86%	89%	90%	89%	90%
4 - Patients with Diabetes HgbA1c < 9%	60%	60%	47%	68%	61%	65%	60%
5 - Hospitalized Patients	50%	85%	64%	67%	60%	80%	78%

The number of metrics met by each health center for the first round of metrics is depicted by the green highlighted fields in Table 1 above. The health centers earned $394,233.14 of the initial incentive pool leaving a remaining balance of $81,426.83.

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

Table 2 Pay-for-Performance Criteria	Threshold	*Actual Outcomes Achieved*					
		GH	MHD	FC	BJKP	County	Total
Referral Rate to Specialists	680/1000	280	322	528	337	536	351

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

Table 3 – Amount Due to Each Health Center				
Health Center	**Incentive Pool**	**First Round Earnings**	**Second Round Earnings**	**Total Due to Providers**
GH	$ 213,567.57	$ 170,854.06	$ 36,560.01	$ 207,414.07
MHD	$ 81,870.75	$ 65,496.60	$ 14,015.21	$ 79,511.81
FC	$ 34,681.44	$ 27,745.15	$ 5,937.01	$ 33,682.16
BJKP	$ 77,014.42	$ 61,611.54	$ 13,183.87	$ 74,795.41
County	$ 68,525.79	$ 68,525.79	$ 11,730.73	$ 80,256.52
Total	**$ 475,659.97**	**$ 394,233.14**	**$ 81,426.83**	**$ 475,659.97**

SUMMARY OF CALCULATIONS

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

Step 1: Determine the initial pool amount.
Step 2: Determine which of the following first-tier performance metrics were achieved for each organization:

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

Step 3: Calculate the earnings for the initial pool based on the number of first-tier metrics achieved.
Step 4: Determine the second pool amount, which is unearned amount from the initial pool.
Step 5: Calculate health center's share of available earnings based on enrollment.
Step 6: Determine which of the following second-tier performance metrics were achieved:

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

Step 7: Calculate the earnings for the second pool based on the number of second-tier metrics achieved.
Step 8: Calculate the total payment to the health center by summing the earnings from both pool

PRIMARY CARE TRENDING REPORT

Pay-for-Performance Criteria	Threshold	Grace Hill						Myrtle						Family Care					
		Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15
TIER 1 OUTCOMES																			
1 – New patients (1 visit)	80%	68%	52%	75%	67%	65%	74%	56%	58%	86%	71%	75%	83%	70%	73%	74%	80%	81%	78%
2 - Patients with chronic diseases (2 visits)	80%	73%	81%	80%	83%	80%	86%	82%	87%	95%	87%	92%	94%	75%	18%	14%	89%	96%	85%
3 - Patients with diabetes HgbA1c tested	85%	62%	91%	88%	87%	91%	92%	67%	78%	72%	48%	91%	86%	68%	70%	81%	100%	100%	89%
4 - Patients with diabetes HgbA1c <9%	60%	61%	60%	61%	60%	61%	60%	50%	48%	50%	58%	77%	47%	54%	53%	64%	75%	71%	68%
5 - Hospitalized Patients	50%	100%	83%	71%	87%	83%	85%	100%	59%	37%	73%	88%	64%	100%	100%	38%	64%	50%	67%
TIER 2 OUTCOMES																			
1 - Emergency Department Utilization[3]	28/1000	34	13	12	N/A	N/A	N/A	28	10	27	N/A	N/A	N/A	12	11	20	N/A	N/A	N/A
2 - Referral Rate to Specialists	680/1000	447	427	315	277	272	280	454	353	309	345	287	322	656	647	567	599	518	528

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

Pay-for-Performance Criteria	Threshold	BJK People's						St. Louis County						Total					
		Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15	Jul-Dec 12	Jan-Jun 13	Jul-Dec 13	Jan-Jun 14	Jul-Dec 14	Jan-Jun 15
TIER 1 OUTCOMES																			
1 – New patients (1 visit)	80%	75%	61%	80%	72%	80%	58%	69%	75%	77%	87%	88%	89%	65%	62%	79%	72%	74%	74%
2 - Patients with chronic diseases (2 visits)	80%	50%	68%	81%	92%	82%	90%	89%	95%	82%	92%	97%	97%	74%	73%	77%	86%	86%	90%
3 - Patients with diabetes HgbA1c tested	85%	71%	57%	85%	89%	81%	90%	71%	83%	85%	89%	92%	89%	66%	77%	83%	80%	90%	90%
4 - Patients with diabetes HgbA1c <9%	60%	46%	37%	55%	56%	62%	61%	39%	64%	63%	68%	80%	65%	54%	53%	59%	63%	68%	60%
5 - Hospitalized Patients	50%	100%	77%	28%	67%	62%	60%	100%	100%	52%	83%	65%	80%	100%	78%	54%	81%	78%	78%
TIER 2 OUTCOMES																			
1 - Emergency Department Utilization[1]	28/1000	24	16	17	N/A	N/A	N/A	9	7	14	N/A	N/A	N/A	26	12	12	N/A	N/A	N/A
2 - Referral Rate to Specialists	680/1000	598	440	363	425	346	337	547	510	487	484	506	536	496	443	365	363	338	351

Appendix IV
Projected Budget Neutrality Impact Through 2017

	DY 1 FFY 2010 07/28/2010 - 09/30/2010	DY 2 FFY 2011 10/01/2010 - 09/30/2011	DY 3 FFY 2012 10/01/2011- 9/30/2012	DY 4 FFY 2013 10/01/2012- 09/30/2013	DY 5 FFY 2014 10/01/2013- 9/30/2014	DY 6 FFY 2015 10/01/2014- 09/30/2015	DY 7 FFY 2016 10/01/2015- 09/30/2016	DY 8 FFY 2017 10/01/2016- 09/30/2017	DY 9 FFY 2018 10/01/2017- 12/31/2017	Total - 7.5 year demonstration 07/28/2010 to 12/31/2017
No. of months in DY	3 months	12 months	12 months	12 months	12 months	12 months	12 months	12 months	3 months	
No. of months of direct payments to facilities	3 months	12 months	9 months	0 months	0 months	0 months	0 months	0 months	0 months	
No. of months of Pilot Program (will be implemented on 07/01/2012)	0 months	0 months	3 months	12 months	12 months	12 months	12 months	12 months	3 months	
Without Waiver Projections										
Estimated DSH Allotment**	$189,681,265	$748,599,611	*$766,126,399*	*$811,102,775*	$814,509,721	*$809,021,633*	*$813,628,633*	*$768,570,551*	*$203,407,158*	**$5,924,647,746**
Without Waiver Total	**$189,681,265**	**$748,599,611**	**$766,126,399**	**$811,102,775**	**$814,509,721**	**$809,021,633**	**$813,628,633**	**$768,570,551**	**$203,407,158**	**$5,924,647,746**
With Waiver Projections										
Residual DSH	*$167,785,998*	*$679,083,062*	*$675,602,811*	*$735,329,474*	*$713,152,789*	*$714,046,801*	*$787,294,778*	*$742,534,487*	*$196,898,142*	*$5,411,728,342*
St. Louis ConnectCare	*$4,850,000*	*$18,150,000*	*$14,879,909*	*$3,148,648*	*$118,489*	*$0*	*$0*	*$0*	*$0*	*$41,147,045*
Grace Hill Neighborhood Health Centers	*$1,462,500*	*$5,850,000*	*$5,071,706*	*$5,016,507*	*$6,073,656*	*$6,147,313*	*$6,011,196*	*$5,943,010*	*$1,485,752*	*$43,061,639*
Myrtle Davis Comprehensive Health Centers	*$937,500*	*$3,750,000*	*$3,097,841*	*$2,108,161*	*$1,838,040*	*$2,364,279*	*$2,396,051*	*$2,368,873*	*$592,218*	*$19,452,963*
Contingency Provider Network	*$0*	*$0*	*$379,372*	*$4,254,902*	*$5,469,199*	*$5,539,520*	*$5,806,076*	*$5,740,224*	*$1,435,056*	*$28,624,350*
Voucher	*$0*	*$0*	*$0*	*$4,541,262*	*$6,358,786*	*$8,121,788*	*$8,170,454*	*$8,078,548*	*$2,019,637*	*$37,290,476*
Infrastructure	$0	$0	$975,000	*$1,925,000*	*$0*	$0	$0	$0	$0	$2,900,000
SLRHC Administrative Costs	$75,000	$300,000	$300,000	*$300,000*	*$75,000*	*$0*	*$0*	*$0*	*$0*	$1,050,000
SLRHC Administrative Costs Coverage Model			$584,155	*$4,328,950*	*$3,692,463*	$3,581,906	*$3,950,078*	*$3,905,410*	*$976,352*	$21,019,315
CRC Program Administrative Costs	$91,684	$700,000	$700,000	*$700,000*	*$175,000*	*$0*	*$0*	*$0*	*$0*	$2,366,684
Actual expenditures for DY3 DOS				$2,670,607	*$33,308*	*$0*	*$0*	*$0*	*$0*	$2,703,915
Projected expenditures for DY4 DOS*				$0	*$0*	*$0*	*$0*	*$0*	*$0*	$0
Actual expenditures for DY4 DOS				$0	*$2,540,653*	*$6,559*	*$0*	*$0*	*$0*	$2,547,212
Projected expenditures for DY5 DOS*						*$138,030*	*$0*	*$0*	*$0*	$138,030
Actual expenditures for DY5 DOS						*$2,402,336*	*$0*	*$0*	*$0*	$2,402,336
Total With Waiver Expenditures	**$175,202,682**	**$707,833,062**	**$701,590,793**	**$764,323,513**	**$739,527,383**	**$742,348,532**	**$813,628,633**	**$768,570,551**	**$203,407,158**	**$5,613,891,943**
Amount under (over) the annual waiver cap	$14,478,583	$40,766,549	$64,535,605	$46,779,262	$74,982,338	$66,673,100	$0	$0	$0	$310,755,803
Annual expenditure by DY Payment Date as reported on CMS 64s (Demo expenses NOT including residual DSH)			$25,987,982	$28,994,039	$26,374,594	$28,301,731	$26,333,855	$26,036,064	$6,509,016	
Annual expenditure authority cap by DY DOS (Demo expenses NOT including residual DSH)	$7,416,684	$28,750,000	$28,691,897	$28,870,644	$26,340,999	$25,754,806	$26,333,855	$26,036,064	$6,509,016	

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

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

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

Assumptions for 2017 Extension:

1. **Funding for the program is consistent with 2016.**
2. **Insulin and inhalers are included in the benefit package.**
3. **Program costs are consistent with the 2016 projected costs per the actuarial report.**
4. **FMAP for medical services is the same as FFY 2016 (63.28%)**

Note: FFY 2010 FMAP for MO = 64.51%; FFY 2011 FMAP for MO = 63.29%; FFY 2013 FMAP = 61.37%. FFY 2014 FMAP = 62.03; FFY 2015 FMAP= 63.45; FFY 2016 FMAP=63.28

Appendix V

Public Notice Concerning
Missouri's Gateway to Better Health Section 1115 Demonstration Project
Number: 11-W-00250/7

The State of Missouri, Department of Social Services (DSS), hereby notifies the public of its intent to request a one-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2016. A copy of the demonstration extension application under consideration may be found at http://dss.mo.gov/mhd/. We are providing this notice pursuant to Centers for Medicare & Medicaid Services (CMS) requirements in 42 C.F.R. 431.408.

The Gateway to Better Health Demonstration is designed to provide coverage to low-income adults residing in St. Louis City and St. Louis County who do not qualify for Medicaid. The State is requesting the authority to continue funding expenditures for primary and specialty care services provided to uninsured individuals, ages 19 through 64, with family incomes between 0 and 100 percent of the Federal poverty level (FPL). Should the State opt to expand Medicaid during the extension period, the Demonstration will terminate.

Public Comments and Hearings

The public is invited to review and comment on the State's proposed waiver extension request. The full public notice document for the Gateway to Better Health Waiver extension request can be found at http://dss.mo.gov/mhd/ under Alerts and Notifications. Appointments may be made to view a hard copy of the full public notice document, as well as a draft of the extension application, by calling 314-446-6454, ext. 1011. Appointments may be made during regular business hours, 8:00 a.m. - 4:30 p.m., Monday through Friday. Appointments to view the documents will take place at 1113 Mississippi Avenue, St. Louis, MO 63104.

Comments will be accepted 30 days from the publication of this notice. The comment period ends December 30, 2015. Comments may be sent to:

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

Public hearings are scheduled for:

Tuesday, December 1, 2015, 7:30-8:30 a.m.*
Ethical Society of St. Louis
9001 Clayton Road
St. Louis, MO 63117

Wednesday, December 2, 2015, 10-11:30 a.m.
BJK People's Health Centers
5701 Delmar Blvd.
St. Louis, MO 63112

**This meeting is part of the regularly scheduled Provider Services Advisory Board meeting of the St. Louis Regional Health Commission. Individuals wanting to participate in the December 1st public hearing via conference call may dial 888-808-6929, access code: 9158702.*

Appendix VI

Public Notice of
Missouri's Application to Extend the
Gateway to Better Health Demonstration Project
Section 1115 Demonstration (Number: 11-W-00250/7)

November 30, 2015

The State of Missouri, Department of Social Services (DSS), hereby notifies the public that it intends to apply for a one-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2016. A copy of the draft Demonstration extension application may be found at http://dss.mo.gov/mhd/. We are providing this notice pursuant to Centers for Medicare and Medicaid Services (CMS) requirements in 42 C.F.R. § 431.408.

DSS proposes that Gateway's "Safety Net Pilot Program" be extended for a period up to one year. The original goal of the Demonstration was to preserve the St. Louis City and St. Louis County safety net of health care services for the uninsured until a transition to health care coverage became available. At this time, Missouri has not yet opted to implement Medicaid expansion under the Affordable Care Act. Therefore, the extension is being requested in order to continue to provide access to services for the uninsured in St. Louis City and County. The State is requesting renewal of covered services to individuals with income below 100% of the federal poverty level. Should the State opt to expand Medicaid during the extension period, the Demonstration will terminate.

I. Program Description and Goals

On July 28, 2010, CMS approved the State of Missouri's "Gateway to Better Health" Demonstration, which 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 percent increase in the number of uninsured persons receiving services at St. Louis ConnectCare, Affinia Healthcare (formerly known as Grace Hill) and Myrtle Hilliard Davis Comprehensive Health Centers.

For the first two years of the Demonstration, certain providers were paid directly for uncompensated care. These providers included St. Louis ConnectCare, Affinia Healthcare (formerly known as Grace Hill) and Myrtle Hilliard Davis Comprehensive Health Centers. As of July 1, 2012, the program transitioned to a coverage model.

The Demonstration was amended in June 2012 to enable the Safety Net Pilot Program to be implemented by July 1, 2012. The July 1, 2012 implementation of the Pilot Program ensured patients of the St. Louis safety net maintained access to primary care and specialty care through a coverage model.

The Pilot Program is designed to provide primary, urgent and specialty care coverage to uninsured[4] adults in St. Louis City and St. Louis County, aged 19-64, who are below 100 percent of the FPL through a coverage model known as Gateway to Better Health. The Demonstration also includes a performance and incentive structure for the primary care providers and tracks health outcomes.

Under the Demonstration, the State has authority to claim as administrative costs limited amounts incurred for the functions related to the design and implementation of the Demonstration pursuant to a Memorandum of Understanding with the St. Louis Regional Health Commission (SLRHC), which is a non-profit, non-governmental organization whose mission is to 1) increase access to health care for people who are medically uninsured and underinsured; 2) reduce health disparities among populations in St. Louis City and County; and 3) improve health outcomes among populations in St. Louis City and County, especially among those most at risk.

This Demonstration Project and the funding mechanisms that preceded it have been critical to maintaining and improving access to health care for uninsured individuals in St. Louis City and County since the closure of the city's last remaining public hospital in 1997.

CMS offers additional information about Section 1115 waivers generally and the Gateway waiver specifically at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

During the extension period, the State proposes to continue the Demonstration, until such time as Missouri's Medicaid eligibility is expanded to include the waiver population, or up to one year, whichever is first.

During this extension of the Demonstration, the State, SLRHC and providers will continue to demonstrate how coverage and access to preventative care cost-effectively improves the health of a low-income population.

The objectives for the extension period of the Demonstration continue to be:

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 in Missouri under the Affordable Care Act;
II. 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;
III. Maintain and enhance quality service delivery strategies to reduce health disparities.

[4] To be considered to be "uninsured" applicants must not be eligible for coverage through the Medicaid State Plan. Screening for Medicaid eligibility is the first step of the Gateway to Better Health eligibility determination.

II. Beneficiaries and Eligibility Criteria

Gateway to Better Health will continue to provide access to primary care, specialty care and urgent care and will continue to be available to individuals who meet the following requirements:

- 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 100%
- Not eligible for coverage under the federal Medicare program or Missouri Medicaid
- Patients with a primary care home at one of the in network primary care sites.

III. Delivery System

Gateway to Better Health services are provided through a limited provider network. Beneficiaries will continue to choose a primary care home in which to enroll. Primary care homes in the network include:

- BJK People's Health Centers
- Family Care Health Centers
- Affinia Healthcare (formerly known as Grace Hill Health Centers)
- Myrtle Hilliard Davis Comprehensive Health Centers
- St. Louis County Department of Public Health

Primary care provider organizations will continue to be paid under an alternative payment methodology.

For specialty care, beneficiaries may be referred by their primary care physician for specialty care services at a participating specialty care provider, including for physician inpatient services or outpatient hospital care. Specialty care providers will continue to be paid for on a fee-for-service basis for care provided to all Gateway beneficiaries.

IV. Benefits

Beneficiaries enrolled in Gateway to Better Health will continue to receive the following benefits:

Preventative; wellcare; dental (diagnostic, preventive); internal and family practice medicine (up to 5 five urgent care visits); gynecology; podiatry, generic prescriptions dispensed at primary care clinics as well as brand name insulin and inhalers; 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; non-emergency medical transportation.

The State seeks to continue to provide all benefits currently approved for the Gateway to Better Health Demonstration. The final actuarial rates for the extension period will be established in 2016.

V. Cost Sharing

There is no premium for Gateway to Better Health. Beneficiary co-pays are the same as those for patients of Missouri Medicaid, MO HealthNet.

VI. Aggregate and Historical Budgetary and Expenditure Data

Under the current Demonstration, the State is authorized to spend up to $30 million (total computable) annually in lieu of spending that amount of statutorily authorized funding on payments to disproportionate share hospitals (DSHs). The extension application seeks authority for a total computable budget of $30 million (total computable) annually.

VII. Anticipated Changes in Enrollment

It is anticipated that approximately 21,400 individuals would be enrolled in Gateway to Better Health during the extension period. These projections are subject to change when additional actuarial analysis is conducted in the third quarter of 2016.

VIII. Waiver and Expenditure Authorities

It is anticipated the Waiver and Expenditure Authorities would include:

- **Demonstration Population 1:** Effective January 1, 2014, expenditures for uninsured individuals, not eligible for Medicaid, who are living in St. Louis City or St. Louis County, and are between the ages of 19-64 years of age with income up to 100 percent of the FPL to pay for primary care provided by a designated primary care provider or specialty care provider when referred by a designated primary care provider.
- **Expenditure for Managing the Coverage Model:** Effective January 1, 2014, expenditures pursuant to a memorandum of understanding and not to exceed $4,500,000 for costs incurred by the SLRHC to activities related to the continued administration of the coverage model during the extension period.

The state also seeks continued waivers of the following Medicaid requirements:

Statewideness **Section 1902(a)(1)**

To the extent necessary, to allow the State to limit enrollment in the Demonstration to persons residing in St. Louis City and St. Louis County.

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary, to enable the State to establish an enrollment target and maintain waiting lists for the Demonstration population.

Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To the extent necessary, to permit the State to offer benefits that differ among the Demonstration population and that differ from the benefits offered under the Medicaid state plan.

Standards and Methods **Section 1902(a)(17)**

To the extent necessary, to permit the State to extend eligibility for the Demonstration population for a period of up to eighteen months without redetermining eligibility.

Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary, to enable the State to mandatorily enroll the Demonstration population into a delivery system that restricts free choice of provider.

Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary, to enable the State to not provide medical assistance to the Demonstration population prior to the date of application for the Demonstration benefits.

Payment for Services by Federally Qualified Health Centers (FQHCs) **Section 1902(a)(15)**

To the extent necessary, to enable the State to make payments to participating FQHCs for services provided to Demonstration Population using reimbursement methodologies other than those required by section 1902(bb) of the Act to the limited nature of the benefits.

IX. Evaluation of the Gateway to Better Health Demonstration

The State intends to measure progress against the Demonstration objectives throughout the Demonstration and during the extension period. Interim evaluation activities to date indicate that all Demonstration objectives have been met or significant progress can be demonstrated. Additional activities will evaluate whether or not the coverage model proves out the following hypothesis:

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

II. Uninsured patients who receive coverage under the pilot program will use community emergency departments for non-emergent visits at a lower rate than other uninsured patients.

III. The prevalence of preventable hospitalizations, hospital re-admissions and ED utilization will be reduced among patients with chronic medical conditions.

IV. For those patients aging out of Medicaid who need a coverage option, the pilot project provides a transition to coverage available under the Affordable Care Act, providing an effective bridge for these patients.

X. Public Notice and Input Process

The public is invited to review and comment on the State's proposed waiver extension request.

A draft of the Gateway to Better Health Waiver extension request can be found at http://dss.mo.gov/mhd/. Appointments may be made to view a hard copy of the draft of the extension application by calling 314-446-6454, ext. 1011. Appointments may be made during regular business hours, 8:00 a.m. - 4:30 p.m., Monday through Friday. Appointments to view the documents will take place at 1113 Mississippi Avenue, St. Louis, MO 63104.

Comments will be accepted until December 30, 2015, and may be sent to the following address:

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

Public hearings are scheduled for:

Tuesday, December 1, 2015, 7:30-8:30 a.m.*
Ethical Society of St. Louis
9001 Clayton Road
St Louis, MO 63117

Wednesday, December 2, 2015, 10-11:30 a.m.
BJK People's Health Centers
5701 Delmar Blvd.
St. Louis, MO 63112

**This meeting is part of the regularly scheduled Provider Services Advisory Board meeting of the St. Louis Regional Health Commission. Individuals wanting to participate in the December 1st public hearing via conference call may dial 888-808-6929, access code: 9158702.*

The State and the St. Louis Regional Health Commission will accept verbal and written comments at the public hearings. The outcome of this process and the input provided will be summarized for CMS upon submission of the notification of request for Demonstration extension.

In addition, on June 16, 2015, a public hearing was held to inform the public on the progress of the Gateway demonstration, in compliance with 42 C.F.R. § 431.420(c). This meeting was held as part of the regularly scheduled Community Advisory Board of the St. Louis Regional Health Commission. Approximately, 25 people attended the meeting. Attendees received information on the number of people served and the number of services and visits provided by Gateway each year. The current membership of the program, including a demographic profile of Gateway members, and an overview of patient and provider satisfaction feedback was also presented. The highlight of the presentation was the overview of the member orientations Gateway started offering this year to assist new members with navigating the Gateway program.

Appendix VII

Post-Award Public Input Forum Notice
Public Hearing Concerning Missouri's Gateway to Better Health Section 1115 Demonstration Project Number: 11-W-00250/7

In July 2015, The State of Missouri, Department of Social Services (DSS), received a one-year extension of its Gateway to Better Health Demonstration from the Centers for Medicare and Medicaid Services (CMS). The Gateway to Better Health Demonstration provides coverage for certain outpatient care to low-income, uninsured adults residing in St. Louis City and St. Louis County who do not qualify for Medicaid. This program provides a bridge for safety net providers and approximately 20,000 uninsured patients to Medicaid coverage available through the Affordable Care Act.

Under the terms of the extension, Gateway to Better Health provides primary and specialty care services to uninsured individuals, ages 19 through 64, with family incomes below 100 percent of the Federal poverty level (FPL). The program was originally approved in July 2010 and currently is scheduled to expire on December 31, 2016.

Hearing

The public is invited to comment on the progress of the demonstration at a public hearing scheduled for

Tuesday, March 15, 2015
8:30 – 10:00 AM
Employment Connection
2838 Market Street
St. Louis, MO 63103

This meeting is part of the regularly scheduled Community Advisory Board meeting of the St. Louis Regional Health Commission (SLRHC).

The State and the SLRHC will take verbal and written comments at the public hearing. The community input provided will be summarized for CMS.