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State/Territory Name: MO

State Plan Amendment (SPA) #: 16-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

December 22, 2016

Brian Kinkade
Director
Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102-1527

Dear Mr. Kinkade:

The Centers for Medicare & Medicaid Services (CMS), Kansas City Regional Office, has completed its review of Missouri State Plan Amendment (SPA) Transmittal Number #16-0007. This amendment was submitted on June 20, 2016 for the purpose of making the data conversion from the Medicaid Model Data Lab (MMDL) and to add additional chronic care conditions as qualifying conditions for community mental health centered health homes.

SPA 16-0007 was approved on December 20, 2016, with an effective date of June 1, 2016, as requested by the state. Enclosed is a copy of the CMS 179 form, as well as, the approved pages for incorporation into the Missouri State plan.

If you have any questions regarding this state plan amendment, please contact Sandra Levels at Sandra.Levels@cms.hhs.gov or (816) 426-5925.

Sincerely, 12/22/2016

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosure

cc:
Joseph Parks, M.D., Director
Debbie Meller

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date: Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MO-16-07

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MO-11-0011

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Socia**

Name of Health Homes Program:

Community Mental Health Center – Health Homes

State Information

State/Territory name:	**Missouri**
Medicaid agency:	MO HealthNet

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Debbie Meller
Title:	Executive Assistant
Telephone number:	(573) 751-6884
Email:	debbie.meller@dss.mo.gov

The primary contact for this submission package.

Name:	Joseph Parks, M.D

Title: Director, MO HealthNet Division

Telephone number: (573) 751-6884

Email: Joe.Parks@dss.mo.gov

The secondary contact for this submission package.

Name:

Title:

Telephone number:

Email:

The tertiary contact for this submission package.

Name:

Title:

Telephone number:

Email:

Proposed Effective Date

06/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
Data conversion from previous Medicaid Model Data Lab. Supersedes Transmittal Number:00-0000 Transmittal Number:11-0011
This State Plan Amendment is in Attachment 3.1-H of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B (48) of the State Plan.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 118973.00
Second Year	2017	$ 90450.00

Federal Statute/Regulation Citation

Section 2703 of the Affordable Care Act and Section 1945 of the Social Security Act

Governor's Office Review

- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date:

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date: Attachment 3.1-H Page Number:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ( ) **Public notice was not required and comment was not solicited**
- ( ) **Public notice was not required, but comment was solicited**
- (●) **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

- [ ] **Newspaper Announcement**
- [x] **ublication in State's administrative record, in accordance with the administrativ**

Date of Publication:
10/17/2011 (mm/dd/yyyy)

- [ ] **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:
(mm/dd/yyyy)

Description:

☐ **Website Notice**

Select the type of website:

☐ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: (mm/dd/yyyy)

Website URL:

☐ Website for State Regulations

Date of Posting: (mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date:

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date: Attachment 3.1-H Page Number:

Submission - Tribal Input

☐ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☐ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date:

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Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 02/28/2011 (mm/dd/yyyy)	

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date:

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Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☑ **Two or more chronic conditions**

Specify the conditions included:

☑ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	
Developmental disability	

Additional description of other chronic conditions:
CMHCs will be the state's designated provider for individuals of any age with:
• Developmental disability: this term is used as defined in section 630.005(9) of the Revised Statutes of Missouri.
• Chronic Obstructive Pulmonary Disorder: changes in the lungs and airways that impede the flow of air, including emphysema and chronic bronchitis.

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

☑ **Mental Health Condition**
☑ **Substance Abuse Disorder**
☑ **Asthma**
☑ **Diabetes**
☑ **Heart Disease**
☑ **BMI over 25**

Other Chronic Conditions	
Developmental disability	

Specify the criteria for at risk of developing another chronic condition:

Additional description of other chronic conditions:
Description of "At Risk" Criteria:
1.Tobacco use (tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD).
2.Diabetes (Diabetes is considered an at-risk behavior for chronic conditions such as CVD and BMI over 25).

CMHCs will be the state's designated provider for individuals of any age with:
• Developmental disability: this term is used as defined in section 630.005(9) of the Revised Statutes of Missouri.
• Chronic Obstructive Pulmonary Disorder: changes in the lungs and airways that impede the flow of air, including emphysema and chronic bronchitis

(The description below is a continuation of the "criteria for a serious and persistent mental health condition" that was started in the box below)

10. Anxiety Disorders
   A. Generalized Anxiety Disorder
   B. Panic Disorder with Agoraphobia
   C. Panic Disorder without Agoraphobia
   D. Agoraphobia without Panic Disorder
   E. Social Phobia
11. For children and youth only
   A. Major depressive disorder, single episode
   B. Bipolar
   C. Reactive attachment disorder of infancy or early childhood
12. For adults aged sixty (60) years and over
   A. Major depressive disorder, single episode
13. Adults with a DLA-20© mGAF score of 40 or lower, in combination with one of the following DSM diagnoses, meet the disability and diagnostic requirements:
   A. Bipolar Disorder, Most Recent Episode Unspecified
   B. Shared Psychiatric Disorder
   C. Conversion Disorder
   D. Dissociative Identity Disorder
   E. Dysthymic Disorder
   F. Depersonalization Disorder
   G. Body Dysmorphic Disorder
   H. Hypochondriasis
   I. Somatization Disorder
   J. Undifferentiated Somatoform Disorder
   K. Paranoid Personality Disorder
   L. Cyclothymic Disorder
   M. Schizoid Personality Disorder
   N. Schizotypal Personality Disorder
   O. Obsessive-Compulsive Personality Disorder
   P. Histrionic Personality Disorder
   Q. Dependent Personality Disorder
   R. Antisocial Personality Disorder
   S. Narcissistic Personality Disorder
   T. Avoidant Personality Disorder
   U. Personality Disorder NOS
   V. Pain Disorder Associated with Psychological Factors
   W. Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

X. Intermittent Explosive Disorder

14. Individuals younger than 18 with a DLA-20© mGAF or CGAS score of 50 or lower, in combination with the following DSM psychiatric diagnoses, meet the disability and diagnostic requirements:

A. Any diagnosis listed above, or
B. Separation Anxiety Disorder
C. Oppositional Defiant Disorder
D. Attention-Deficit/Hyperactivity Disorder (Predominantly Inattentive Type, Predominantly Hyperactive-Impulsive Type, Combined Type)

15. Youth or adults, meeting the age-appropriate DLA-20© mGAF or CGAS score requirements and who have one of the following Not Otherwise Specified (NOS) Disorders, also meet the disability and diagnostic requirements. When an NOS disorder is used as the diagnosis, documentation must specifically include a detailed history/examination for each of the non-NOS criteria and a clear rationale for how those criteria are not met, thus supporting the appropriateness of an NOS diagnosis.

A. Mood Disorder NOS
B. Anxiety Disorder NOS
C. Dissociative Disorder NOS
D. Personality Disorder NOS
E. Depressive Disorder NOS
F. Impulse Control Disorder NOS
G. Disruptive Behavior Disorder NOS
H. AD/HD NOS
I. Bipolar Disorder NOS

• Duration. Rehabilitation services shall be provided to those individuals whose mental illness is of sufficient duration as evidenced by one (1) or more of the following occurrences:

1. Persons who have undergone psychiatric treatment more intensive than outpatient more than once in a lifetime (crisis services, alternative home care, partial hospital, inpatient);
2. Persons who have experienced an episode of continuous residential care other than hospitalization, for a period long enough to disrupt the normal living situation;
3. Persons who have exhibited the psychiatric disability for one (1) year or more; or
4. Persons whose treatment of psychiatric disorders has been or will be required for longer than six (6) months;

• A functional assessment may be used to establish eligibility and the need for and amount of services, including results from a standardized assessment prescribed by the department; and
• Whenever discrepancies occur regarding the appropriateness of an ICD-10-CM versus a DSM diagnosis, the DSM diagnosis shall prevail.

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
In Missouri, 'Serious and Persistent Mental Health Condition' is labeled 'Serious Mental Illness' (SMI). SMI is defined by disability, diagnosis, and duration; which are outlined below:

• Disability. There shall be clear evidence of serious and/or substantial impairment in the ability to function at an age or developmentally-appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning, as indicated by intake evaluation and assessment:

o Social role functioning/family life— the ability to sustain functionally the role of worker, student, homemaker, family member, or a combination of these; and

o Daily living skills/self-care skills— the ability to engage in personal care (such as grooming, personal hygiene) and community living (handling individual finances, using community resources, performing household chores), learning ability/self-direction, and activities appropriate to the individual's age, developmental level, and social role functioning;

• Diagnosis. A physician or licensed psychologist shall certify a primary Diagnostic and Statistical Manual (DSM) diagnosis using the current edition of the manual. This diagnosis may coexist with other psychiatric diagnoses.

1. Schizophrenia
A. Disorganized
B. Catatonic
C. Paranoid
D. Schizophreniform
E. Residual

F. Schizoaffective
G. Undifferentiated
2. Delusional disorder
3. Bipolar I disorders
A. Single manic episode
B. Most recent episode manic
C. Most recent episode depressed
D. Most recent episode mixed
4. Bipolar II disorders
5. Psychotic disorders NOS
6. Major depressive disorder-recur
7. Obsessive-Compulsive Disorder
8. Post-Traumatic Stress Disorder
9. Borderline Personality Disorder

(This description is continued above in the box for "Additional description of other chronic conditions")

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

○ **Opt-In to Health Homes provider**

Describe the process used:

◉ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:
Individuals eligible for Health Home services and identified by the state as being existing service users of a Health Home will be auto-assigned to eligible providers based on qualifying conditions. Upon enrollment, individuals assigned to a Health Home will be informed by the state via U.S. mail and other methods as necessary of all available Health Homes throughout the state. The notice will describe individuals' choice in selecting a Health Home as well as provide a brief description of Health Home services, and describe the process for individuals to opt-out of receiving treatment services from the assigned Health Home provider. Individuals who have been auto-assigned to a Health Home provider will have the choice to opt out of receiving treatment services from the assigned Health Home provider and select another service provider from the available Health Homes throughout the state at any time. Individuals who have been auto-assigned to a Health Home provider may also opt out of the Health Home program altogether at any time without jeopardizing their existing services. Other individuals with qualifying chronic conditions who are not currently receiving services at the Health Home may request to be part of the Health Home. Potentially eligible individuals receiving services in the hospital ED or as an inpatient will be notified about eligible Health Homes and referred based on their choice of provider. Eligibility for Health Home services will be identifiable through the state's comprehensive Medicaid electronic health record. Health Home providers to which patients have been auto-assigned will receive communication from the state regarding a patient's enrollment in Health Home services. The Health Home will notify other treatment providers (e.g., primary care and specialists such as OB/GYN) about the goals and types of Health Home services as well as encourage participation in care coordination efforts.

☑ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☑ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

CMHCs will serve as designated providers of Health Home services. All designated providers will be required to meet state qualifications. CMHCs are certified and designated by the Department of Mental Health and provide services through a statewide catchment area arrangement. The Missouri CMHC catchment area system divides the state into separate catchment areas. Each catchment area has the specific responsibility of one or more CMHCs.

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:
CMHCs will be supported in transforming service delivery by participating in statewide learning activities. Given CMHCs' varying levels of experience with practice transformation approaches, the State will assess providers to determine learning needs. CMHCs will therefore participate in a variety of learning supports, up to and including learning collaboratives, specifically designed to instruct CMHCs to operate as Health Homes and provide care using a whole person approach that integrates behavioral health, primary care and other needed services and supports. Learning activities will be supplemented with periodic calls to reinforce the learning sessions, practice coaching, and monthly practice reporting and feedback.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.
CMHCs will serve as designated providers of Health Home services. All designated providers will be required to meet state qualifications. CMHCs are certified and designated by the Department of Mental Health and provide services through a statewide catchment area arrangement. The Missouri CMHC catchment area system divides the state into separate catchment areas. Each catchment area has the specific responsibility of one or more CMHCs (three CMHCs are assigned more than one catchment area), assuring statewide and complete coverage of all catchment areas.

CMHC Health Homes will be physician-led with an individual's multi-disciplinary team minimally comprised of the individual's treating psychiatrist, qualified mental health professional, mental health case manager, and nurse care manager. Additional multi-disciplinary team members may include an individual's treating primary care physician, as well as other representatives as appropriate to meet client needs (e.g. educational, employment, or housing representatives). All members of an individual's team will be responsible for ensuring that care is person-centered, culturally competent and linguistically capable. In addition, CMHC Healthcare Homes will include a Health Home Director, Primary Care Physician Consultant, and Care Coordinator/Clerical Support staff. The Health Home Director is responsible for championing practice transformation designed to integrate physical and behavioral health and wellness; managing health home enrollments, discharges, and transfers; overseeing the daily operations of the health home, including overseeing the development, and submission, of required monthly health home reports to the State; and, if appropriately credentialed, participating in health education activities. The Primary Care Physician Consultant establishes organizational priorities for disease management and improving health status; participates in case consultation with multi-disciplinary teams; helps educate clinical staff on the nature, course, and treatment of chronic diseases; and develops collaborative relationships between the organization and treating Primary Care Physicians, between treating Primary Care Physicians and Psychiatrists,, and between the organization and other healthcare professionals and facilities. The care coordinator/clerical support staff facilitates the multi-disciplinary teams' reviews of monthly care management and hospital admission reports; completes metabolic screening data entry; assists with appointment scheduling and client tracking; provides technical assistance to the multi-disciplinary teams in utilizing the automated care management reporting systems; and may, if appropriately credentialed, at the request of a multi-disciplinary team, assist in providing case management services. The cost of the Nurse Care Manager, Health Home Director, Primary Care Physician Consultant, and Care Coordinator/Clerical Support staff will be covered by the PMPM rate described in the Payment Methodology section below.

CMHCs will be supported in transforming service delivery by participating in statewide learning activities. Given CMHCs' varying levels of experience with practice transformation approaches, the State will assess providers to determine learning needs. CMHCs will therefore participate in a variety of learning supports, up to and including learning collaboratives, specifically designed to instruct CMHCs to operate as Health Homes and provide care using a whole person approach that integrates behavioral health, primary care and other needed services and supports. Learning activities will be supplemented with periodic calls to reinforce the learning sessions, practice coaching, and monthly practice reporting (data and narrative) and feedback.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
Initial Provider Qualifications

1. State Qualifications: In addition to being a state-designated CMHC, each Health Home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each Health Home:
a. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals, defined as receiving medical assistance from Medicaid or the

Children's Health Insurance Program (CHIP), furnished uncompensated care by the provider, or furnished services at either no cost or reduced based on a sliding scale. Patient percentage requirements will be determined by the state;
b. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated through the application process and agreement to participate in learning activities including in-person sessions and regularly scheduled phone calls; and that agency leadership have presented the state approved "Paving the Way for Health Care Homes" PowerPoint introduction to Missouri's Health Home Initiative to all agency staff and board of directors;
c. Meet state requirements for patient empanelment (i.e., each patient receiving CMHC health home services must be assigned to a physician);
d. Meet the state's minimum access requirements as follows: Prior to implementation of health home service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week;
e. Actively use MO HealthNet's comprehensive electronic health record (EHR) to conduct care coordination and prescription monitoring for Medicaid participants;
f. Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;
g. Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns;
h. Conduct wellness interventions as indicated based on clients' level of risk;
i. Complete status reports to document clients' housing, legal, employment status education, custody etc.;
j. Agree to convene regular, ongoing and documented internal Health Home team meetings to plan and implement goals and objectives of practice transformation;
k. Agree to participate in CMS and state-required evaluation activities;
l. Agree to develop required reports describing CMHC Health Home activities, efforts and progress in implementing Health Home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of Primary Care Nurse Manager's time and activities);
m. Maintain compliance with all of the terms and conditions as a CMHC Health Home provider or face termination as a provider of CMHC Health Home services; and
n. Present a proposed Health Home delivery model that the state determines to have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the Health Home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

2. Ongoing Provider Qualifications Each CMHC must also:
a. Within 3 months of Health Home service implementation, have developed a contract or MOU with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a Health Home site, and in addition motivate hospital staff to notify the CMHC Primary Care Nurse Manager or staff of such opportunities. The state will assist in obtaining hospital/Health Home MOU if needed;
b. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
c. Demonstrate continuing development of fundamental health home functionality at 6 months and 12 months through an assessment process to be applied by the state;
d. Demonstrate significant improvement on clinical indicators specified by and reported to the state;
e. Provide a Health Home that demonstrates overall cost effectiveness; and
f. Meet NCQA level 1 PCMH requirements as determined by a DMH review or submit an application for NCQA recognition by month 18 from the date at which supplemental payments commence OR meet equivalent recognition standards approved by the state as such standards are developed.

Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

- [x] **Fee for Service**
- [ ] **PCCM**

  - ○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

  - ○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

    The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

    - [ ] **Fee for Service**

    - [ ] **Alternative Model of Payment (describe in Payment Methodology section)**

    - [ ] **Other**

      Description:

    - [ ] **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

      If yes, describe how requirements will be different:

- [ ] **Risk Based Managed Care**

  - ○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

    - [ ] **The current capitation rate will be reduced.**

    - [ ] **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

      Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Rate Basis/Development

Overview of Payment Structure: Missouri has developed the following payment structure for designated CMHC Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Missouri. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. Clinical Care Management per-member-per-month (PMPM) payment:

Cost Assumptions/Factors Used to Determine Payment

Missouri will pay CMHC health homes the cost of staff primarily responsible for delivery of services not

covered by other reimbursement (Primary Care Nurses, Physician Consultants, and Administrative Support staff) whose duties are not otherwise reimbursable by MO HealthNet. In addition, CMHC Health Homes receive payments related to Health Home specific training, technical assistance, administration, and data analytics.
• Staff cost is based on a provider survey of all CMHCs statewide and includes fringe, operating & indirect costs.
• All CMHC Health Home providers will receive the same PMPM rate.
• The PMPM method will be reviewed periodically to determine if the rate is economically efficient and consistent with quality of care.

Clinical Care Management Standards
Managed Care: All Health Home payments including those for MO HealthNet ("MHN") participants enrolled in managed care plans will be made directly from MHN to the Health Home provider. As a result of the additional value that managed care plans will receive from MHN direct paid Health Home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the CMS reimbursed health home services. This Health Home delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care. The managed care plan will be informed of its members that are in Health Home services and a managed care plan contact person will be provided for each Health Home provider to allow for coordination of care.
• The managed care plan will be required to inform either the individual's Health Home or MO Health Net of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.
• The CMHC Health Home team will provide Health Home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the CMHC Health Home.

Minimum Criteria for Payment:
The criteria required for receiving the PMPM payment is:
A. The person is identified as meeting CMHC health home eligibility criteria on the State-run health home patient registry;
B. The person is enrolled as a health home member at the billing health home provider and is enrolled in only one health home at a time;
C. The minimum health home service required to merit payment of the PMPM is that the person has received Care Management monitoring for treatment gaps; or another health home service was provided that was documented; and
D. The health home will report that the minimal service required for the PMPM rate payment occurred on a monthly health home attestation report.

Except as otherwise noted in the plan, state-developed per-member-per-month rates are the same for both governmental and private providers of health home services. The agency's per-member-per-month rate is published on the website at: http://dmh.mo.gov/mentalillness/mohealthhomes.html and is effective for services provided on or after the effective date of this state plan amendment."

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
Health Home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future Health Home state plan benefits, and other state plan services). In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
Comprehensive care management services are:
a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;
b. assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes;
c. assignment of health team roles and responsibilities;
d. development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
e. monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
f. development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices and schools. The tool is a HIPAA-client portal that enables providers to:
- Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
- View dates and providers of hospital emergency department services;
- Identify clinical issues that affect an enrollee’s care and receive best practice information;
- Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
- Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
- Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee’s pharmacy of

choice; and
- Review laboratory data and clinical trait data;
- Determine medication adherence information and calculate medication possession ratios (MPR); and
- Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
CMHC

Description

Care Coordination

Definition:
Care Coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:
-Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
-View dates and providers of hospital emergency department services;
-Identify clinical issues that affect an enrollee's care and receive best practice information;
-Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
-Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
-Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee's pharmacy of choice; and
-Review laboratory data and clinical trait data;
-Determine medication adherence information and calculate medication possession ratios (MPR); and
-Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

CMHC

Description

Health Promotion

Definition:
Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health- promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist clients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Utilization data available through the module includes:
-Administrative claims data for the past three years;
-Cardiac and diabetic risk calculators;
-Chronic health condition information awareness;
-A drug information library; and
-The functionality to create a personal health plan and discussion lists to use with healthcare providers.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

CMHC

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay.
MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the state's data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a health home. The contractor would then immediately notify the health home provider of the admission, which would enable the health home provider to:
- Use the hospitalization episode to locate and engage persons in need of health home services;
- Perform the required continuity of care coordination between inpatient and outpatient; and
- Coordinate with the hospital to discharge and avoid readmission as soon as possible.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

CMHC

Description

Individual and family support, which includes authorized representatives

Definition:
Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with DD the health home will refer to and coordinate with the approved DD case management entity for services more directly related to

Habilitation and coordinate with the approved DD case management entity for services more directly related a particular healthcare condition.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Utilization data available through the module includes:
a. Administrative claims data for the past 3 years;
b. Cardiac and diabetic risk calculators;
c. Chronic health condition information awareness;
d. A drug information library; and
e. The functionality to create a personal health plan and discussion lists to use with healthcare providers.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

CMHC

Description

Referral to community and social support services, if relevant

Definition:
Referral to community and social support services, including long term services and supports, involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples. For individuals with DD, the health home will refer to and coordinate with the approved DD case management entity for this service.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
Health home providers will monitor continuing Medicaid eligibility using the DFS eligibility website and data base. MO HealthNet and the Department of Mental Health will also develop a process to notify health home providers of impending eligibility lapses (e.g., 60 days in advance).

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

CMHC

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
The CMHC outreach worker or a consumer's case manager (CsMgr) offers the opportunity to enroll in the health home, and explains that they will be assigned a Nurse Care Manager (NCM) to assist them in improving their health and wellness goals, these services are free, participation is optional, and choosing not to enroll will have NO impact on their currents services.

Once an individual enrolls, the CMHC completes a comprehensive health screen. The NCM meets with them to review the results of the screen and their treatment history, and to discuss their wellness, health, and healthcare goals.

A multi-disciplinary team collaborates with them to develop a treatment plan, updates at least quarterly, that includes wellness, health, healthcare, and self-management goals.

The consumer's Primary Care Physician (PCP) is notified of enrollment in the health home. If they don't have a PCP, the CMHC works to connect them with one.

The team members carry out their assigned plan responsibilities related to wellness, health status, chronic disease management, housing, employment, and care coordination.

NCMs update care management registries for each individual on their caseload monthly. The registries enable NCMs to identify if consumers receive psychotropic medications outside of best practice guidelines; if they fail to fill prescribed medications for chronic health conditions or psychotropic medications; if consumers with hypertension, diabetes, and cardiovascular disease have lab values that exceed desired levels; and to track progress in controlling BMI levels, tobacco use, and metabolic screening values.

CsMgrs accompany consumers to visits with their PCPs and assist them to improve their health status and manage chronic health conditions.

If they achieve their goals, they may be discharged, or transferred to a Primary Care Health Home for continued care management with the option of returning to the CMHC if needed.

☐ **Medically Needy eligibility groups**

○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

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Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Using claims data, the state will track avoidable hospital readmissions by calculating ACSC readmissions/1000: (# of readmissions with a primary diagnosis consisting of an AHRQ ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.

(continued from Estimates of Cost Savings below)

2. Analysis #2 – Cost Savings of persons already receiving CMHC services and then had a health home model implemented that is similar to the proposed §2703 Health Home model. In this project, Missouri Medicaid contracted with APS to implement a health home model (Chronic Care Improvement Program "CCIP") for more than 86,000 patients statewide in both primary care and CMHC-based health homes, including dual eligibles. There were 6,500 clients in CMHCs that were eligible for APS CCIP. Due to funding limitations, less than 20% of CMHC patients at the time were actually enrolled in the APS program. CMHCs provided approximately 8% of the overall health homes in this project. The cost of the CMHC services was included in the pre/post period costs. The CMHC cohort sub-analysis presented below uses the same methodology applied by Mercer in its independent evaluation of the overall APS CCIP program.

INTERVENTION SAVINGS OFF TREND

CCIP Clients in CMHC Health Homes
Base Period PMPM (CY2006)
$1,556
Expected Trend
16.67%
Expected Trend PMPM with No Intervention
$1,815.81
Actual Trend PMPM in Performance Period (FY2007)
$1,504.34
Gross PMPM Cost Savings
$311.47
Lives
6,757
Gross Program Savings
$25,254,928
Vendor Fees
$1,301, 563
Net Program Savings
$23,953,365
NET PMPM Program Savings
$295.41
Net Program Savings/(Cost) as percentage of Expected PMPM
16.3%

The State will annually perform an assessment of cost savings using a pre/post-period comparison with a control group of Medicaid primary care practices serving clinically similar populations but not participating as Health Homes. Control group practices will be similar to participating practices to the extent that it is feasible to do so. They will be identified by practice type (e.g., FQHC), geographic region, and number of Medicaid beneficiaries with serious mental illness or 2 or more chronic conditions. Savings calculations will be risk-adjusted, truncated claims of high-cost outliers annually exceeding 3 standard deviations of the mean, and will net out the value of supplemental payments made to the participating sites during the 8-quarter period.

It is important to note that the cohorts used in both the preceding analyses included dual eligibles in the intervention groups, however the analyses did not include the Medicare costs. If the analyses had included Medicare costs, it is believed that there would have been additional proportional savings in these costs as well. Missouri did not explicitly flag which patients were dual eligibles or attempt to model how their inclusion impacted the overall savings. However, approximately 50% of the clients and service will be dual eligible at any given time in Missouri's CMHC programs. Taken together for our proposed § 2703 CMHC Health Home, the State conservatively estimates including the cost of the Health Home intervention:

• Year 1 will yield 5% Savings over year 0 total costs trended forward
• Year 2 will yield 10% Savings over year 0 total costs trended forward
• Year 3 will yield 15% Savings over year 0 total costs trended forward

SFY2010 Total Medicaid Healthcare Costs for CMHC SMI Patients are:
Adults: $1,616 PMPM
Children: $1,070 PMPM
Age Weighted Average: $1,471 PMPM

Estimated savings off-trend including the cost of the Health Home intervention:

• Year 1: $ 74 PMPM
• Year 2: $147 PMPM
• Year 3: $221 PMPM

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
The State will annually perform an assessment of cost savings using a pre/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. It will also be broken out for each CMHC Health Home. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditure. Savings calculations will be trended for inflation and will truncate the claims of high-cost outliers annually exceeding three standard deviations of the mean. Savings calculations will include the cost of PMPM payments received by Health Home Providers. The assessment will also include the performance measures enumerated in the Quality Measures section.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
To facilitate the exchange of health information in support of care for patients receiving or in need of health home services, the state will utilize several methods of health information technology (HIT).

The following is a summary of HIT currently available for Health Home providers to conduct comprehensive care management, care coordination, health promotion, individual and family support and referral to community and social support services. Also included is a description of the state's process to improve health information exchange (HIE) for comprehensive transitional care services.

As Missouri implements its Health Home models, the State will also be working toward the development of a single data portal to facilitate information exchange, measures documentation and calculation and state reporting to CMS. The state will also continue to refine a process for HIE between CMHCs and primary care practices and has contacted SAMSHA to learn more about opportunities available under the national technical assistance center on integrated care.

1. HIT for Comprehensive Care Management and Care Coordination – MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-compliant portal that enables providers to:

(a) Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);;
(b) View dates and providers of hospital emergency department services;
(c) Identify clinical issues that affect an enrollee's care and receive best practice information;
d) Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
e) Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
(f) Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice; and

(g) Review laboratory data and clinical trait data;
(h) Determine medication adherence information and calculate medication possession ratios (MPR); and
(i)Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

2. HIT for Health Promotion and Individual and Family Support Services – A module of the MO HealthNet comprehensive, web based EHR allows enrollees to access their own healthcare utilization information and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Health Home providers will provide instruction to individuals on the use of the module. Utilization data available through the module includes:
(a) Administrative claims data for the past 3 years;
(b) Cardiac and diabetic risk calculators;
(c) Chronic health condition information awareness
(d) A drug information library; and
(e) The functionality to create a personal health plan and discussion lists to use with healthcare providers.

3. HIT for Comprehensive Transitional Care – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the states data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a Health Home. The contractor would then immediately notify the Health Home provider of the admission, which would enable the Health Home provider to:
(a) Use the hospitalization episode to locate and engage persons need of health home services;
(b) Perform the required continuity of care coordination between inpatient and outpatient; and
(c) Coordinate with the hospital to discharge an avoidable admission as soon as possible. The daily data transfer will be in place within six months of implementation of the SPA. In the interim, Health Homes will continue to implement or develop memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.

4. Referral to Community and Social Support Services – Health Home providers will be encouraged to monitor continuing Medicaid eligibility using the FSD eligibility website and data base. MO HealthNet and the Department of Mental Health will also refine process to notify Health Home providers of impending eligibility lapses (e.g., 60 days in advance).

5. Specific HIT Strategies for CMHCs Customer Information Management, Outcomes and Reporting (CIMOR) - CMHCs will continue to utilize CIMOR for routine functions (e.g., contract management, billing, benefit eligibility, etc.); however CIMOR's capacity will continue to be expanded in support of CMHC comprehensive care management and care coordination functions. CIMOR will enable assignment of enrollees to a CMHC Health Home based on enrollee choice and admission for services. CMHC Health Home providers utilize CIMOR to report Department of Mental Health required outcome measures. In addition, the CMHC Health Home enrollment data in CIMOR will be cross referenced with MO Health Net inpatient pre-authorization data to enable the automated real-time reporting of inpatient authorizations to the appropriate CMHC.

6. Behavioral Pharmacy Management System (BPMS) – CMHCs utilize BPMS to receive aggregate and individual identification and reporting of potentially problematic prescribing patterns.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Hospital Admissions

Measure Specification, including a description of the numerator and denominator.
Measure: The rate of acute inpatient care and services (total, maternity, mental health, surgery, and medicine) per 1,000 enrollee months among Health Home enrollees. This measure applies to Health Home enrollees of all ages. This measure includes discharges and days for total inpatient use and by type of use (medical/surgical, maternity, mental health).

Measure Specifications, including a description of the numerator and denominator.
Numerator: total number of inpatient discharges. Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year. Refer to the codes in Table IU.A to identify total inpatient discharges. Use the guidelines and formulas outlined in the technical speciation published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014) to report inpatient discharges.
Denominator: Health Home enrollee months
Data Sources:
MMIS claims and encounter data; Health Home enrollment data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

Emergency Room Visits

Measure Specification, including a description of the numerator and denominator.
Measure: The rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.
Measure Specifications, including a description of the numerator and denominator.
Numerator: Count the total number of ED visits for Health Home enrollees that Medicaid paid for during the measurement year, following the technical specifications published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014).
Denominator: Health Home enrollee months

Data Sources:
MMIS claims and encounter data; Health Home enrollment data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:
Nursing Facility Utilization
Measure Specification, including a description of the numerator and denominator.
Measure: The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months. This measure applies to Health Home enrollees age 18 and older.
Measure Specifications, including a description of the numerator and denominator.
Numerator: Identify all admissions to nursing facilities following the technical specifications published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014). An enrollee may be counted more than once in the numerator if the individual had more than one admission to a nursing facility followed by a discharge to the community during the measurement year.
Denominator: Number of Health Home enrollee months.
Data Sources:
MMIS claims and encounter data; Health Home enrollment data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
The State will consolidate data from its fee-for-service MMIS-based claims system and from MCO-generated encounter data for the participating health homes sites to assess hospital admission rates by services (medical, surgical, Maternity, mental health, and chemical dependence), for the participating health home sites. The analysis will compare admission rates by service for the year prior to admission to a health home with admission rates by services for the year following admission to a health home for all individuals enrolled in a health home for at least one year.

Chronic Disease Management
The State will audit each practice's implementation of chronic disease management, with a special focus on comprehensive care management. Audits will assess: (a) documented self-management support goal setting, (b) multi-disciplinary team telephonic or face-to-face beneficiary follow-up within 72 hours after hospitalization, (c) documentation that there is a care manager in place, and (d) that the care manager is operating consistently with the requirements set forth for practices by the State.

Coordination of Care for Individuals with Chronic Conditions

The State will assess provision of care coordination services for individuals with the chronic conditions specified in this State Plan Amendment in the following fashion. The State will measure: (a) multi-disciplinary team telephonic or face-to-face beneficiary follow-up within 72 hours after hospitalization; (b) active care management; (c) behavioral activation; and (d) connection with a Primary Care Physician.

Assessment of Program Implementation
The State will monitor implementation in two ways. First, a Health Homes Work Group comprised of Department of Social Services and Department of Mental Health personnel and provider representatives will meet regularly to track implementation against a) a work plan, and b) against performance indicators to assess implementation status. The meetings will initially occur on a biweekly basis, and then will transition to monthly meetings six months into implementation. Second, the two Departments will join private payers and provider representatives on the Steering Committee of the Missouri Medical Home Collaborative to review monthly practice data submissions and analysis by the Missouri Foundation for Health, as well as the status of practice transformation activities in conjunction with a Missouri Foundation for Health-funded learning collaborative and possible practice coaching to be provided to at least some of the participating practices.

Processes and Lessons Learned
The aforementioned work group, as well as the Steering Committee of the Missouri Medical Home Collaborative will approach the health home transformation process for the participating practices as an ongoing quality improvement exercise. Using a combination of evaluation data, information from the learning collaborative Quality Improvement Advisor who will be reviewing regularly submitted practice narrative and data reports, feedback from any practice coaches, and feedback provided to the Health Homes Work Group and the Collaborative Steering Committee by practice representatives, the State will assess what elements of its practice transformation strategy are working – and which are not. Critical attention will be paid to a) critical success factors, some of which have already been identified in the literature, and b) barriers to practice transformation.

Assessment of Quality Improvements and Clinical Outcomes
The State will utilize the quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, and at the aggregate level for all participating health homes. For registry and claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. For registry-based measures for which national Medicaid benchmark data is available for Medicaid managed care plans, comparisons will be made to regional and national benchmarks, even though such benchmarks are not specific to persons with chronic conditions.

Estimates of Cost Savings

☐ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

Transmittal Number: MO-16-07 Supersedes Transmittal Number: MO-11-0011 Proposed Effective Date: Jun 1, 2016 Approval Date:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.