

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850



State Demonstrations Group

April 03, 2024

Todd Richardson
Director
P.O. Box 6500
Jefferson City, MO 65102-6500

Dear Mr. Richardson:

Thank you to you and your staff for your work on the implementation plans for the Missouri Substance Use Disorder & Serious Mental Illness (Project Number: 11-W-00411/7). We are writing to approve both the serious mental illness (SMI) & serious emotional disturbance (SED) and substance use disorder (SUD) implementation plans. A copy of the approved SMI & SED and SUD implementation plans are enclosed with this letter.

If you have any questions or concerns, please contact your assigned project officer, Mr. Felix Milburn. His contact information:

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We look forward to continuing to partner with you and your staff.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure:

cc: Mandy Strom, State Monitoring Lead, Medicaid and CHIP Operations

Attachment C: Missouri Substance Use Disorder & Serious Mental Illness Implementation Plans

CMS' New Opioid and Other SUDs 1115 Demonstration Initiative:

Goals and Milestones to be Addressed in State Implementation Plan Protocols

CMS is committed to working with states to provide a full continuum of care for people with opioid use disorder (OUD) and other SUDs and in supporting state-proposed solutions for expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Milestones

1. Access to Critical Levels of Care for OUD and Other SUDs

To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (MAT) (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management.

Current State

The Division of Behavioral Health (DBH), formerly the Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services, is responsible for assuring the availability of substance use prevention, treatment, and recovery support services for the State of Missouri (State). The director of the DBH is responsible for leading and managing the Division; directing policy and strategic plans for the DBH; coordinating with other state officials; and representing the DBH in discussions, negotiations and partnerships with other state and federal organizations. The DBH is organized into the following functional units:

- Community Programs;
- Psychiatric Facility Operations;
- Children's Services;
- Recovery Services;
- Prevention and Mental Health Promotion;
- Administration; and
- Regional Operations.

Included under Community Programs are all mental health and substance use community-based treatment programs, the Substance Awareness Traffic Offender Program (SATOP), Healthcare Homes, certification, billing and service review and fidelity review. In addition to leading and managing these programs, the Deputy Director for Community Treatment is also responsible for working with key stakeholders, to include other state agencies, to improve community-based services.

DBH contracts with 66 community-based agencies for the provision of substance use treatment and/or psychiatric rehabilitation services: 38 for substance use treatment only, 14 for psychiatric rehabilitation services only, and 14 for both. The certification standards of care contain core rules, adopted in 2001 and most recently updated in 2019, which apply to both mental health and substance use programs. DBH staff conduct annual reviews of contracted community organizations. DBH certifies 125 organizations for substance use treatment, 15 organizations for substance use prevention, and 73 organizations for mental health treatment. Additionally, 19 of 43 primary care health home organizations provide MAT as of January 2023.

DBH substance use treatment programs include:

- Comprehensive Substance Treatment and Rehabilitation (CSTAR) program;
 - Women & Children
 - General Population
 - Opioid Program
 - Adolescents
- SATOP;
- Department of Corrections (DOC) programs;
- State Targeted Response to the Opioid Crisis (STR); and
- State Opioid Response (SOR) programs.

The CSTAR programs are designed to provide an array of comprehensive, but individualized, treatment services with the aim of reducing the negative impacts of SUDs to individuals, family members and society. All but the Opioid programs offer a residential component for individuals who need that type of structure and support. Available services include assessment; individual and group counseling; group rehabilitation support; community support; residential or housing support, as appropriate; trauma-specific individual counseling and group rehabilitation support; individual co-occurring disorders counseling; family therapy; and medications, physician, and nursing services to support medication therapy. CSTAR features three levels of outpatient care that vary in duration and intensity, with specific services received based on individuals' needs. Persons may enter treatment at any level in accordance with eligibility criteria. A designated Program Specialist, acting as the State Opioid Treatment Authority (SOTA), provides oversight and clinical assistance to the Opioid programs to ensure that treatment is consistent with best practices and federal requirements. The CSTAR programs are targeted for specialized populations including Women and Children, the General Population, the Opioid Program, and Adolescents. DBH's CSTAR programs are the only substance use treatment programs reimbursable by Medicaid in the State. In 2011, DBH was successful in amending the Medicaid State Plan to include a CSTAR Modified Medical Detoxification Program.

The DBH also maintains the Primary Recovery Plus (PR+) program. Similar to the CSTAR General Population Program, PR+ offers a full continuum of services within multiple levels of care to assist those individuals without Medicaid coverage. DBH oversees several programs designed specifically for DOC's offenders under community supervision who need substance use

treatment. These include CSTAR Women and Children Alternative Care, Improving Community Treatment Success (ICTS) and the Vivitrol Pre-Release Project. As established in all DBH SUD contracts, priority populations for substance use treatment include:

- Women who are pregnant and inject drugs;
- Women who are pregnant;
- Persons who have injected drugs in the prior 30 days;
- Civil involuntary commitments;
- High risk offenders referred by the DOC's institutions and Division of Probation and Parole via referral form and protocol;
- Applicants and recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services (DSS), Family Support Division, via referral form and protocol; and
- Adolescents and families served through the Children's System of Care.

Substance use treatment for adolescents is provided in the CSTAR Adolescent program. Designed for youth age 12 to 17, the CSTAR Adolescent program offers a full spectrum of treatment services. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Youth in residential settings are offered academic support services to minimize disruptions in their education. For youth with co-occurring mental health and SUDs, treatment services are provided through coordination of care between youth Community Psychiatric Rehabilitation (CPR) and CSTAR adolescent programs. Multiple domains of the youth's life are addressed including family, school, employment, and social support. The Assertive Community Treatment for Transitional Age Youth (ACT-TAY) model for ages 16-25, utilizes a transdisciplinary approach to provide a comprehensive array of services to address both mental health and substance use.

All contracted agencies providing substance use treatment are required to screen individuals requesting services to determine potential eligibility as a priority population and/or a crisis situation. Individuals identified as a priority population who request or are referred to treatment must be assessed and admitted to an appropriate level of care within 72 hours of initial contact or scheduled release date, whichever is the later. Otherwise, the provider must initiate interim services. Pregnant women and civil involuntary commitments, however, require immediate admission. Pregnant women are to be referred to a CSTAR Women and Children Program unless there is clinical justification to admit her to a general treatment program.

Future State

The MO HealthNet Division (MHD), in partnership with the DBH will make changes to the CSTAR program under this 1115 waiver demonstration. As part of this demonstration, Missouri will add reimbursement for beneficiaries receiving services in a residential facility that is an

IMD. This will include reimbursement for American Society of Addiction Medicine (ASAM) levels 3.3, 3.5, and 3.7 residential services provided within facilities that meet criteria as an IMD. With the addition of residential services, MHD will expand access to a full continuum of services across ASAM levels of care statewide, including those newly eligible for Medicaid under the State’s Medicaid expansion implemented in 2021.

Milestone 1. Access to Critical Levels of Care for OUD and Other SUDs

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current SUD treatment services covered by the state in each level of care. For services currently covered in the state plan, list the benefit category and page location; for services currently covered in a demonstration, include the program name and Special Term and Condition number.	Provide an overview of planned SUD treatment services to be covered by the state in each level of care: indicate whether planned services will be added to the state plan or authorized through the 1115.	Provide a list of action items needed to be completed to meet milestone requirements, if any. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.

<p>Coverage of outpatient services and ASAM LOC</p>	<p>The below services are covered under the Rehabilitation Option of the CSTAR State Plan. DMH is still operating under CSTAR as well as ASAM. Providers have a transition period to come into compliance with ASAM. As of now, providers are operating under both CSTAR and ASAM.</p> <p>The following levels of care are covered in the state plan:</p> <ul style="list-style-type: none"> • Assessment–page 17aaaa • Community Support-page 17aaaa, 17aaaa-2, and 17 aaaa-3 • Medication Services-page 17aaaa-9 • Medication Services Support-page 17aaaa-9 • Adolescent Treatment Support page 17aaaa-9 • Individual Counseling-page 17aaaa-3 • Trauma Individual Counseling-page 17aaaa-3 • Co-occurring Disorder Individual Counseling-page 17aaaa-3 • Communicable Disease Counseling-page 17aaaa-4 • Crisis Intervention-page 17aaaa-4 	<p>Currently covered under State Plan. Services delivered in facilities that qualify as an IMD will be authorized under the demonstration.</p> <p>DMH is still operating under CSTAR as well as ASAM. Providers have a transition period to come into compliance with ASAM. As of now, providers are operating under both CSTAR and ASAM. Providers should be fully transitioned by the end of calendar year 2024.</p>	<p>N/A</p>
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	<ul style="list-style-type: none"> • Collateral Dependent Counseling-page 17aaaa-5 • Group Rehabilitative Support-page 17aaaa-6 • Day Treatment-page 17aaaa-6 • Family Therapy-page 17aaaa-7 • Family Conference-page 17aaaa-8 • Medically Monitored Withdrawal Management-page 17aaaa-8 • Treatment Plan – component of assessment page 17aaaa • Co-Dependent Individual Counseling • Peer and Family Support-page 17aaaa-10 & 17aaaa-11 • Group Counseling-page 17aaaa-5ASAM Level .5-Early Intervention-page 17aaaa-12 • ASAM Level 1- Outpatient Services-page 17aaaa-12 • ASAM Level 1 – Opioid Treatment Services-page 17aaaa-12 • ASAM Level 2.1- Intensive Outpatient Services-page 17aaaa-12 • ASAM Level 2.5- Partial Hospitalization-page 17aaaa-13 		
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	<ul style="list-style-type: none"> • ASAM Level 1-WM-Ambulatory Withdrawal Management without Extended On-site Monitoring-page 17aaaa-13 • ASAM Level 2-WM-Ambulatory Withdrawal Management without Extended On-site Monitoring-page 17aaaa-13 • ASAM Level 2-WM-EM-Ambulatory Withdrawal Management with Extended On-site Monitoring-page 17aaaa-14 <p>Additional ASAM services approved in the CSTAR SPA (Note: residential excludes room and board)</p> <ul style="list-style-type: none"> • ASAM Level 3.1-Clinically Managed Low Intensity Residential Services-page 17aaaa-14 • ASAM Level 3.2-WM—Clinically Managed Residential Withdrawal Management-page 17aaaa-15 • ASAM Level 3.3-Clinically Managed Population-Specific High Intensity Residential Services-page 17aaaa-15 • ASAM Level 3.5-Clinically Managed 		
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	<p>High Intensity Residential Services- page 17aaaa-16</p> <ul style="list-style-type: none">• ASAM 3.7- Medically Monitored Intensive Inpatient Services- page 17aaaa-16• ASAM 3.7-WM- Medically Monitored Intensive Inpatient Services- page 17aaaa-16		
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Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of intensive outpatient services	Day Treatment	Currently covered under State Plan.	
Coverage of MAT (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the State)	Current coverage of Buprenorphine, Naloxone, and Vivitrol Coverage for Methadone provided by OTPs	MAT became a mandatory benefit effective 10/1/2020 as a result of the SUPPORT Act. A SPA was submitted to CMS to be compliant with this change. This SPA was approved by CMS with an effective date of 10/1/2020.	N/A
Coverage of intensive levels of care in residential and inpatient settings	Adolescent Treatment Support	Adult Residential Treatment to be added through 1115 waiver, including waiver of IMD exclusion to allow reimbursement to IMDs (3.3, 3.5, & 3.7).	Approval of 1115 Waiver application

2. Use of Evidence-based, SUD-Specific Patient Placement Criteria

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries

have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Current State

All individuals, including those who are Medicaid enrolled, in need of behavioral health services from facilities operated by the DBH or contracted service providers receive an initial assessment. For individuals needing substance use treatment, an individual receives a structured interview completed by a Certified Alcohol & Drug Counselor (CADC). For individuals seeking services from the SATOP, the self-administered Driver Risk Inventory II (DRI-II), in conjunction with an individualized interview with a SATOP Qualified Professional (SQP), determines the level of program placement.

Missouri 9 CSR 10-7.010, Core Rules for Psychiatric and Substance Use Disorder Treatment Programs, Essential Principles and Outcomes, requires service providers to incorporate a number of evidence- and research-based practices and other nationally recognized practices into their service array. The Core Principle Least Restrictive Environment requires that individuals be served in the most appropriate setting available based on their personal goals for recovery/resiliency and readiness to change, while assuring emotional and physical safety and protection from harm. Performance indicators may include, but are not limited to:

- Utilization rate of inpatient hospitalization, residential support, and out-of-home placement;
- Length of stay for inpatient hospitalization, residential support, and out-of-home services;
- Consistent use of admission eligibility criteria;
- Distribution of individuals served among settings;
- Ongoing assessment of individuals to ensure the appropriate and least restrictive environment; and
- Satisfaction with services as conveyed by individuals served and their family members or other natural supports.

Also included in the Core Rules' essential principles are the CMS recommendations for a qualified and competent workforce, *Final Competency Set*, December 2014. Providers are required to maintain a core workforce that is appropriately qualified and competent to address the behavioral health needs of individuals served. This includes using person-centered practices, helping individuals achieve and maintain good physical and emotional health, and respecting cultural differences. Care planning and coordination, person- and family-centered care, utilization of peer supports and social networks, employment, co-occurring disorder services, trauma-informed care, and easy and timely access to services, based upon nationally recognized practices, are also part of each provider's service array. Each individual assists in developing his/her treatment plan, with input from family members/natural supports, as appropriate. Each individual's participation in and response to treatment is monitored on a regular basis in order to match and adjust the type and intensity of services to the individual's needs and ensure timely and unduplicated provision of care. The treatment plan is also utilized to link the individual to multiple services, healthcare providers, and community resources to meet

their needs, including transportation, housing, and social supports.

The Department of Mental Health (DMH) does not prescribe an assessment tool to be utilized by providers in the assessment process; however, tools must be reviewed and approved by DMH and must demonstrate that the assessment is compliant with components and standards set forth by DMH in order for a provider to become certified. DMH deems those providers who are fully accredited with CARF International, the Council on Accreditation (COA), or the Joint Commission, but does review the respective assessment. DMH conducts a full review of the assessment tool for agencies not CARF, COA, or Joint Commission accredited. Outpatient services are organized and certified according to levels of care which vary in the intensity and duration of services offered. A participant may initiate service in any level of care as determined by need and treatment history.

Level I: The Community-based Primary Treatment level of care is the most structured, intensive, and short-term service delivery option with services offered on a frequent, almost daily basis. Unless contraindicated by the individual's medical, emotional, legal and/or family circumstances and unless residential support is provided and/or if otherwise authorized by DMH, structured services shall be offered at least five days per week with the opportunity to participate in at least 25 hours of structured service per week. At least one hour of service per week must be individual counseling. Additional individual counseling is provided in accordance with the individual's needs.

Level II: The Intensive Outpatient Rehabilitation level of care provides intermediate structure, intensity and duration of treatment and rehabilitation, with services offered on multiple occasions per week. Unless otherwise authorized by the DMH, this level of care provides a minimum of 10 hours of structured services per week of which at least one hour must be individual counseling, unless contraindicated by the individual's medical, emotional, legal and/or family circumstances.

Level III: Supported recovery level of care provides treatment and rehabilitation on a regularly scheduled basis, with services offered on approximately a weekly basis as clinically indicated. Unless otherwise authorized by DMH, this level of care provides a minimum of three hours of structured service per week. Each person is expected to participate in a combination of services deemed clinically necessary.

The levels of care are used in a manner that provides individualized treatment options and offers service intensity in accordance with the needs, progress, and outcomes of each person served. A person can move from one level of care to another over time in accordance with symptoms, progress, outcomes, and other clinical factors. The duration of each level of care shall be individualized based on the participant's needs. A person may be transferred to a more intensive level of care if there is a continuing inability to make progress toward treatment and rehabilitation goals.

DBH Billing and Service Reviews (BSR)

Through Billing and Service Reviews (BSR), Safety and Basic Assurance Reviews (SBARS), and Certification surveys, the DBH assesses compliance with program requirements and standards. Through these surveys, agencies receive feedback regarding deficiencies and/or recommendations. DBH has implemented a Monitoring Database and other processes to track the monitoring process including scheduling of site/virtual visits, findings and deficiencies, action plan requirements, action plan approval, certification status, and related communications and reports. DBH uses the survey outcomes to target technical assistance.

Missouri Medicaid Audit & Compliance Unit (MMAC)

The Missouri Medicaid Audit & Compliance Unit (MMAC) is responsible for administering and managing Medicaid (Title XIX) audit and compliance initiatives and managing and administering provider enrollment contracts under the Medicaid program. MMAC is charged with detecting, investigating, and preventing fraud, waste and abuse of the Medicaid Title XIX, CHIP Title XXI, and waiver programs. The MMAC Provider Review Group is responsible for reviewing and monitoring statewide utilization and program compliance of Medicaid fee-for-service providers. The Group conducts post-payment reviews and researches complaints. Following a review, the Group may issue provider sanctions in accordance with applicable federal and state laws and regulations, including, but not limited to, educational letters, recovery of improperly paid funds, and request for a corrective action plan.

Future State

As part of the State's reform, the CSTAR program has been modified to align with ASAM levels of care. More specifically, when an individual seeks care, they will be assessed and referred to levels of care and subsequent services that align with ASAM definitions, as opposed to the existing CSTAR levels. The state has a SPA in place to align existing and the newly added residential services with ASAM criteria. This will require updates to existing provider existing certification regulations as well as new regulations to ensure programs align with ASAM criteria. Providers with CARF certification for ASAM levels of care will have deemed status for these requirements.

The State will continue providing routine annual BSR and providers will continue to be subject to MMAC processes. BSR responsibilities include all programs for adult and youth populations served through the CSTAR program. Individual chart reviews are conducted to determine provider compliance with established policies and requirements. All services billed, regardless of payment status, to the Department must meet service definitions of the service provided by the funding source and are subject to review. All annual reviews have the potential of financial recoupments associated with them.

In addition to annual reviews, a provider may be subject to expanded or focused reviews. These reviews are typically conducted as virtual reviews; however, based on the size and scope of the review, may be conducted on site. Expanded or focused reviews are requested by DBH staff when a complaint suggests the need for a broader review or to address a specific concern such as, but not limited to: outliers as identified through unusual patterns of service or utilization, total service costs, and questions regarding compliance with certification standards or contract requirements. Focused reviews may also be conducted after implementation of a new service/program, as informed by MMAC or for oversight of services and programs, including adoption of ASAM criteria for level of care decision making. Focused reviews may involve participation from content experts from DMH, DBH monitoring staff, or when indicated, the involvement of DMH Audit Services may be requested.

Milestone 2. Use of Evidence-based, SUD-Specific Patient Placement Criteria

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	Individuals are provided a comprehensive assessment, with service authorization and referral aligned with the CSTAR Level of Care (LOC) Criteria.	Individuals will be assessed applying ASAM criteria and service authorization and referral will align with these criteria. Current assessment requirements align with dimensions needed to establish ASAM LOC. Providers will have until September 30, 2024 to come into compliance with utilizing ASAM LOC criteria.	Review and update certification rules to ensure alignment of assessment and service criteria with ASAM criteria for each level of care. State will initiate this process upon CMS approval of the SPA which aligns with ASAM levels of care and associated enhanced reimbursement rates.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care</p>	<p>Individuals are currently assigned to an outpatient CSTAR level of care (1, 2 or 3) based on an eligibility screening and comprehensive assessment. Each level of care has limits for CSTAR services based on LOC. ASAM criteria is utilized to determine need for inpatient medically monitored detox. Clinical utilization review through the BSR ensures the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.</p>	<p>Individuals will be assessed applying ASAM Criteria and service authorization and referral will align with these criteria. Current assessment requirements align with dimensions needed to establish ASAM LOC.</p>	<p>Review and update certification rules to ensure alignment of assessment and service criteria with ASAM criteria for each level of care. The State has started the process for updating existing CSTAR regulations and promulgation of one new regulation to incorporate the ASAM criteria. In addition to the DBH internal review process, the state’s rulemaking regulation requires a 30-day public comment period, as well as a 30-day period for review by the Joint Committee on Administrative Rules. In total it takes approximately five to six months for final publication of the rule in the <i>Code of State Regulations</i>. The anticipated completion date is May 2023.</p>

<p>Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care</p>	<p>Services currently funded by MO HealthNet and the DMH are subject to clinical review by department staff to ensure they are necessary, appropriate, likely to benefit the individual, and provided in accordance with admission criteria and service definitions. DMH has authority in all matters subject to clinical review including eligibility,</p>	<p>Milestone met</p>	<p>N/A</p>
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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>service definition, authorization, and limitations.</p> <p>Following approval of the SPA, the state updated its certification rules to align with ASAM criteria for each level of care. 9 CSR 30-3.150</p> <p>CSTAR amendment effective 9/30/21, includes:</p> <ol style="list-style-type: none"> 1. Quality of care including licensed prescribers to provide approved medications which can be provided in an outpatient setting for the treatment of opioid use and other SUDs; 2. National accreditation; and 3. Use of evidence-based practices, including the ASAM criteria. 		

<p>Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings</p>	<p>The state utilizes a retrospective review process through its annual BSRs. In addition to annual reviews, a provider may be subject to expanded or focused reviews.</p> <p>In addition, the MMAC Provider Review Group is responsible for reviewing and monitoring statewide utilization and program compliance of Medicaid fee-for-service providers. The Group conducts post-payment reviews and research of complaints. Following a review, the Group may issue provider sanctions in accordance with applicable federal and state laws and regulations, including, but not limited to, educational letters, recovery of improperly paid funds, and request for a corrective action plan.</p>	<p>The BSR and MMAC processes will include residential SUD services.</p>	<p>Addition of new residential services to BSR process- including updates to BSR Manual. DMH anticipates a completion date of July 1, 2023.</p>
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DMH is working in conjunction with MMAC on an ASAM monitoring tool that will be used by BSR and MMAC.

1. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Current State

The DMH is mandated to develop certification standards and to certify an organization's level of service, treatment, or rehabilitation as necessary for the organization to operate, receive funds from the Department, or participate in a service network authorized by the Department and be eligible for reimbursement for the Medicaid CSTAR services.

The primary function of the certification process is to assess an organization's compliance with standards of care. The review process ensures that providers maintain compliance with applicable state standards and provide quality services that remain consistent with the Department's Mission, Vision, and Values. Surveyors are charged with the task of reviewing multiple sources of information to arrive at a global view of the agency, while making recommendations for change as agencies strive for quality services. A key goal of certification is to enhance the quality of care and services with a focus on the needs and outcomes of persons served. The DMH currently ensures through administrative rule that certified providers, including residential providers, have service delivery practices that incorporate the following essential principles:

- Is adapted to the needs of different populations served;
- Is understood and practiced by staff providing services and supports;
- Is consistent with clinical studies and guidelines for achieving positive outcomes;
- Supports individuals in improving their capacities in all areas of functioning; and
- Assists individuals in achieving their goals for recovery/resiliency and successfully managing their symptoms.

The DMH, DBH, grants deemed certification to organizations with full accreditation from CARF

international, The Joint Commission, National Alliance for Recovery Residences (NARR), or Council on Accreditation under standards for behavioral healthcare that are equivalent to the DBH program standards. Those organizations without accreditation must submit additional application materials to demonstrate compliance with certification requirements.

The Missouri DMH administrative rule describes the essential principles and outcomes applicable to Opioid Treatment Programs (OTPs), CSTAR, Gambling Disorder Treatment Programs, Institutional Treatment Centers, Recovery Support Programs, SATOP, SUD Treatment Programs, Required Education Assessment and Community Treatment Programs (REACT), CPR Programs, and Outpatient Mental Health Treatment Programs. Performance indicators listed in this rule are examples of how an essential principle can be measured. The performance indicators include data that may be compiled by a program as well as areas a state surveyor may observe or monitor, including satisfaction and feedback from individuals served, and other data the Department may compile and distribute. A program may also use additional or other means to demonstrate achievement of these principles and outcomes. Principles include:

- Maintaining a therapeutic alliance;
- Providing person- and family-centered care;
- Providing services in the least restrictive environment;
- Promoting recovery and resilience;
- Providing access to peer support and social networks;
- Ensuring access to medication services;
- Providing services for co-occurring disorders;
- Delivering trauma-informed care;
- Maintaining easy and timely access to services;
- Ensuring a qualified and competent workforce;
- Promoting and supporting employment of clients served; and
- Providing care planning and care coordination.

Future State

The Missouri DMH currently maintains certification requirements for residential providers. These providers will be required to enroll as Medicaid providers in order to receive Medicaid reimbursement for the new residential services available under the waiver. The DMH will review current provider certification rules to ensure program staffing and programming align with ASAM criteria for delivery of residential services. The State will continue a requirement for residential providers to ensure access to MAT while individuals are receiving residential services.

Milestone 3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider qualifications for residential treatment facilities and how these compare to nationally recognized SUD-specific program standards, e.g., the ASAM Criteria	Provide an overview of planned use of nationally recognized SUD-specific program standards in improving provider qualifications for residential treatment facilities.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Implementation of residential treatment provider qualifications in certification requirements, policy manuals, managed	Any organization contracting with the DBH and MO HealthNet is required to obtain and maintain certification by DMH.	The certification standards will be updated to align with ASAM criteria.	The State will create a new Medicaid CSTAR Manual for ASAM to include requirements for residential services will be completed by summer of 2023.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>care contracts, or other guidance. Qualifications should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings</p>	<p>Standards for Certification, including core rules for programming and operation and general department regulations are established in DMH Rule Division 10 chapters 5, and 7 and Division 30 chapter 3.</p> <p>The DMH, through an inter-agency agreement with the DSS, MMAC, reviews all requests for participation in the current CSTAR Program and provides validation of the applicant's certification status to MMAC. The MMAC Unit, based upon review of the application and certification by DMH, approves or denies the application request.</p>		<p>and associated administrative rule changes. The State will initiate this process upon CMS approval of the SPA which aligns with ASAM levels of care and associated enhanced reimbursement rates. The rulemaking process involves:</p> <ol style="list-style-type: none"> 1. Internal review and development of rule language (60 days minimum); 2. Provider review and DBH response to comments (60 days); 3. Rule posted for informal public comments on DBH website (15-30 days); 4. Review and approval from Governor's Office (15-30 days); 5. File with Secretary of State (SOS) for publication in the <i>Missouri Register</i> for a 30-day public comment period); 6. Submit final order of

	<p>The CSTAR Provider Manual outlines all requirements for the delivery of CSTAR services.</p>		<p>rulemaking to SOS which includes a review by the Joint Committee on Administrative Rules (60 days).</p> <p>Development of a new Medicaid CSTAR Manual requires lengthy internal review and discussion to ensure billing codes, billing requirements and limitations, staffing requirements, and service descriptions align with the approved SPA. Following internal development and review, the manual is reviewed by CSTAR service providers, and any questions or outstanding issues are addressed prior to submitting the manual to the MO HealthNet Division for publication on its website. Expected completion Summer, 2023.</p>
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<p>Implementation of a state process for reviewing residential treatment providers to ensure compliance</p>	<p>Providers certified and contracted by DMH are currently subject to onsite or virtual reviews conducted by DMH. Billing and Services reviews are conducted annually. Certification reviews are conducted initially and every three years.</p>	<p>Continue process for onsite or virtual reviews of certified providers. Milestone met.</p>	<p>N/A</p>
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Milestone Criteria	Current State	Future State	Summary of Actions Needed
with these standards			
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site	Providers certified and contracted by DMH must offer or arrange for MAT for clients served. In addition, an October 2016 DMH memo to all SUD providers clarified that MAT must be delivered in a way that is demonstrated by evidence, including the duration for receiving MAT services.	Continue current requirement. Milestone complete.	N/A

2. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Current State

In 2021 Missouri surveyed its SUD provider system that is certified and/or contracted with the DMH. Missouri has not yet implemented the ASAM Criteria, so agencies were asked to report Outpatient programs (Level 1), Intensive Outpatient/Partial Hospitalization (Level 2), OTPs, waived physicians, and we asked them to use their best judgement to apply the ASAM Criteria to their current residential programs to assign ASAM levels 3.1, 3.3, 3.5, and 3.7. Data was collected by county (114 counties, plus the city of St. Louis = 115 total) and is reported as the number of sites where that ASAM level is offered. Missouri has 171 Level 1 sites that accept Medicaid. 103/115 counties (90%) have Level 1 treatment sites. 103 sites that accept Medicaid provide Level 2 services in 63/115 counties (55%). There are 33 OTP sites accepting Medicaid in 32/115 counties (28%). For residential level that accept Medicaid, there are 26 Level 3.1 sites

in 16/115 counties (14%), 12 Level 3.3 sites in 10/115 counties (12%), 32 Level 3.5 sites in 22/115 counties (19%), and 18 Level 3.7 sites in 14/115 counties (12%). The surveyed DMH certified and/or contracted providers reported 160 waived physicians with access available in 101/115 counties (89%).

ASAM Level of Care	Number of Providers accepting Medicaid	Number of Counties	% of Sites in Counties with Provider
Outpatient programs	171	103/115	90%
OTP	33	32/115	28%
Intensive Outpatient/Partial Hospitalization	103	63/115	55%
3.1 Residential	26	16/115	14%
3.3 Residential	12	10/115	12%
3.5 Residential	32	22/115	19%
3.7 Residential	18	14/115	12%
Waivered MDs	160	101/115	89%

Only 20% of Missouri counties have residential treatment sites. With a maximum of 16 beds per site, those 88 residential sites amount to roughly 1,408 SUD treatment beds for Missouri’s 6.1 million residents. This does not include private, for-profit SUD agencies that do not bill Medicaid and therefore do not contract with DMH. It is expected that the number of Medicaid residential treatment beds will increase upon approval of the waiver.

Missouri fully supports the use of evidence-based practices in substance use treatment, which includes MAT. Missouri has 16 OTP sites that are certified to provide methadone maintenance treatment within the State. Two agencies are located in St. Louis, and two programs are provided by one agency in Kansas City. In addition, DMH has been introducing new medications into its non-OTPs since 2006 as part of a Robert Wood Johnson Advancing Recovery Grant. Medication services were added to treatment contracts in 2007. In 2010, Missouri began credentialing for a MAT specialty. DMH continues to work to integrate MAT into substance use treatment where clinically appropriate. Missouri’s efforts in expanding the use of evidence-based practices for the treatment of OUD, including the use of substance use treatment medications, was considerably enhanced with the federal opioid crisis grants. These grants have helped increase the pace and scale of EBP adoption and gave rise to Missouri’s “Medication First” approach to treating OUD. The National Quality Forum recommendations state that pharmacotherapy should be made available to all adults diagnosed with an alcohol or Opioid

dependence if no medical contradictions are applicable (National Quality Forum, 2007).

Emergency Room Enhancement (ERE) program

The State of Missouri, through the DMH DBH, was appropriated funds to improve the mental health system by making behavioral health care more accessible to individuals, families, and communities. Hospitals across the state were experiencing increases in emergency room visits by patients needing care for psychiatric conditions or SUDs; increases in boarding patients awaiting psychiatric care; lack of facilities accepting placement of patients after medical stabilization; increases in short-term detoxification services with little to no transition to outpatient SUD services; and lack of appropriate transportation services.

The ERE program is one component of the Strengthening Missouri's Mental Health System initiative approved by Governor Jay Nixon. It was implemented in seven sites across the state in September 2013. In accordance with Governor Nixon's recommendation that Missourians should be provided with "timely and effective treatment in their own communities," the DBH solicited proposals that promote this outcome. The DBH administers these programs through the funding of ERE programs in seven parts of the state to develop models of effective intervention for people in behavioral health crises, creating alternatives to unnecessary hospitalization or extended hospitalization.

Since 2013, ERE programs have been operating in multiple hospitals in and around Rolla, Kansas City, Springfield, St. Louis, Columbia, Poplar Bluff, and Hannibal. In 2017, ERE programs were initiated in more cities/areas of the state as part of the federal Certified Community Behavioral Health Organization (CCBHO) demonstration. In 2019, the Jefferson City region including four additional counties joined, and most recently in 2020 the newest region, West Central accounting for 10 additional counties were added. Currently ERE services are available in 92 of 114 Missouri counties, accounting for 76% of Missouri's population.

As Missouri's ERE program concludes its seventh year of funding, it is associated with significant improvements across all primary individual outcomes identified as key indicators of success. As of June 2020, when examining improvements in outcomes across the life of the project, the number of ER visits has been reduced on average by 2.48 visits per 90 days per individuals served. Extrapolating out, this is a potential reduction of over 20,128 visits to the emergency room just this year. Similarly, hospitalizations have been reduced, on average across project year and provider region, by 1.21 visits per 90 days – amounting to a potential 9,820 hospitalizations avoided during just FY20.

Changes observed in ERE Year 6 are consistent with these overall outcomes across the life of the program. In year 7, a total of 2,029 individuals were eligible and engaged in services. The overall number of ER visits was reduced by 65% after 3 months, and 74% at 6 months across all regions during Year 6. Similar reductions were observed in number of hospitalizations with a 66% reduction after 3 months, and 74% after 6 months. Strong gains were also observed for those

who identified as experiencing homelessness at baseline with a 62% reduction in those self-identifying as homeless after 3 months, and 77% reduction in reported homelessness after 6 months. Changes in unemployment status were also promising with the number of individuals who endorsed being unemployed reduced by 40% after 3 months, and 60% after 6 months. A 69% reduction in contact with law enforcement was also observed from intake to 6-month follow-up assessment.

Lastly, CCBHOs were required to expand access to MAT. As a result, according to data provided by CCBHOs, the number of individuals receiving MAT services at CCBHOs has increased 122% from FY 2017 to FY 2021.

Future State

It is expected the number of Medicaid residential treatment beds will increase upon waiver approval. The State will complete an annual availability assessment and create an action plan for any areas where there are provider shortages identified. Additionally, Missouri is addressing gaps by piloting integration initiatives with partnering Federally Qualified Health Centers (FQHCs) and CSTAR programs. In addition, thirteen new behavioral health crisis centers will open in 2022, providing urgent care and 23-hour withdrawal management.

In addition to implementing ASAM state-wide, additional evidence-based practices (EBP) will be required of DMH's contracted SUD providers. DMH already requires agencies to employ and use peer support specialists and employ or contract with prescribers for MAT. New EBP requirements include employment of a Tobacco Treatment Specialist, implementation of Zero-Suicide, and implementation of trauma-informed care (along with employing clinical staff who specialize in the treatment of trauma). In addition, all agencies will be required to have attained national accreditation from CARF, The Joint Commission, or the Council on Accreditation.

Milestone 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider capacities throughout the state to provide SUD treatment at each of the critical levels of care listed in Milestone 1.	Provide an overview of planned improvements to provider availability and capacity intended to improve Medicaid beneficiary access to treatment throughout the state at each of the critical levels of care listed in Milestone 1.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the State (or at least in participating regions of the State) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; MAT (medications as well as counseling and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	Please see attached SUD Provider Network Adequacy table.	Availability of adult residential treatment through 1115 waiver, including waiver of IMD exclusion to allow reimbursement to IMDs (3.3, 3.5, & 3.7).	Complete annual assessment and create action plan for any areas where there are provider shortages identified.

3. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

To meet this milestone, states must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Current State

The Missouri Opioid STR and Missouri SOR and SOR 2.0 projects have expanded access to integrated prevention, treatment, recovery support, and harm reduction services for individuals with OUD and, most recently, stimulant use disorder (StimUD) throughout the state. Although the STR grant ended in 2019, SOR and the current SOR 2.0 project have built upon the foundation laid with STR while also adding new, innovative programming. The DMH is leading the project, with administration, implementation, and evaluation activities provided by the University of Missouri, St. Louis - Missouri Institute of Mental Health (UMSL-MIMH) – as well as behavioral healthcare agencies, academic institutions, people with lived experience with addiction, and other content experts from around the state.

The Missouri STR and SOR projects have expanded access to integrated prevention, treatment, and recovery support services for individuals with OUD throughout the state. The primary goals of the Opioid STR/SOR projects include: 1) Increase provider and student focused opioid use and overdose prevention initiatives and programs; 2) Increase access to evidence-based medication for OUD (MOUD) for uninsured individuals with OUD through provider training, direct service delivery, healthcare integration, and improved transitions of care; 3) Increase the number of individuals with an OUD who receive recovery support services; and 4) Enhance sustainability through policy and practice changes as well as demonstrated clinical and cost effectiveness of grant-supported protocols.

Prevention activities have centered on increased awareness and decreased availability of prescription opioids, as well as comprehensive strengths-based programming for teens facing hardship and lacking environmental support. There has also been significant focus on harm reduction under the umbrella of prevention, particularly Overdose Education and Naloxone Distribution (OEND), as well as clinical mentorship and consultation services for primary care providers treating chronic pain. Within the treatment realm, the focus has largely been on increasing access to and engagement with MOUD through a Medication First treatment approach, designed to provide rapid and longer-term access to evidence-based medications like

buprenorphine and methadone. Regarding recovery supports, recent efforts have centered on the importance of training and employing Certified Peer Specialists across care settings, expanding medication-friendly recovery housing, and launching Recovery Community Centers (RCCs) in high-need areas of the state to promote prosocial activities, connections to resources, and community.

Medication First Approach

Missouri's STR/SOR team, in consultation with local, State, and national experts, developed and disseminated the Medication First treatment approach, which is based off the Housing First approach to chronic homelessness. Agencies that provide OUD treatment services through the grant are required to deliver treatment in accordance with the four core principles of Medication First:

1. People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
2. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
3. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy; and
4. Pharmacotherapy is discontinued only if it is worsening the person's condition.

This approach has been adopted by health care providers throughout the state and has gained national attention for succinct framing of evidence-based OUD treatment practices.

Special Populations

The Missouri STR/SOR teams have developed and deployed specific initiatives to save and improve the lives of people who use drugs. Some highlights in the prevention, treatment, and recovery support domains are harm reduction street outreach, mobile app for people in treatment, and jail-based MOUD program at the St. Louis County jail. In addition to the initiatives above, family support services are also offered and include recovery-oriented programs for families of people with SUD, family education workshops, and connections to treatment.

SOR grant also supports the Big Brothers, Big Sisters program that provides mentoring and wraparound services to 181 young people, ages 5-25, particularly African American males. Services include matching young people with professionally trained, thoroughly screened adult volunteer mentors AND providing robust wraparound support to youth and their families. In addition to Big Brothers, Big Sisters, the SOR grant funds the Boys and Girls Club which provides the Positive Action curriculum for K-12 youth at 14 sites, which includes education about turning down invitations to misuse drugs, and teaches prosocial behaviors. Also, PreventEd Prevention Programming implements the Generation RX program to high schools students in schools across St. Louis City and Jefferson, Lincoln, Warren, and St. Louis Counties. Generation RX materials are incorporated into the fourth lesson of Check Your Attitude, PreventEd's existing 4-lesson series that covers alcohol, tobacco, marijuana, and

heroin/prescription opiates. Generation RX lessons are also offered as a single-session lesson. They also provide community resources and naloxone distribution.

Recovery Housing

The DMH, in partnership with the Missouri Coalition of Recovery Support Providers (MCRSP) and the NARR state affiliate, has certified 130 recovery houses, with over 1,200 beds available. The majority of the recovery houses across the state are MAT-friendly. Houses pass the NARR accreditation process and indicate their willingness to serve individuals receiving all forms of medical treatment for OUD.

Recovery Community Centers

STR/SOR has funded four RCCs to provide OUD and Stimulant Use Disorder recovery support services. These RCCs are independent, non-profit organizations that mobilize resources to increase the prevalence and quality of long-term recovery. Recovery coaching, telephone-based recovery services, recovery meetings, employment support, life skills groups, and other services are offered. There are two RCCs in St. Louis, one in Springfield, and one in Kansas City.

Family Support Services

Recovery Lighthouse provides Family Recovery services through SOR. This program includes open support groups for families, family education workshops, and connection to treatment.

Peer Workforce

Missouri has expanded the Certified Peer Specialist workforce by providing trainings every month across the State. Treatment agencies, RCCs, and recovery housing providers have increased the utilization of peer support specialists to engage individuals in meaningful recovery.

Future State

Missouri remains committed to sustaining the infrastructure, programs, and services developed in response to the Opioid crisis. The State continues to leverage data from our partners at the UMSL-MIMH to both monitor progress as well identify areas for the State's focus.

Milestone 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current treatment and prevention strategies to reduce opioid use and OUD in the state.	Provide an overview of planned strategies to prevent and treat opioid use and OUD.	Specify a list of action items needed to be completed to meet milestone requirements as detailed above. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid use	Missouri Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs	Milestone complete	N/A

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>(MDHSS/BNDD) published <i>Controlled Substance Guidelines for Missouri Practitioners</i> in November 2020.</p> <p>Funded by SOR grant dollars, the Missouri Telehealth Network through the University of Missouri, Columbia, has expanded its ECHO (Extension for Community Health Outcomes) program to include interdisciplinary, effective practices for pain management in primary care. This Show-Me ECHO clinic is geared towards community primary care providers who primarily serve the uninsured and Medicaid populations in Missouri and are interested in learning more about topics such as the intersection of pain and sleep problems, the application of behavioral health approaches to pain, patient-centered communication strategies, and more. The Pain Management ECHO integrates medical, pharmacological and</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	psychological considerations into the treatment of chronic pain.		
Expanded coverage of, and access to, naloxone for overdose reversal	SOR grant funds support the MO-HOPE project which offers training and tools, including naloxone, for overdose prevention and reversal to diverse professional and community audiences, including at-risk individuals in the criminal justice system. In addition, Missouri has a standing order that allows any person who asks for naloxone from a pharmacy for themselves or to help a person experiencing an opioid overdose can purchase naloxone, with or without a prescription.	Milestone complete	N/A
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	As further described in the Health Information Technology (HIT) Plan, in May 2021, the Missouri Legislature passed SB 63, creating a statewide PDMP. Currently, a county-based PDMP system is operational. The St. Louis County PDMP has 75 subscribing counties, covering 85% of the State’s population and 94% of healthcare providers.	Implementation of the statewide PDMP in accordance with SB 63. The Joint Oversight Task Force for Prescription Drug Monitoring, established by SB 63, was charged with procuring a PDMP vendor. The request for proposal was issued October 18, 2022 and the contract was awarded to Bamboo Health on January 11, 2023.	Full implementation of a statewide PDMP is now underway, with real-time functionality anticipated by January 1, 2024.

4. Improved Care Coordination and Transitions between Levels of Care

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Current State

Engaging Patients in Care Coordination (EPICC)

Led by the Behavioral Health Network of Greater St. Louis, EPICC began as a nine-month pilot project in December 2016, serving St. Louis City, St. Louis, and surrounding counties to connect patients from hospitals to evidence-based substance use treatment and grassroots recovery supports. EPICC utilizes certified peer specialists, referred to as recovery coaches (people with lived experience), to encourage individuals' engagement with community treatment providers through intensive outreach services. Recovery coaches, dispatched 24/7 through dedicated hotlines, establish immediate linkages to substance use and MAT services. Needs associated with housing, transportation, access to technology and more also are case managed. In July 2017, funds were received from the Missouri DMH via STR Substance Abuse and Mental Health Services Administration (SAMHSA) funds to continue and expand the project to additional health care systems and substance use treatment providers in the eastern region. In March 2018, the Missouri Hospital Association, in partnership with Behavioral Health Network (BHN), DMH, the Missouri Institute of Mental Health and many other State agencies, identified other Missouri communities disproportionately affected by opioid overdose deaths and began to replicate EPICC programming.

The goals for the EPICC program include linking opioid overdose survivors at a point of crisis to community-based care via peer outreach (certified peer specialists/recovery coaches) across institutional and community settings. Specific goals include increased access to recovery support services, rapid patient engagement across multiple access (referral) points, e.g., hospitals, emergency medical services, admissions to treatment programs, reduced emergency department utilization, fewer repeat overdoses, provision of Opioid Overdose Education and Naloxone Distribution (OEND), increased patient access to pharmacotherapy, and increased retention in OUD treatment services. EPICC programming delivery is based on the SBIRT model.

Recovery Support Services

DBH contracts for Recovery Support Services providing care coordination, peer recovery coaching, spiritual counseling, group support, recovery housing and transportation before, during, after SUD treatment and in coordination with other SUD service providers. These services are offered by 51 certified Recovery Support Service providers in a multitude of settings including community, faith-based and peer recovery organizations. Recovery Support programs are person-centered and self-directed. Recovery Housing certification requires the provider to

also obtain accreditation through the MCRSP/NARR. Currently, 120 Recovery Houses with over 1,200 beds are accredited. DMH receives a SAMHSA SOR grant for the purpose of expanding access to integrated prevention, treatment, and recovery support services for individuals with OUD throughout the State, including development of local RCCs. Four RCCs provide a peer-based supportive community that builds hope and supports healthy behaviors for individuals with OUD searching for or maintaining recovery.

Peer Services

Peer support services are available to individuals in recovery from SUDs. Provided by credentialed Recovery Support Specialists, recovery coaching is the development of a supportive peer relationship to foster recovery-oriented problem-solving skills. The recovery coach's role emphasizes reconnection to support systems in the community. In 2012, DBH worked with the Addiction Technology Transfer Center Network (ATTC) to bring the Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy to Missouri.

Disease Management (DM) Projects

The DSS, MHD, and DMH, DBH implemented the DM Project in 2009. The DM Projects identify Medicaid-eligible individuals with high medical costs who have a diagnosis of serious mental illness (SMI) or SUD and are not currently receiving DMH behavioral health services. DM 3700 identifies Medicaid-eligible individuals with high medical costs who have a diagnosed SMI, and SUD DM identifies Medicaid-eligible individuals with high medical costs who have a diagnosed SUD. Once the individual is identified, they are placed on a DM Cohort to be outreached for services by DMH contracted providers, with the goal of locating and enrolling these individuals in behavioral health services to improve health outcomes and reduce related medical costs. Those identified on the DM 3700 cohort are presumptively eligible for the CPR program. Those identified on the SUD DM cohort are presumptively eligible for the CSTAR Program.

The Community Mental Health Center Healthcare Home (CMHC HCH) initiative was implemented in 2012. CMHCs which meet DMH criteria may be designated as a behavioral health HCH. HCH functions include but are not limited to: ensuring access to primary and specialty care; promoting healthy lifestyles; supporting individuals in managing chronic health conditions; diverting inappropriate ER visits; coordinating post hospitalization care; and using health information technology to monitor for care management gaps. The individuals served include adults and youth with the following:

- A SMI or severe emotional disturbance; or
- A mental health condition and SUD; or
- A mental health condition or SUD, and a chronic health condition or risk factor (diabetes, asthma/COPD, cardiovascular disease, developmental disability, overweight {BMI \geq 25}, use tobacco).

The SUD DM Project was implemented in 2014 through a partnership with DSS/MHD and DMH/DBH. The SUD DM targets Medicaid-eligible individuals with high medical costs who have a diagnosed SUD and are not receiving DMH behavioral health services. Each provider added a nurse liaison to assist with care coordination of complex physical health conditions of program participants.

Providers participating in the SUD DM program have access to the Customer Information Management, Outcomes, and Reporting (CIMOR) system. This DMH web-based information system includes a wide range of data on individuals served including demographics, screening and assessment results, benefit and eligibility (Medicaid) status, service encounters, and billing. Reports generated from CIMOR allow DMH staff and providers to measure and track program performance and manage quality improvement and other projects on a statewide basis.

In addition to CIMOR, CyberAccess is a web-based, HIPAA compliant portal that enables users to view the complete medical and drug claim history for MO HealthNet fee-for-service participants. The claim history is extracted from paid claims and goes back approximately two years. CyberAccess provides valuable health information on prescriptions, procedures, diagnoses, and services an individual has received from MO HealthNet providers in the state. With this tool, the end users are able to identify clinical issues that affect an individual's care. The application will display alert messages when an individual may be noncompliant with medication refills and/or treatment plans. The CyberAccess Patient Profile provides a summary of the individual's medical, behavioral, and medication claim history and is a helpful tool for the DM project.

Future State

The State will continue to expand access to a comprehensive provider network of CCBHOs with the addition of more CCBHOs across the state in 2022, expanding access to care coordination, including transition supports that are required of these providers.

EPICC programming is now offered in the central, eastern, southwest, and western regions of the State. Currently, expansion of EPICC is underway in the southeastern and southcentral parts of the State. This will allow for statewide coverage of the program.

Milestone 6. Improved Care Coordination and Transitions between Levels of Care

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community- based services and supports following stays in these facilities	Provide an overview of current care coordination services and transition services across levels of care.	Provide an overview of planned improvements to care coordination services and transition services across levels of care.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community- based services and supports following stays in these facilities	DBH contracts for Recovery Support Services providing care coordination, peer recovery coaching, spiritual counseling, group support, recovery housing and transportation before, during, after SUD treatment and in coordination with other SUD service providers. In addition to Recovery Support providers, Missouri CCBHOs and CMHC HCH are required to participate in transition planning for individuals served. CCBHO policies and procedures must promote and describe its care coordination roles and responsibilities, and whenever possible, the development of formal agreements with community organizations and practitioners that document mutual care coordination roles and responsibilities, with	Milestone complete	N/A

	particular attention to emergency room, hospital, and residential treatment		
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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>admissions and discharges. Members of the CMHC Care Team must provide 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. Members of the Care Team collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing individuals' 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. (9 CSR 30-6.010)</p>		
<p>Additional policies to ensure coordination of care for co-occurring physical and mental health conditions</p>	<p><u>PCHH includes anxiety and depression as well as substance use disorders as qualifying conditions, in addition to the chronic physical health conditions that are qualifying conditions. Behavioral health consultants work closely with other</u></p>	<p>Milestone complete</p>	<p>N/A</p>

	<p><u>members of the primary care team to coordinate care for co-occurring physical and mental health conditions.</u></p> <p><u>CCBHOs are required to promote collaborative treatment planning by providing the individual's Primary Care Provider (PCP) with relevant assessment, evaluation, and treatment plan information, seeking all relevant treatment and test results from the PCP, and inviting the PCP to participate in treatment planning.</u></p> <p><u>Community-based providers such as Certified Community Behavioral Health Organizations (CCBHO) and Community Mental Health Center Healthcare Homes (CMHC HCHs) are required to participate in transition planning for their clients. CCBHO policies and procedures must promote and describe its care coordination roles and responsibilities, and whenever possible, the development of formal agreements with community organizations and practitioners that document mutual care coordination roles and responsibilities, with particular attention to emergency room, hospital, and residential treatment</u></p>		
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	<p><u>admissions and discharges. Members of the CMHC HCH Care Team must provide 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. Members of the Care Team collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing individuals' 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.</u></p> <p>Hospital Care Transition (HCT) Management: Members identified through the MO HealthNet health plan hospital discharge risk assessment and in need of transition of care assistance, receive onsite HCT management services upon admission to a hospital, at the discretion of the health plan. <u>HCT management services are relevant to individuals with co-occurring physical health, SUD and/or mental health conditions.</u> HCT</p>		
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	<p>Coordinators will assist individuals with SUD and/or mental health conditions by obtaining discharge disposition/location information and collaborating with in-network secondary level of care (i.e., acute inpatient rehab, long-term acute care hospitals, skilled nursing facilities, behavioral health services, etc.) to ensure referral and access to high-quality services. The services provided under the HCT program must integrate with and enhance</p>		
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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>the discharge planning and care transition activities required of the hospital by CMS. The efforts of all collaborative work must maintain the patient and caregiver goals as the cornerstone of the discharge planning and transition management process, taking into consideration the provider diagnosis, assessment, prognosis, and provider recommendations for post-acute services.</p> <p>The purpose of HCT management services is to bridge the gap between hospital and community, enhance member experience and satisfaction, improve clinical outcomes, and increase the overall value of services provided by the health plan. HCT Coordinators will collaborate with facility staff responsible for discharge planning to understand the discharge risk assessment, patient and caregiver goals of care, and provider recommendations. The HCT Coordinators assist the member in the transition of members' care by providing education about in-network care providers, programs they may be eligible for, and community-based resources, etc.</p>		

Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the Implementation plan.

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Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment A – Template for SUD Health Information Technology (IT) Plan

Section I.

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state’s PDMP.

Overview of Current PDMP Functionality

In May 2021, the Missouri Legislature passed SB 63, creating a statewide PDMP. The legislation establishes the Joint Oversight Task Force of Prescription Drug Monitoring within the Office of Administration, with members selected from the Board of Registration for the Healing Arts, the Board of Pharmacy, the Board of Nursing, and the Missouri Dental Board. The legislation mandated procurement of a PDMP vendor through a competitive bid process.

Passage of SB 63 is the culmination of legislative efforts dating back several years. Since 2005, bills to establish a PDMP were introduced in every legislative session but failed to pass. In 2017, former Governor Greitens issued Executive Order 17-18 directing the Department of Health and Senior Services (DHSS) to implement a multi-phase PDMP. In the first phase, DHSS was required to enter into contracts with pharmacy benefit management (PBM) organizations to analyze prescriber and pharmacy prescription and dispensing data for schedule II-IV controlled substances. The executive order directed DHSS to use the analyses to identify activity indicating that controlled substances are being inappropriately prescribed, dispensed or obtained, investigate such activity, and make referrals to law enforcement and professional licensing boards. For the second phase of the PDMP, the executive order directed DHSS to promulgate rules requiring dispensers to submit controlled substance prescription and dispensation information to DHSS or its designee.

The Opioid Prescription Intervention (OPI) Program operates in response to this executive order. The OPI Program has provided clinical advisory mailings to prescribers caring for MO HealthNet participants since 2010. The program involves selected evidence-based, best practice Quality Indicators™ (QIs) applied to MO HealthNet pharmacy and medical claims data to generate a customized packet of information to providers regarding their prescribing activity. Effective March 1, 2018, the DSS/MHD began working collaboratively with the DMH and the DHSS to enhance interactions with providers and accelerate the goals of the OPI Program, including implementation of the following:

- *Adherence to CDC Guideline for Prescribing Opioids for Chronic Pain.* MO HealthNet developed clinical policy based on best practices, including the CDC 2016 Guideline for Prescribing Opioids for Chronic Pain. Clinical Edits in the Pharmacy Program reflect these recommendations.
- *OPI Quality Indicators.*TM Individualized mailing packets are sent to providers whose prescribing activity results in flagging one or more of the following Quality Indicators:TM
 - Use of Buprenorphine with another Opioid (Prescribed by another Physician)
 - Use of Buprenorphine with a Benzodiazepine (Prescribed by another Physician)
 - Patient's Use of Four or More Pharmacies for Opioid Prescriptions
 - Patient's Use of Five or More Prescribers for Opioid Prescriptions
 - Patient's Use of Four or More Pharmacies for Opioid Prescriptions (Under 18 Years)
 - Patient's Use of Four or More Prescribers for Opioid Prescriptions (Under 18 Years)
 - Use of Opioids for 60 or More Days with a Diagnosis Suggesting Opioid, Alcohol, or Other Substance Abuse in the Last Year
 - Use of Opioids at a High Dose without a Malignant Cancer Diagnosis
 - Use of Opioids at a High Dose without a Malignant Cancer Diagnosis or Other Supporting Diagnosis (65 Years and Older)
 - Use of Opioids for 60 or More Days with Two or More Diagnoses of Malingering, Somatization, or Factitious Disorder
 - Use of Opioids for 60 or More Days in Absence of a Diagnosis Supporting Chronic Use
 - Use of Opioids for 60 or More Days in Absence of a Diagnosis Supporting Chronic Use (Under 18 Years)

The following process is implemented based on the aforementioned data mining:

1. A first letter is mailed to prescribers which does not constitute formal findings that the provider violated a standard of care.
 2. A second letter is mailed, following up with certain providers. Providers that receive the second letter are given 20 business days to respond.
 3. Providers that fail to respond or whose responses lack information are notified by telephone that they will be referred to the Bureau of Narcotics and Dangerous Drugs (BNDD).
 4. Providers that fail to respond or whose responses lack information will be referred to BNDD.
 5. BNDD investigates its referrals for appropriate action.
- *Implementation of Updated and New Opioid Clinical Edits.* Effective March 6, 2018, enhanced Opioid Clinical Edits were implemented in the Pharmacy Program. The edits, based on CDC Opioid Guidelines, deny pharmacy claims based on clinical criteria consistent with the QIs identified in the OPI mailing program. A Morphine-

Milligram-Equivalent (MME) Accumulation Edit was implemented May 1, 2018, to more accurately identify total MME daily dosing and the risk of harm from overdose. For MO HealthNet participants requiring opioid therapy exceeding the criteria established in these Clinical Edits, providers need to obtain prior authorization.

MMAC also has the authority to "Lock-In" Medicaid enrollees to a specific medical and/or pharmacy provider for reasons relating to misuse.

Additionally, a county-based PDMP system was developed to address the lack of a statewide PDMP. On March 1, 2016, St. Louis County enacted legislation to establish operation of a PDMP by the St. Louis County Department of Public Health (DPH). The program's goals are to:

- Improve controlled substance prescribing by providing critical information regarding a patient's controlled substance prescription history.
- Inform clinical practice by identifying patients at high-risk who would benefit from early interventions.
- Reduce the number of people who misuse, abuse, or overdose while making sure patients have access to safe, effective treatment.

St. Louis County selected Appriss as the PDMP vendor through a Request for Proposals (RFP) process. The PDMP was launched in 2017 with 14 participating jurisdictions. Any Missouri jurisdiction may subscribe to the St. Louis County PDMP upon enacting authorizing legislation and signing a User Agreement with St. Louis County. As of August 2021, there are 75 subscribing counties. These 75 jurisdictions cover 85% of the State's population and 94% of healthcare providers. Nearly 18,000 healthcare providers have registered for the PDMP. Those with PDMP accounts prescribing or dispensing in Missouri represent approximately 74% of Missouri's healthcare providers with controlled substance prescriptive or dispensing authority; this represents a 26% increase from 2018.

In accordance with St. Louis County Revised Ordinances (SLCRO) Chapter 602, dispensers are required to electronically report Schedule II-IV controlled substance dispensation information to the St. Louis County PDMP. A "Dispenser" is defined in Section 602.801 SLCRO as a person who delivers a Schedule II, III, or IV controlled substance to a patient. A "Dispenser" does not include:

- A hospital as defined in Section 197.020 R.S.Mo. that distributes such substances for the purpose of inpatient care or dispenses prescriptions for controlled substances at the time of discharge from such facility;
- A practitioner or other authorized person who administers such a substance; or
- A wholesale distributor of a Schedule II, III, or IV controlled substance.

The St. Louis County PDMP has enabled the following three clinical alerts:

- *Multiple Provider Episodes*: This alert displays when a patient fills controlled substance prescriptions written by three or more prescribers and filled at three or more pharmacies within six months.
- *Overlapping Opioid and Benzodiazepine Prescriptions*: This alert displays when a patient has filled an opioid and benzodiazepine prescription that overlaps at least one day.
- *Daily Opioid Dosage*: This alert displays when a patient receives a cumulative daily opioid dosage of greater than 90 morphine milligram equivalent (MME).

MO HealthNet receives routine reports from the St. Louis County PDMP regarding Medicaid recipient's patient Rx information.

In addition, MO HealthNet maintains a web based electronic health record (EHR) called CyberAccess, accessible to enrolled Medicaid providers that includes access to prescribed drug information and 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 PDL and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
- 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;
- Review laboratory data and clinical trait data; and
- Determine medication adherence information.

Future State

In accordance with SB 63, the Joint Oversight Task Force for Prescription Drug Monitoring has procured a statewide PDMP vendor, with contract awarded to Bamboo Health on January 11, 2023. The St. Louis County PDMP remains in place until the statewide PDMP is fully operational and available for access by healthcare providers. In accordance with SB 63, the following information must be submitted to the PDMP for each dispensation of a Schedule II, III, or IV drug by the dispenser within 24 hours:

- The pharmacy's Drug Enforcement Administration (DEA) number
- The date of dispensation

- Prescription number, whether the prescription is new or a refill and the prescriber's DEA or NPI number
- National Drug Code (NDC)
- Quantity and dosage
- Patient's identification number

Beginning January 11, 2023, Bamboo Health will begin phasing in a requirement that dispensers report patient dispensation information in real time, with all dispensation information to be submitted in real time by January 1, 2024. All patient dispensation information submitted to the PDMP will be shared with the State's health information exchanges (HIE) upon request of the HIE.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	As of November 2018, the St. Louis County PDMP is participating in interstate data sharing through PMP InterConnect (PMPi). This allows a healthcare provider to query multiple state PDMPs at once, and results are collated into a single patient report. The PDMP is currently participating in interstate data sharing with 19 states including: Alabama, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan North Carolina, Ohio, Oklahoma, South Carolina and Tennessee, Texas.	Legal reviews of 195.600 RSMo have determined that sharing data with other states is not permitted. The PDMP hubs (RxCheck, PMPi) which are used to facilitate interstate sharing do not meet the definition of a health information exchange (HIE) as defined in our statute, so interstate sharing is not possible without a statutory change. MO statute requires that patient dispensation information submitted to the PDMP shall be shared with any health information exchange operating in MO, upon the request of the health information exchange. The PDMP vendor is required to treat patient dispensation information and any other individually identifiable patient information as protected health information under HIPAA.	The Joint Oversight Task Force of Prescription Drug Monitoring within the Office of Administration will oversee the implementation of contract requirements for the statewide PDMP. MO is exploring connecting the statewide PDMP with the four health information networks operating in MO.

<p>Enhanced “ease of use” for prescribers and other state and federal stakeholders</p>	<p>The St. Louis County PDMP provides data to a variety of authorized recipients, such as:</p> <ul style="list-style-type: none"> • <i>Local Public Health Agencies</i>: Receive routine, quarterly reports that provide county-specific reports on prescribing 	<p>Implementation of statewide PDMP in accordance with 195.600 RSMo. .Bamboo Health’s platform will allow integrated EHR and Pharmacy Management System access to healthcare providers. The Statewide PMP Gateway approach will drastically improve the ease with which providers access their patient’s controlled-substance history, leading to safer prescribing patterns at the population level. PMP Gateway provides seamless integrated access to multi-state PDMP data through PMP InterConnect.</p>	<p>Once the statewide PDMP is fully operational, work can begin to enhance ease of use for prescribers and other state and federal stakeholders to the extent permitted by 195.600 RSMo. The Joint Oversight Task Force will oversee implementation rollout.</p>
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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>practices</p> <ul style="list-style-type: none"> • <i>Prescribers & Dispensers:</i> Registered users have full access to the PDMP • <i>Board of Pharmacy & State Regulatory Boards:</i> Information related to professionals under the jurisdiction of the State board and with a current/open investigation <p>The PDMP also provides clinical alerts, as described above, which provide clear notification to providers regarding potential prescribing concerns.</p> <p>The PDMP platform also links to a Provider Toolbox, giving providers quick access to evidence-based practices and guidelines to help healthcare providers deliver compassionate, clinically appropriate pain management and OUD treatment. The Provider Toolbox was designed by members of the Opioid Community of Practice (OCP), a multi-jurisdictional, multi-sector</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>collaborative coordinated by the St. Louis County Department of Public Health.</p> <p>Medicaid providers also have access to data on all their Medicaid enrollees via the aforementioned CyberAccess EHR.</p>		
<p>Enhanced connectivity between the State's PDMP and any statewide, regional, or local health information exchange</p>	<p>The St. Louis County PDMP does not currently connect to Missouri's health information networks (HINs).</p>	<p>In accordance with 195.600 RSMo, PDMP information will be shared with any HIE operating in Missouri upon the request of the HIE.</p>	<p>The Joint Oversight Task Force will oversee implementation rollout. Once fully operational, all patient dispensation information submitted to the statewide PDMP, operated by Bamboo Health, will be shared with the State's health information exchanges (HIE) upon request of the HIE.</p>

<p>Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also “Use of PDMP” #2 below)</p>	<p>As described above, prescribing patterns are reviewed via the OPI Program and provider outreach is conducted when aberrant practices are identified. Additionally, if a Medicaid enrollee is found to be misutilizing, the individual may be restricted to a physician/clinic, pharmacy, or both.</p> <p>The St. Louis County PDMP enables participating prescribers to view, track and analyze trends in their prescribing. Routine prescribing summaries provide information to providers about their controlled substance</p>	<p>Implementation of statewide PDMP in accordance with 195.600 RSMo. This statute allows dispensation information in the PDMP of MO HealthNet participants to be shared with MO HealthNet for purposes of providing the division and MO HealthNet providers patient dispensation history and facilitating MO HealthNet claims processing and information retrieval; provided, that no patient dispensation information shall be utilized for any purpose prohibited under this section. The statute prohibits patient dispensation information from being used to obtain arrest or search warrants. The statute also prohibits patient dispensation information from being provided to local, state, or federal law enforcement or prosecutorial officials, both in-state and out-of-state, or any regulatory board, professional or otherwise, for any purposes other than those explicitly set forth in HIPAA and any regulations promulgated thereunder.</p>	<p>The Joint Oversight Task Force will oversee implementation rollout, including compliance with requirement to provide the ability to analyze a single prescriber and view prescriber patterns in more detail.</p>
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Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>prescribing compared to that of their peers (by specialty) and all prescribers in the PDMP. These summaries are provided to individuals who have prescribed 15+ controlled substances to 15+ patients in the previous quarter and either practice in a participating jurisdiction or have created a PDMP account. Summaries are intended to be an informative resource to highlight potentially risky prescribing, such as co-prescribing opioids and benzodiazepines.</p> <p>MO HealthNet also employs clinical edits based on CDC guidelines.</p> <p>Medicaid providers also have access to data on all their Medicaid enrollees via the aforementioned CyberAccess EHR.</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Current and Future PDMP Query Capabilities			
<p>Facilitate the State’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the State’s master patient index (MPI) strategy with regard to PDMP query)</p>	<p>St. Louis County’s PDMP vendor, Appriss, maintains a proprietary patient matching algorithm to match patients receiving opioid prescriptions which utilizes a referential database, probabilistic and deterministic matching.</p>	<p>Bamboo Health’s solution will provide identity resolution capabilities through a best-in-class patient-matching engine. This identity resolution system processes thousands of records per minute from various data sources to consolidate patient records for single individuals. This common ID provides the most accurate record of a patient’s history available to date. The solution’s matching and consolidation process is dynamic, allowing new IDs to be connected, deleted, and evolve in real time via machine learning. Bamboo’s ID utilizes a combination of probabilistic matching, referential matching, deterministic matching, and manual matching to overcome issues with minor data entry errors, variations in spelling, diminutive names, maiden name changes, and more to provide the most accurate results possible. It allows for the correction of irregularities</p>	<p>The Joint Oversight Task Force will oversee implementation rollout, including compliance with requirements for matching patients in PDMP.</p>

		<p>noted by healthcare providers, and an audit trail of all changes made to the system ensures that manual changes and improvements can be integrated into the algorithms. The algorithms also can detect fraudulent or bogus data elements and adapt over time.</p>	
<p>Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes</p>			
<p>Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow</p>	<p>When providers log on to the St. Louis County PDMP they see alerts that apply to patients who have crossed certain threshold criteria (DPH established thresholds with input from the Technical Advisory Committee). Currently, three alerts are in place including: multiple provider episodes, overlapping opioid and benzodiazepine prescriptions and daily opioid dosage. Alerts may assist in the identification of a problematic pattern of controlled substance use for which additional screening and intervention may be beneficial. Providers can also pull a prescription history on their patients.</p> <p>Healthcare providers are</p>	<p>Implementation of statewide PDMP in accordance with 195.600 RSMo.</p>	<p>The Joint Oversight Task Force will oversee implementation rollout to ensure contract requirements around enhanced provider workflows are met.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>performing over 10,600 patient searches per day; this is a 77% increase from 2018. An average of 19,233 schedule II-IV controlled substances were dispensed across the system in January 2021. This means approximately 55% of patient prescription histories were reviewed compared to prescriptions written during this time period.</p> <p>The average number of patient searches per day has also increased over time as noted below¹:</p> <ul style="list-style-type: none"> • Q2 2017: 1,013 • Q3 2017: 1,222 • Q4 2017: 1,425 • Q1 2018: 2,548 • Q2 2018: 3,788 • Q3 2018: 4,582 • Q4 2018: 6,039 • Q1 2019: 7,097 <p>PDMP users also have access to the aforementioned clinical alerts and Provider Toolbox.</p>		

¹ Jackson M. & Varner E. 2018 Annual Report, Prescription Drug Monitoring Program. St. Louis County, MO: Department of Public Health. April 2019.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>Medicaid providers also have access to data on all their Medicaid enrollees via the aforementioned CyberAccess EHR.</p>		
<p>Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription</p>	<p>The St. Louis County PDMP provides access to individual patients' history of controlled substance prescriptions prior to issuance of an opioid prescription.</p> <p>Medicaid providers also have access to data on all their Medicaid enrollees via the aforementioned CyberAccess EHR.</p>	<p>Implementation of statewide PDMP in accordance with 195.600 RSMo.</p>	<p>The Joint Oversight Task Force will oversee implementation rollout, including compliance with requirements for enhanced supports for clinicians to review patient history prior to prescribing.</p>
Master Patient Index / Identity Management			
<p>Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.</p>	<p>St. Louis County's PDMP vendor, Apriss, maintains a proprietary patient matching algorithm to match patients receiving opioid prescriptions which utilizes a referential database, probabilistic and deterministic matching.</p>	<p>Bamboo Health's platform will provide identity resolution capabilities through a best-in-class patient-matching engine to support early identification, prevention, and management of substance use disorder.</p>	<p>The Joint Oversight Task Force will oversee implementation rollout, including compliance with requirements for patient matching.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Overall Objective for Enhancing PDMP Functionality & Interoperability			
<p>Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids</p>	<p>Missouri has several programs to implement effective controls to minimize the risk of inappropriate opioid overprescribing, including the following aforementioned programs:</p> <ul style="list-style-type: none"> • Lock-in Program • Clinical edits reflecting the CDC Guidelines for Prescribing Opioids for Chronic Pain • QPI Quality Indicator mailings to providers whose prescribing activities results in flagging a quality indicator • Enhanced opioid clinical edits based on CDC Opioid Guidelines <p>Additionally, the aforementioned prescribing summaries include a section on payment section, including a breakout by Medicaid. This allows providers to see the breakdown of payment methods among their patients at an aggregate level.</p>	<p>The full implementation of a statewide PDMP will represent a significant improvement over current state in terms of minimizing risk of inappropriate opioid overprescribing.</p>	<p>The Joint Task Force will oversee implementation rollout to ensure compliance with state objectives including those related to utilization of opioids in the Medicaid program.</p>

Attachment A, Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

Name and Title: Amy Kessel, Director of Support Services

Telephone Number: 573-526-2708

Email Address: Amy.Kessel@dmh.mo.gov

Attachment A, Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment E: SMI & SED Implementation Plan

Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state’s approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on “Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]” over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state’s implementation plan.

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Eric Martin, PhD
Director, Behavioral Health Services
MO HealthNet Division

Telephone Number: (573) 522-8336

Email Address: Eric.D.Martin@dss.mo.gov

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

1. Title page for the state’s SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	Missouri
Demonstration name	Section 1115 IMD Waiver for SMI & SED
Approval date	December 6, 2024
Approval period	December 6, 2024 – December 31, 2028
Implementation date	CMS Approval

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state’s SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place “NA” in the summary cell if a prompt does not pertain to the state’s demonstration. Answers are meant to provide details beyond the information provided in the state’s special terms and conditions.

Answers should be concise, but provide enough information to fully answer the question. This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
<p><i>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</i></p> <p><i>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</i></p>	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
<p>1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid</p>	<p><i>Current Status:</i> Missouri’s Hospital Licensing Law requires all hospitals in the state to maintain licensure issued by the Department of Health and Senior Services (DHSS) (Mo. Rev. Stat. § 197.040). Compliance with Medicare conditions of participation is deemed to constitute compliance with the standards for hospital licensure (Mo. Rev. Stat. § 197.005). In accordance with 19 CSR 30-20.013 Missouri licensed psychiatric hospitals must strictly meet the Medicare Conditions of Participation and surveys performed for state licensure are conducted per Medicare standards.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<i>Summary of Actions Needed:</i> N/A – milestone requirements already met.

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
<p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</p>	<p><i>Current Status:</i> The DHSS is required by statute to annually inspect each licensed hospital and make any other inspections and investigations as it deems necessary for good cause shown. The DHSS accepts reports of hospital inspections from or on behalf of governmental agencies, the joint commission, DNV, and the American Osteopathic Association Healthcare Facilities Accreditation Program, provided the accreditation inspection was conducted within one year of the date of license renewal. Prior to granting acceptance of any other accrediting organization reports in lieu of the required licensure survey, the accrediting organization's survey process must be deemed appropriate and found to be comparable to the Department's licensure survey (Mo. Rev. Stat. § 197.040).</p> <p>In accordance with 19 CSR 30-20.015, initial licensure compliance surveys are announced, and complaint investigations are unannounced.</p> <p>The DHSS is responsible for issuing citations to hospitals in the event of regulatory or quality non-compliance. The DHSS will submit a 2567 (statement of deficiencies) to the hospital for completion. The hospital must respond to the 2567 statement with a plan of correction (PoC), which is reviewed by the DHSS for approval or denial. If the DHSS denies a 2567 statement, the hospital must revise the PoC and resubmit in order to pursue approval for a credible corrective plan. After the PoC is approved and implemented, the DHSS may revisit the hospital to ensure compliance, or substantial compliance of the cited issue. If the hospital demonstrates non-compliance, the DHSS will rescind the 2567 statement and the process will restart. If the hospital is in compliance, the DHSS will close the incident and send the hospital a letter of compliance.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p data-bbox="552 440 1314 472"><i>Future Status:</i> Continued operation of current requirements.</p> <p data-bbox="552 508 1478 540"><i>Summary of Actions Needed:</i> N/A – milestone requirements already met.</p>
<p data-bbox="132 578 457 829">1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</p>	<p data-bbox="552 578 1885 743"><i>Current Status:</i> Managed care organizations (MCOs) are contractually required to utilize LOCUS/CALOCUS for psychiatric inpatient hospital admissions, continued stay reviews and retrospective reviews. MO HealthNet conducts ongoing oversight of the MCO’s utilization management decisions, including review of contractually required reports of inpatient certifications/prior authorizations and discharges.</p> <p data-bbox="552 781 1885 979">In the fee-for-service (FFS) delivery system, all inpatient hospital admissions require admission certification. MO HealthNet contracts with Conduent for utilization management functions. Conduent utilizes the Milliman Care Guidelines® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations including those for adult and child psychiatric care. Conduent also conducts a quarterly validation review of utilization and quality of care for a statistically valid sample of certifications.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p><i>Future Status:</i> In July 2022, the Missouri Children’s Division (CD) engaged Center for Health Care Strategies (CHCS) with the support of Casey Family Programs to help Missouri improve access and outcomes for children and youth with behavioral health needs.</p> <p>CHCS will work closely with the state to establish shared principles and goals, identify capacity needs and gaps, and prioritize strategies to strengthen the continuum of care. CHCS will produce a report that will focus on:</p> <ul style="list-style-type: none"> • Prevention services, • Coordination of services and funding, • Developing pathways to build family resiliency, and • Developing community resources to support and stabilize families. <p>This report will be the roadmap to support fewer residential stays and shorter lengths of stay in residential care. Missouri will make incremental changes during the CHCS assessment process to support community care and shorten lengths of stay in residential facilities.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

	<p>Missouri has also invested \$5.0 million in community settings grants to assist providers in transitioning business models and programs from residential-based to community care settings. A CHCS Missouri system scan to identify gaps in community-based services and to determine the best way to use these transition funds. An additional \$1.0 million in funds for a contractor will be available to assist in the coordination and implementation of these grants will help assure grants are aligned with the CHCS recommendations and Missouri’s vision for a continuum of care model anchored in prevention and community-based care. Close coordination and planning with the specialty managed care plan serving Missouri’s foster care population and youth adopted out of the foster care system will be key in implementing a system less reliant on institutional care and situated to support kids and families in community settings. Although the goal is to sunset the system’s reliance on large residential care facilities, this transition may not be complete in a two-year span. Missouri has been transparent with the General Assembly about the possibility of a continued need for state general revenue funds to support residential care through a longer than two-year transition. Or perhaps Missouri decides it is in the best interest of children to continue to support facilities serving certain populations.</p> <p><i>Summary of Actions Needed:</i> Based on the current CHCS timeline:</p> <ul style="list-style-type: none"> • July – August 2023 – CHCS will conduct an environmental scan by analyzing and summarizing information provided by state agencies. • September – November 2023 – CHCS will develop a final report and presentation summarizing the results of the environmental scan and recommendations. • December 2023 – CHCS will lead and facilitate at least one site visit to review findings and recommendations from the environmental scan with the state team. • Beginning January 2023 – Based on CHCS recommendations, \$5 million in grants will be disbursed by MO Department of Social Services to assist providers in transitioning business models and programs from residential-based to community-based settings.
<p>1.d Compliance with program integrity requirements and state compliance assurance process</p>	<p><i>Current Status:</i> In order to receive reimbursement for Medicaid authorized services, participating psychiatric hospitals must be enrolled as MO HealthNet providers. The Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit processes provider applications in full compliance with 42 CFR Part 45 Subparts B&E.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone requirements already met.</p>
<p>1.e State requirement that psychiatric hospitals and residential settings screen</p>	<p><i>Current Status:</i> In accordance with Centers for Medicare & Medicaid Services (CMS) conditions of participation and Joint Commission standards, all hospitals are required to utilize evidence-based suicide assessment tools and must conduct a physical exam within 24 hours of an individual’s admission.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
<p>beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</p>	<p><i>Future Status:</i> The requirement for psychiatric hospitals to screen beneficiaries for co-morbid physical health, SUDs and suicidal ideation and to facilitate access to treatment for those conditions will be added to the MO HealthNet Provider Manuals.</p> <p><i>Summary of Actions Needed:</i> The Hospital Provider Manual will be updated within the first 90 days of demonstration approval.</p>
<p>1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.</p>	<p><i>Current Status:</i> MO HealthNet implements a variety of quality improvement activities related to behavioral health. For example, MCOs are contractually required to set a goal to improve the HEDIS Follow-up After Hospitalization for Mental Illness (30 days) each year by at least two percentage points. Additionally, MCOs are required to participate in a statewide performance improvement project to improve coordination of follow-up care in the community after inpatient behavioral health admissions.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i></p>
<p>SMI/SED. Topic 2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</p>	
<p><i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i></p>	
<p>Improving Care Coordination and Transitions to Community-based Care</p>	

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
<p>2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.</p>	<p><i>Current Status:</i> Hospital Care Transition (HCT) Management: Members identified through the MO HealthNet health plan hospital discharge risk assessment and in need of transition of care assistance, receive onsite HCT management services upon admission to a hospital, at the discretion of the health plan. The services provided under the HCT program must integrate with and enhance the discharge planning and care transition activities required of the hospital by CMS. The efforts of all collaborative work must maintain the patient and caregiver goals as the cornerstone of the discharge planning and transition management process, taking into consideration the provider diagnosis, assessment, prognosis, and provider recommendations for post-acute services.</p> <p>The purpose of HCT management services is to bridge the gap between hospital and community, enhance member experience and satisfaction, improve clinical outcomes, and increase the overall value of services provided by the health plan. HCT Coordinators will collaborate with facility staff responsible for discharge planning to understand the discharge risk assessment, patient and caregiver goals of care, and provider recommendations. The HCT Coordinators assist in the transition of members' care by providing education about in-network care providers, programs they may be eligible for, and community-based resources etc. In doing so, HCT Coordinators abide by facility policies and procedures, and other applicable federal and state laws governing access to patients and secure patient data. This program does not replace the health plan's existing member care management, disease management, or utilization management programs required under the MO HealthNet contract.</p> <p>The goal of the HCT program is to achieve the following outcomes:</p> <ul style="list-style-type: none"> • Ensure patient goals of care and medical necessity serve as the basis for discharge planning and transition of care services; • Align and communicate discharge plans that are developed between the patient, responsible caregiver, hospital, and health plan. The discharge plan must be based on the patient's goals of care, medical necessity, quality, and other data available to the patient. The health plan will be responsible for communicating with the patient and identifying potential in-network care and service providers; • Reduce administrative burden and prevent unnecessary delays in discharge; • Reduce avoidable bed days and readmissions, and coordinate referrals to internal programs and community services; and • Increase communication with primary care providers, specialty providers, and caregivers regarding admission, discharge, and follow-up care.

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>In addition to HCT, community-based providers such as Certified Community Behavioral Health Organizations (CCBHO) and Community Mental Health Center Healthcare Homes (CMHC HCHs) are required to participate in transition planning for their clients. CCBHO policies and procedures must promote and describe its care coordination roles and responsibilities, and whenever possible, the development of formal agreements with community organizations and practitioners that document mutual care coordination roles and responsibilities, with particular attention to emergency room, hospital, and residential treatment admissions and discharges. Members of the CMHC HCH Care Team must provide 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. Members of the Care Team collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing individuals' 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.</p> <p>Medicare conditions of participation (COP) for hospitals require an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. Medicare COP also require that hospitals transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p><i>Future Status:</i> Continue HCT and requirements of CCBHOs and CMHC HCHs. Continued performance improvement initiatives with managed care plans for aftercare following inpatient psychiatric admissions.</p> <p><i>Summary of Actions Needed:</i> N/A – Milestone requirement already met.</p>
<p>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries’ housing situations and coordinate with housing services providers when needed and available.</p>	<p><i>Current Status:</i> The Division of Behavioral Health's (DBH) Recovery Services includes housing, employment, peer services, and coordination of the DBH State Advisory Council. The Director of Recovery Services oversees DBH's housing unit who works to connect homeless individuals who are challenged with behavioral health issues with safe, decent, and affordable housing options that best meet their individual and family needs. In addition to providing education and technical assistance, DBH's housing unit manages 27 U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Permanent Support Housing (PSH) grants that provides rental assistance for individuals who 1) are homeless, 2) have a serious mental illness (SMI), a chronic substance use problem, a severe and chronic developmental disability, or a diagnosis of HIV/AIDS, and 3) meet the "very low" income requirement. Projects for Assistance in Transition from Homelessness (PATH) grants support service delivery to adults (age 18 or older) with SMI, as well as those with co-occurring SUDs, who are homeless or at risk of becoming homeless. Services include community-based outreach; support services such as case management, employment skills training, psychosocial education, and group therapy; and some temporary housing services. Supported community living programs are provided for persons with mental illness who do not have a place to live or who need more structured services while in the community. Persons in these programs receive support through case management and community psychiatric rehabilitation (CPR) programs provided by administrative agents. Recovery Housing accredited by the National Alliance for Recovery Residences (NARR) is an option for individuals with SUDs who choose abstinence-based peer support housing.</p> <p>If an individual is not already linked to a CCBHO/CMHC, the patient is linked to the provider in their service</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

	<p>area and assessed for services. Assessment expectations include gathering information on social environment and living situations. The CMHC/CCBHO links individuals to services prior and throughout the discharge process. CMHCs and CCBHOs in turn engage individuals in community support services that result in positive outcomes including but not limited to the following areas: employment/education, food, housing, social connectedness, decreased criminality/legal involvement, family involvement, decreased psychiatric hospitalizations, and improved physical health.</p>
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p><i>Future Status:</i> Add requirement to assess housing situations and coordinate with housing services providers when needed and available to MO HealthNet Hospital Provider Manual.</p> <p><i>Summary of Actions Needed:</i> The Provider Manuals will be updated within the first 90 days of demonstration approval.</p>
<p>2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge</p>	<p><i>Current Status:</i> Physical Health (PH) and CMHC HCHs are expected to complete follow-up, including medication reconciliation, within 72 hours of discharge from both inpatient hospitalization and emergency departments for any HCH enrollee.</p> <p>Hospitals, in accordance with Medicare COP and accreditation requirements, schedule follow-up appointments for patients with community-based providers prior to discharge.</p> <p><i>Future Status:</i> Continued care transition requirements for CMHC HCH and PCHH. Add requirement to contact beneficiaries within 72 hours post discharge via most effective means possible (e.g., e.g., email, text, or phone call) to MHD Hospital Provider Manual.</p> <p><i>Summary of Actions Needed:</i> The Provider Manual will be updated within the first 90 days of demonstration approval.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<p>2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission</p>	<p><i>Current Status:</i> CCBHOs must provide or contract with another certified entity to provide outreach services to reduce unnecessary utilization of emergency rooms by individuals with SMI, serious emotional disturbance (SED), and/or SUD, including case managers to respond to and engage individuals who present at collaborating emergency rooms, access necessary resources to meet the individual’s basic needs on an emergency basis, and assist individuals in accessing CCBHO services on an emergency, urgent, and/or routine basis, as needed.</p> <p>As part of comprehensive care management, CMHC HCHs identify high-risk individuals and use information obtained during the enrollment process to determine level of participation in care management services.</p> <p>The State of Missouri, through the DMH DBH, was appropriated funds in 2015 through the Strengthening Mental Health Initiative to improve the mental health system by making behavioral health care more accessible to individuals, families, and communities. This was accomplished through implementing Emergency Room Enhancement (ERE), Community Behavioral Health Liaison (CBHL), and Crisis Intervention Team (CIT) programming as well as Mental Health First Aid and NAMI led trainings. These initiatives continue to identify and connect Missourians with a mental health or substance use disorder to services before they reach a crisis point. Outcomes for these initiatives are included in Section 5.</p> <p>Hospitals across the state were experiencing increases in emergency room visits by patients needing care for psychiatric conditions or SUDs; increases in boarding patients awaiting psychiatric care; lack of facilities accepting placement of patients after medical stabilization; increases in short-term detoxification services with little to no transition to outpatient SUD services; and lack of appropriate transportation services.</p> <p>In addition, MO HealthNet managed care contracts require a care management assessment when a member has had three ED visits in a quarter. In addition, some MCOs have implemented a specific ED care management team focusing on frequent ED users.</p>
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Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
	<p>The Missouri Care Coordination Insight Project complements the state’s Provider Health Information Exchange Onboarding Program. The Missouri Care Insight Project was included in a HITECH Implementation Advanced Planning Document Update (IAPD) This IAPD aligns with Missouri’s strategy for advancing Health Information Technology (HIT) and health information exchange (HIE) in Missouri by supporting the design and implementation of an HIE Onboarding Program for Medicaid Eligible Professionals (EPs) and Eligible Hospitals (EHs) aligned with Missouri’s Medicaid Promoting Interoperability Program authorized by the American Recovery and Reinvestment Act of 2009 (ARRA).</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>The Missouri Care Coordination Insights Project was designed to:</p> <ul style="list-style-type: none"> • Maximize the value of state and federal investment in the Promoting Interoperability (PI) Program by leveraging certified electronic health record technology (CEHRT) to promote health care quality and exchange of electronic health information. • Increase utilization and improve interoperability of HIT and HIE among Medicaid providers • Enable Medicaid hospitals to meet CMS Conditions of Participation requiring electronic event notifications of Admission, Discharge, and/or Transfer to the healthcare facility, community provider or practitioner as identified by the patient. • Provide timely, relevant predictive analytic alerting and notification capabilities for specialized populations of interest targeting super-utilization, re-admissions and other high costs/high need beneficiary cohorts. • Enable evaluation of care coordination gaps and effective best practices. • Improve the delivery and quality of electronic HIE to support medical decision-making and care coordination. • Reduce preventable medical errors and avoid duplication of treatment. • Improve data exchange with the State’s public health reporting infrastructure. <p>As of December 2022, 90 of Missouri’s 112 acute care hospitals are connected and transmitting Admission, Discharge, and Transfer (ADT) data, representing over 90% of Missouri discharges.</p> <p>Five acute care hospitals have integrated Hospital Industry Data Institute (HIDI) content directly into their EHR via HL7 Observation Result (ORU). Hospitals that have not integrated have access to content via a website/portal. 394 users currently have access. Users have access to a range of coordination notifications, including for ED Super Utilizers and for a range of conditions prevalent among the SMI population.</p> <p>Two demonstration projects of the system’s capabilities are underway. The first involves 15,000 clients of the Missouri Department of Mental Health (DMH), Division of Developmental Disabilities and the second 3,500 clients of the MO HealthNet Primary Care Health Home operated by Truman Medical Center. The goal of both demonstrations is to improve care coordination for enrolled participants and more effective transitions of care for participants who use hospital services. The real time nature of the ADT alerts enables care managers to intervene quickly if participants use emergency room care unnecessarily.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Future Status: Although the IAPD funding for the Missouri Care Coordination Insights project ended in September 2021, HIDI will continue to build on the platform established and technology enabled through the IAPD project through partnerships with state agencies, Missouri's HIEs, Missouri hospitals, and other health care providers. HIDI is targeting efforts in coordination with the Missouri Hospital Association's Behavioral Health Network to enable use of the platform to HIDI participating Missouri behavioral health providers in 2023. 14 of the 20 behavioral health hospitals in Missouri participate in HIDI. In addition, MHA has the goal to incrementally increase participation in their Point of Care Solutions platform. To date, 93 hospitals voluntarily support the operations for and submit real-time data to HIDI. This represents over 90% of Missouri's discharge volume. Participating ED providers have access to historical behavioral health data to inform better clinical decision-making which can decrease lengths of stay in EDs among individuals with SMI or SED and facilitate care coordination and use of community-based lower levels of care.

Summary of Actions Needed: HIDI will soon be releasing additional ED content, safety and security events and SUD notifications. The goal is to incorporate that content via *Fast Healthcare Interoperability Resource (FHIR)* which would allow for further standardization and EHR integration. *Specific milestones for the remainder of calendar year 2023 include:*

Q2 2023:

- *Two+ Care Coordination Challenges Identified*
- *Introduce Point of Care Solutions to Behavioral Health Providers*
- *Program Introduction to MHA Behavioral Health Network*

Q3 2023

- *Letters of Commitment Received*
- *Promotional Program Sheet Designed and Developed*
- *Onboarded 50% (7 of 14) Providers*
- *Program Progress Update to MHA Behavioral Health Network*
- *Two+ Behavioral Health Alerts Defined that Help Mitigate Identified Challenges*
- *Two+ Behavioral Health Alerts Prototyped and Validated*

Q4 2023

- *Onboarded 75% (11 of 14) Providers*
- *Deployed Two+ Behavioral Alerts in HIDI Advantage Point of Care Solutions Platform*
- *Ongoing Provider Education and Training*
- *Program Progress Update to MHA Behavioral Health Network*

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

- *Promotional Case Study Paper Developed*

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
<p>2.e Other State requirements/policies to improve care coordination and connections to community-based care</p>	<p><i>Current Status:</i> CCBHOs are required to promote collaborative treatment planning by providing the individual’s Primary Care Provider (PCP) with relevant assessment, evaluation, and treatment plan information, seeking all relevant treatment and test results from the PCP, and inviting the PCP to participate in treatment planning.</p> <p>For all individuals in the populations of focus, CCBHO staff must inquire whether they have a PCP, assist individuals who do not have a PCP to acquire one, and establish policies and procedures that promote and describe the coordination of care with each individual’s PCP.</p> <p>For all individuals in the populations of focus, CCBHO staff must document in the individual record the name of each individual’s PCP, indicate they are assisting him or her in acquiring a PCP, or the individual refuses to provide the name of their PCP or accept assistance in acquiring a PCP.</p> <p>CCBHO policies and procedures must also promote and describe its care coordination roles and responsibilities, and whenever possible, the development of formal agreements with community organizations and practitioners that document mutual care coordination roles and responsibilities, with particular attention to emergency room, hospital, and residential treatment admissions and discharges.</p> <p>CCBHO policies and procedures ensure reasonable attempts are made and documented to track admissions and discharges of individuals to and from a variety of settings, and to provide transitions to safe community settings; and follow up with individuals served within 24 hours following hospital discharge.</p> <p><i>Future Status:</i> Continued requirements for CCBHOs and CMHC HCHs.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria are met.</p>
<p>SMI/SED. Topic 3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services</p>	
<p><i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i></p>	
<p>Access to Continuum of Care Including Crisis Stabilization</p>	

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

3.a The state's strategy to conduct annual assessments of the availability of mental	<i>Current Status:</i> Missouri Medicaid contracts with CCBHOs to provide comprehensive behavioral health services within designated service areas. CCBHOs provide services to the following focus populations: Adults with SMI; children and adolescents with SED; children, adolescents, and adults with moderate to severe SUDs; children with
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Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
<p>health providers including psychiatrists, other practitioners, outpatient, community mental health centers (CMHC), intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state’s demonstration application. The content of annual assessments should be reported in the state’s annual demonstration monitoring reports.</p>	<p>behavioral health disorders who are in state custody; and individuals involved with law enforcement, the courts, and hospital emergency rooms who have been identified as in need of community behavioral health services. CCBHO coverage spans all 114 counties in the State of Missouri.</p> <p>Core services for the DBH’s CPR Program (28 contracts), targeted case management (19 contracts), and supported community living (147 contracts) are provided in a community-based and consumer-centered manner. Services provided in DBH’s CPR Program for adults (28 contracts) and youth (23 contracts) are Medicaid reimbursable. The types of services provided in the CPR program include evaluation, crisis intervention, community support, medication management, and psychosocial rehabilitation. Outpatient community-based services provide the least-restrictive environment for treatment. Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services. Moderate-term placement in residential care provides services to individuals with non-acute conditions who cannot be served in their own homes. Intensive CPR programs include Enhanced Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Assertive Community Treatment for Transition Age Youth (ACT-TAY) and Integrated Treatment for Co-Occurring Disorders (ITCD). Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be a danger to themselves or others because of their mental disorder. DBH also oversees Community Mental Health Treatment (CMHT) and Offenders with Serious Mental Illness (OSMI) (29 contracts) for Department of Corrections' (DOC) offenders under community supervision and who have mental illness.</p> <p>Target populations for mental health treatment include:</p> <ul style="list-style-type: none"> • Forensic clients pursuant to Chapter 552 RSMo; • Adults, children, and youth with SMI being discharged from DBH operated inpatient facilities, being transitioned from DBH-operated or contracted residential settings, being transitioned from DBH alternatives to inpatient hospitalization; • Adults, children, and youth at risk of homelessness; • Children and youth referred through the Custody Diversion Protocol; • Individuals with a clinical or personality disorder, other than a principal diagnosis of substance use or ICF/IID, who also qualify as an adult with severe disabling SMI or children and youth with

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

	SED, as defined by the Department.
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>DBH supports ACT, a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and/or 4) are homeless. ACT provides highly individualized, intensive services directly to consumers in their homes and communities as opposed to a psychiatric unit. ACT team members are trained in the areas of psychiatry, social work, nursing, substance use, and vocational rehabilitation. DBH contracts with nine agencies to provide ACT including seven contracts for adult ACT and seven contracts for supports ACT-TAY.</p> <p><i>Future Status:</i> MO HealthNet will partner with DMH to continue to monitor provider network capacity on an annual basis.</p> <p><i>Summary of Actions Needed:</i> MO HealthNet will submit an updated Provider Network Template annually and conduct outreach in areas where gaps in services are noted.</p>
3.b Financing plan	<p><i>Current Status:</i> Please refer to Financing Plan below.</p> <p><i>Future Status:</i> Please refer to Financing Plan below.</p> <p><i>Summary of Actions Needed:</i> Please refer to Financing Plan below.</p>
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	<p><i>Current Status:</i> The Missouri Hospital Association, through a subcontract with the DHSS, maintains a statewide license for a reporting tool platform EMResource. EMResource was initially adopted in Missouri as a tool to monitor and coordinate hospital diversion status between health care organizations, emergency medical services and dispatch centers. With the implementation of the federal Hospital Preparedness Program in 2002, EMResource was adopted statewide as the platform to collect and disseminate data and information, having the functionality to include bed availability. As Missouri’s health care preparedness program has developed, the application has expanded in functionality and continues to evolve as statewide health care coordination needs are identified. The system has the capability of tracking inpatient psychiatric bed availability as well. Hospitals utilize EMResource as well as other platforms for tracking and communicating bed availability with other hospitals and community providers. Communicating bed availability is a constantly changing and complex process. DMH, through a subcontract with the Missouri Behavioral Health Council, is currently implementing MOConnect, which is a HIPAA-compliant, electronic platform that will identify, unify, and track all behavioral health inpatient and outpatient resources. MOConnect includes a crisis management module that expedites access for those in crisis, tracks mobile crisis staff to help ensure staff safety, and coordinates crisis response.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<p><i>Future Status:</i> The Missouri Hospital Association will evaluate how to help hospitals participate in the new 988 system, including MOConnect, to provide data to inform systems that promote care integration and reduce redundant workflows.</p>
<p><i>Summary of Actions Needed:</i> Monitor, support, and provide technical assistance for MOConnect implementation. Continue to promote the use of MOConnect at joint meetings with Missouri Hospital Association and any interactions with hospitals.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
<p>3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay</p>	<p><i>Current Status:</i> Per certification requirements, all behavioral health providers must provide a full biopsychosocial assessment that includes domains for level of care determination. DMH approves all assessments utilized by providers who do not have CARF, Joint Commission, or Council on Accreditation (COA) accreditation. Otherwise, accreditation by one of these entities provides deemed status for meeting this requirement.</p> <p>The MO HealthNet Division Managed Care contract requires contracted managed care organizations to use the Level of Care Utilization System (LOCUS) for members over age 18, the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) for members aged 6-18, and the Early Childhood Service Intensity Instrument (ECSII) for members aged 0-5 for psychiatric inpatient hospital and PRTF admissions. In the MO HealthNet fee-for-service delivery system, the contracted professional review organization uses the Milliman Care Guidelines (MCG) to determine appropriate level of care and length of stay for psychiatric inpatient hospital and PRTF admissions.</p> <p>Additionally, all youth under the care of the DSS Children’s Division receive an Initial Family Assessment within four weeks of case opening to prepare for the development of the Social Service Plan to be finalized by the 30th day following the case opening date.</p> <p><i>Future Status:</i> Continue state approval of assessments utilized for level of care determination.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone are met.</p>
<p>3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization</p>	<p><i>Current Status:</i> CCBHOs must ensure individuals have access to crisis response services twenty-four (24) hours per day, seven (7) days per week. If CCBHO staff determine that a face-to-face intervention is required based on the presentation of an individual, then that face-to-face intervention must occur within three (3) hours; and CCBHO staff must monitor and have the capacity to report the length of time from each individual’s initial crisis contact to the face- to-face intervention and take steps to improve performance, as necessary. CCBHO coverage spans all 114 counties in the State of Missouri.</p> <p>In addition, DBH funds eleven regional Access Crisis Intervention Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention, including mobile response teams, and referral for persons experiencing a behavioral health crisis.</p> <p><i>Future Status:</i> Continue with current CCBHO requirements.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone met.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
<i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i>	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported	<i>Current Status:</i> MO HealthNet and DBH recognize the tremendous therapeutic value of employment for working-age individuals with behavioral health disorders and is committed to enhancing employment options for those individuals. Supported Employment is an evidence-based practice that provides individualized services and supports to an individual to find competitive employment to promote stable employment. DBH works with the Department of Elementary and Secondary Education, Vocational Rehabilitation (VR) who provides job counseling, job-seeking

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
<p>employment and supported programs</p>	<p>skills, job placement, and vocational training to provide integrated services in the community behavioral health programs. The DBH provides ongoing benefits planning training for community provider staff and a web-based tool "Disability Benefits 101." DBH has 31 community behavioral health locations designated as VR funded Community Rehabilitation Programs to provide evidence based supportive employment services. DBH provides support services for mental health clients not currently eligible or ready for services from VR. MO HealthNet and DBH staff developed guidance documents on appropriate community support interventions reimbursable under CPR and CSTAR treatment programs for consumers pursuing employment.</p> <p>DBH's School-based Prevention, Intervention, and Resources Initiative (SPIRIT) program implements school-based curricula of proven effectiveness for delaying the onset of substance use and decreasing the use of substances, improves overall school performance, and reduces incidents of violence among children in kindergarten through 12th grade. To achieve these goals, prevention agencies are paired with school districts to provide technical assistance in implementing evidence-based substance use prevention programming. SPIRIT currently operates in four sites serving twelve school districts across the state. These school districts serve high-risk populations characterized by: 1) high percentage of students qualifying for reduced/free lunches, 2) low standardized test scores, 3) high prevalence of substance use, 4) low graduation rates, and/or 5) high rate of juvenile justice referrals. Screening and referral services are provided as needed. In FY 2020, 9,834 students participated in the SPIRIT program. DBH contracts with the Missouri Institute of Mental Health to conduct an annual evaluation of the SPIRIT program.</p> <p>Additionally, the Disease Management (DM) Projects: DM 3700 and SUD DM are a joint collaboration between MHD and DMH. The DM Projects provide health care coordination for high-cost, high-risk Medicaid recipients who are diagnosed with a SMI or SUD and are not currently receiving behavioral health services from the DBH. Once an individual is identified, he/she is placed on a DM Cohort. A DM Cohort is a list of Medicaid-eligible individuals to be outreached by DBH contracted providers. The goal is to locate and enroll the individuals identified in behavioral health services to improve health outcomes and reduce related medical costs.</p> <p>Missouri also has 31 Youth Behavioral Health Liaisons (YBHLs) who assist law enforcement, schools, juvenile courts, and children's division in addressing behavioral health issues of youth and connecting them to services, if appropriate.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

	<p>The MO HealthNet Division collaborates with the Missouri Department of Elementary and Secondary Education along with Missouri’s public school districts and providers in the promotion and implementation of medical care through Medicaid in Missouri’s schools. MO HealthNet reimburses school districts for administrative activities performed in promoting access to health care for students in the school system, preventing costly or long term health care problems for at risk students, and coordinating students’ health care needs with other providers. These administrative activities include behavioral health care and services. MO HealthNet also covers an array of direct care services, including behavioral health services, when provided in a school setting. School based behavioral health services include diagnostic assessment, psychological testing, individual therapy, family therapy, group therapy and applied behavior analysis services for children with autism spectrum disorder.</p>
	<p><i>Future Status:</i> Continue with current employment programs.</p>
	<p><i>Summary of Actions Needed:</i> N/A Milestone criteria met</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<p>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</p>	<p><i>Current Status:</i> Missouri's CMHC HCHs are designed to integrate care for chronic health conditions into the CMHC setting. The CMHC HCHs assist individuals in accessing needed health services and supports, in learning to manage their health conditions, and in improving individuals' general health by monitoring health conditions, healthcare needs and intervening when health conditions are not properly controlled or managed. HCHs promote and encourage wellness, healthy lifestyles and preventative care, educate and teach persons how to better manage their chronic health conditions, educate agency staff about chronic health conditions and how to manage them, and encourage a population health approach to help improve chronic health conditions for persons served by CMHCs. To support this initiative, see Disease Management in the above section.</p> <p>Individuals covered by MO HealthNet are eligible to be served by a CMHC HCH if they have:</p> <ul style="list-style-type: none">• A SMI (including children and adults receiving psychiatric rehabilitation services under the Medicaid Rehabilitation Option); or• A mental health condition and a SUD, or<ul style="list-style-type: none">A mental health condition or a SUD, and one of the following chronic conditions or risk factors<ul style="list-style-type: none">○ Diabetes○ Asthma/COPD○ Cardiovascular Disease○ Developmental Disability○ Overweight (BM >25)○ Use Tobacco <p>Of twenty-one CCBHCs in the state, are also FQHCs. They include Arthur Center, Compass Health Network, COMTREA, Places for People, Preferred Family Healthcare, Swope Mental Health.</p> <p>The DMH also has two Behavioral Health and FQHC Partnership Initiatives. The SUD Provider and FQHC Partnership and the CMHC/CCBHO and FQHC Partnerships. These partnerships support collaboration and integration of behavioral health and primary care services and provide behavioral health services to individuals with previously unrecognized and/or untreated behavioral health disorders.</p>
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>The PCHH initiative offers comprehensive care management services for Medicaid participants who have two or more chronic health conditions including asthma/COPD, developmental disabilities, diabetes, heart disease, obesity and tobacco use). The program also emphasizes the integration of primary care and behavioral health care in order to achieve improved health outcomes. PCHH clinics offer routine, universal screening for depression and substance use disorders for individuals served in order to improve early identification. The MO HealthNet PCHH initiative currently has more than 40 participating organizations with over 160 clinic sites.</p> <p>MHD’s Healthy Children and Youth (HCY) program works to equip MO HealthNet providers with the necessary tools and knowledge to carry out preventive services appropriate to the American Academy of Pediatrics’ standard for pediatric preventive health care, Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.</p> <p>Every applicant under age 21 (or his or her legal guardian) is informed of the HCY Program by the Family Support Division income-maintenance Eligibility Specialists at the initial application for assistance. The participant is reminded of the HCY Program at each annual redetermination review.</p> <p>The goal of MHD is to have a health care home for each child—that is, to have a primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child’s health needs. The health care home should follow the screening periodicity schedule, perform interperiodic screens when medically necessary, and coordinate the child’s specialty needs, including behavioral health.</p> <p>The MHD encourages providers to use age appropriate, validated screening tools rather than less rigorous methods to screen for developmental and mental/behavioral health conditions. The Screening Technical Assistance & Resource (STAR) Center of the AAP provides a list of validated screening tools for children 0 to 5 years that address the following areas: • Development • Autism • Social-emotional development • Maternal depression • Social determinants of health.</p> <p>Maternal depression is a serious and widespread condition that not only affects the mother, but may have a lasting, detrimental impact on the child’s health. MHD covers procedure code 96161, which may be billed under the child’s DCN, for administering a maternal depression screening tool during a well-child visit.</p> <p>MHD’s managed care contract requires each contracted managed care organization to conduct outreach and education of members eligible for HCY and to ensure that HCY well child visits are conducted on all eligible members under age 21 to identify health and developmental problems. These screenings are to include a comprehensive health and developmental history including assessment of both physical and behavioral health</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

	<p>developments.</p> <p>The EBP for FEP is the Coordinated Specialty Care (CSC) model. Currently components of the CSC model are provided across the state. Certified Behavioral Health Organizations and Community Mental Health Centers (CCBHOs/CMHCs) across the state have providers who have been trained to provide certain components of CSC such as Supported Education and Employment (SEE) and Individual Resiliency Treatment (IRT). Additionally, DMH funds agencies interested in bringing up full teams to specialize in providing team-based CSC services.</p> <p>Early Psychosis Care (EPC) Center is a partnership between DMH and MIMH that provides statewide psychosis related resources, trainings, presentations, and conferences for providers who are interested in learning best practices for supporting individuals and families experiencing first episode psychosis. EPC also provides resources and support for individuals and families who are impacted by psychosis. The EPC Center training and support is available for all stakeholders which includes primary care providers, pediatricians, school personnel, law enforcement, psychiatrists, and community behavioral health providers.</p> <p>Psychosis related trainings provided by the EPC Center are available to all community stakeholders. Trainings more specifically designed to train providers on how to provide CSC services are for team members employed by CCBHOs/CMHCs across the state. Through the partnership with DMH and MIMH, the EPC Center makes trainings and presentations accessible across the state. CSC model and related services are only provided by CCBHOs and CMHCS who have providers who have been trained in providing CSC components and related services.</p>
	<p><i>Future Status:</i> Continue HCY program. The PCHH program expands yearly by natural growth as patients are identified, and this growth has accelerated with Medicaid expansion. The state currently anticipates growth at the rate of 2,500 additional participants annually. Additionally, organizations that have successful performance measure outcomes and have required staffing levels needed for the program, can apply to expand to other clinic locations in their healthcare organization. For example, Missouri gained 8 new PCHH locations statewide in last quarter of 2022.</p> <p>Additional training and education on FEP and related practices will increase provider capacity for providing the CSC model, adopting additional EBP like Cognitive Behavioral Therapy for psychosis (CBTp). Along with other related resources and standardized tools, the state will identify and provide training and consultation for CCBHOs/CMCHs on administering a standardized assessment for psychosis. The intent is to shorten the duration of untreated psychosis and support improved clinical and life outcomes for individuals experiencing</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<p>psychosis.</p> <p>MHD is reviewing January 2023 CMS guidance on interprofessional consultation to identify opportunities to improve timely access to specialty care, including behavioral health services. The collaborative care model may be appropriate for coverage in Missouri, but implementation may be complex due to Missouri’s PCHH and CMHC Health Home programs.</p>
<p><i>Summary of Actions Needed:</i> Add approximately 2,500 participants annually to PCHH program through natural growth of the program..</p> <p>Training on the identified standardized screener and assessment will be available for interested providers beginning in June 2023. The state will continue to work with CCBHO, CMHCs, other behavioral health providers, and additional stakeholders to identify necessary training and education on FEP and related evidence based practices. In addition to providing outreach, education, trainings, and information on best practices to support FEP, the state will work to engage people with lived experience so that their voice can provide first-hand experience for providers working to improve FEP and related services.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

<p>4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI</p>	<p><i>Current Status</i></p> <p>Assertive Community Treatment for Transitional Age Youth (ACT/TAY) is a transdisciplinary treatment program serving individuals age 16-25 diagnosed with severe mental illness. They may also have co-occurring substance use or personality disorders. A team providing a full array of evidence-based services and best practices is the key element of successful treatment in assisting individuals to regain and maintain healthy role functioning and quality of life. ACT is provided statewide by CMHCs who participate. There are 25 teams within 9 agencies serving individuals, 9 serve adults, 12 serve TAY, and 4 specialty teams serve parents/children at risk of loss of custody to young child. One team serves both TAY and adult. As of April 1, 2023, 1,000 individuals are being served.</p> <p>DBH also funds other selective prevention services and early intervention activities for designated children, youth, and families. These services involve structured programming and/or a variety of activities including informational sessions and training. Target groups include youth experiencing academic failure and low-income youth and families. Programs are located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the “Bootheel.” DBH contracts with the Missouri Alliance of Boys and Girls Club sites throughout the state for implementation of SMART Moves (Skills Mastery and Resistance Training) and MethSMART. In Fiscal Year 2020, 2,960 high risk youth were served in prevention programs funded through DBH. DBH contracts with DeafLEAD for the provision of prevention services for deaf and hard of hearing youth. DeafLEAD conducts the annual Teen Institute for the Deaf attended by approximately 30 youth ages 12 to 17.</p> <p>Peer support services are available to individuals in behavioral health treatment to aid in the navigation of Medicaid programs and establish linkages to other community resources. Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with a mental health condition, SUD, or both. Through shared understanding, respect, and mutual empowerment, peer support specialists help people become and stay engaged in the recovery process and reduce the likelihood of a return to mental health symptoms or substance use. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of individuals seeking a successful, sustained recovery process. Missouri has over 950 active Certified Peer Specialists who work at CMHCs, Substance Use Treatment Programs, state-operated hospitals, and community recovery programs. DBH funds, through competitive bid, four consumer- operated drop-in centers that emphasize self-help for individuals with mental illness and four recovery community centers for individuals with substance use problems. Family Support Provider is a peer-to-peer service that</p>
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Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

	<p>provides support to parents/caregivers who have children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. A new Youth Peer Specialist credential has added that focuses on working with transition aged youth.</p> <p>Behavioral Health Crisis Centers (BHCCs) are units that provide crisis services for individuals in severe distress with up to twenty-three (23) consecutive hours of supervised care to assist with deescalating the severity of their crisis. As of February 2023, fourteen BHCCs are operational. Eighteen centers will be open by April 2023, and four out of the eighteen BHCCs will serve youth. At least three additional agencies are planning to add youth services to their BHCC.</p>
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p data-bbox="552 683 1354 716"><i>Future Status:</i> Continue current community-based programing.</p> <p data-bbox="552 743 1942 873"><i>Summary of Actions Needed:</i> As of April 2023, eighteen BHCCs are operational and four out of the eighteen BHCCs will serve youth. At least three additional agencies (Burrell Behavioral Health, Compass Health Network, and Preferred Family Healthcare) have advised they are planning to add youth services to their BHCC but no timelines have been provided.</p>
<p data-bbox="132 959 485 1138">4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people</p>	<p data-bbox="552 959 751 987"><i>Current Status:</i></p> <p data-bbox="552 1365 737 1393"><i>Future Status:</i></p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<i>Summary of Actions Needed: N/A</i>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	<i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state’s assessment of current availability of mental health services included in the state’s application.</i>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

<p>F.a Increase availability of non- hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.</p>	<p><i>Current Status:</i> Access Crisis Intervention (ACI) is part of the Missouri Model of Crisis Intervention, which also includes the 988 Suicide & Crisis Lifeline, Emergency Room Enhancement (ERE) regional programs, Community Behavioral Health Liaisons (CBHLs), Youth Behavioral Health Liaisons (YBHLs), Crisis Intervention Teams (CIT), and Behavioral Health Crisis Centers (BHCCs).</p> <p>The purpose of ACI is to assess and provide assistance (or appropriate intervention) for an acute behavioral health crisis, link individuals to services, resources and supports, and maintain individuals in the least restrictive setting and in the community when clinically feasible. ACI provides a timely response, intervention, and referral for persons experiencing a behavioral health crisis, 24 hours per day and 7 days per week. Components of ACI include:</p> <ul style="list-style-type: none"> • 24-hour phone response/consultation • 24-hour mobile response: Face to face evaluation • Arranging next day appointments • Technical assistance to referral sources as to how to complete an involuntary commitment <p>Twenty-four-hour phone response and mobile response is provided through the DBH’s Administrative Agents (AA). The AAs either provides these services directly or through contract with a crisis services provider. Individuals contacting the 24-hour crisis hotline in their area will receive a screening and risk assessment. The crisis worker will attempt to resolve the crisis with the individual on the phone and make any needed referrals to services or social supports. If the crisis cannot be resolved over the phone, the individual will be connected with a mobile crisis mental health professional who can meet with the individual in the community for additional assessment. ACI teams work closely with CIT law enforcement officers in their service area(s).</p> <p>MCOs are required to ensure access to crisis intervention/access services, including but not limited to (1) intake, evaluation, and referral services, including services that are alternatives to out of the home placements, and (2) mobile crisis teams for on-site interventions. MCOs must also operate a 24/7 behavioral health crisis line that is staffed by Qualified Behavioral Healthcare Professionals (QBHP).</p> <p>CCBHOs must ensure individuals have access to crisis response services twenty-four (24) hours per day, seven (7) days per week. If CCBHO staff determine that a face-to-face intervention is required based on the presentation of an individual, then that face-to-face intervention must occur within three (3) hours; and CCBHO staff</p>
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>must monitor and have the capacity to report the length of time from each individual’s initial crisis contact to the face- to-face intervention and take steps to improve performance, as necessary.</p> <p>CCBHO coverage spans all 114 counties in the State of Missouri.</p> <p>Missouri was a recipient of the CMS Mobile Crisis Planning Grant to expand on existing crisis services and enhance mobile crisis response services across the state. Missouri received a No Cost Extension to continue grant activities through September 2023. During the initial planning grant project period, Missouri conducted a Medicaid gap analysis, conducted a statewide crisis needs assessment, and developed a work plan for moving forward with enhancing mobile crisis services. Remaining activities include developing statewide standards/regulations and creating and disseminating a comprehensive mobile crisis response training curriculum. We anticipate completing all grant activities in the upcoming months of the No Cost Extension period.</p> <p>The 988 Suicide & Crisis Lifeline is a national three-digit number for anyone experiencing a mental health, suicide, or substance use crisis. Missouri has six 988 crisis call centers and one text and chat center available 24/7 to respond to all calls, texts, and chats for the state. Local crisis specialists are available to offer free and confidential support by working with the individual in crisis or a third-party caller to address their immediate needs, offering support, and connecting them to local services and resources if needed. Approximately 90% of all contacts can be addressed over the phone. For any individuals needing a higher level of care, 988 crisis specialists may dispatch mobile crisis response services.</p> <p>The Emergency Room Enhancement (ERE) diversion program reduces barriers and increases behavioral healthcare access for individuals who use the emergency room seeking treatment for substance use and/or mental health disorders. ERE provides wrap-around care, care coordination, and connects individuals to housing resources. ERE services are available in 111 of the 114 Missouri counties. In FY21 there were 12,997 individuals engaged in the ERE program.</p> <p>Community Behavioral Health Liaisons (CBHLs) assist law enforcement and the courts in addressing the behavioral health issues of individuals who come to the attention of the justice system. The CBHL model saves valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

and improves outcomes for individuals with behavioral health issues by connecting them to services, if appropriate. There are currently 81 CBHL positions who have assigned service areas, providing statewide coverage in Missouri. In FY22, CBHLs received 22,438 referrals from law enforcement, courts, and jails. Of those referrals, 11,600 individuals were referred to behavioral health services by CBHLs.

Similar to CBHLs, there are 31 Youth Behavioral Health Liaisons (YBHLs) who assist law enforcement, schools, juvenile courts, and children’s division in addressing behavioral health issues of youth and connecting them to services, if appropriate. YBHL positions provide statewide coverage and were funded in FY22; therefore, data is not yet available.

The Missouri Crisis Intervention Team (CIT) program is a partnership with law enforcement and other first responders, behavioral health providers, hospitals, courts, individuals with lived experience, and community partners. The goal of CIT is to promote more effective law enforcement interactions with individuals in crisis, connect individuals in crisis with available resources, improve safety of the first responder and the individual in crisis, reduce stigma, and expand and sustain CIT across the state.

Mental health courts are a problem-solving court designed to engage defendants with mental health disorders in treatment in lieu of incarceration. Mental health courts teams typically involve judges, prosecutors, defense attorneys, treatment providers and law enforcement. Missouri currently has mental health courts operating in Columbia, Independence, Springfield, Kansas City, Carthage, and St. Louis.

Missouri has 18 operational Behavioral Health Crisis Centers (BHCCs). BHCCs provide crisis services for individuals in severe distress with up to twenty-three consecutive hours of supervised care to assist with deescalating the severity of their crisis by triaging, assessing, and providing immediate resources. BHCCs provide a ‘no wrong door’ access model that includes walk-ins and referrals from law enforcement, first responders, hospitals, family members, and mobile crisis response. BHCCs provide options beyond the ER or jail with potential cost savings due to redirecting the individuals to services more appropriately matched for their level of need and preventing unnecessary or overuse of other community resources. BHCCs are operational in the following 18 locations: Bridgeton, Springfield, Columbia, Jefferson City, Wentzville, Rolla, Raymore, Hannibal, Joplin, West Plains, St. Louis, Kirksville, Kansas City, Raytown, Independence, Cape Girardeau, Poplar Bluff, and St. Joseph.

Justice Reinvestment Initiative (JRI) Crisis Response Work Group was established in January 2021, and focuses on supporting diversion from traditional criminal justice case processing for nonviolent offenders with

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

	<p>behavioral health conditions (mental health disorders, SUDs, or both) that are significant factors in bringing them into contact with the justice system. The goal is to promote fiscal, public safety, social and health benefits for participants, communities, justice systems, health systems, and taxpayers, including:</p> <ul style="list-style-type: none">▪ Expansion of law enforcement diversion:<ul style="list-style-type: none">○ Includes promotion and education of crisis response initiatives.<ul style="list-style-type: none">▪ 24 Lunch & Learn sessions highlighting crisis response initiatives in Missouri were recorded from May 2021 through January 2022;▪ Funding was awarded to the Missouri Behavioral Health Council April 2022 by the Missouri Foundation for Health to conduct Sequential Intercept Model (SIM) mapping sessions in each county over the next 3 years.▪ Expansion of prosecution and court diversion<ul style="list-style-type: none">○ Includes promotion of mental health courts, education on pre-plea treatment courts, and education on prosecution diversion programs.<ul style="list-style-type: none">▪ A request was submitted to the Treatment Courts Coordinating Commission to include mental health courts statutorily and in considerations for funding;▪ Lunch & Learn sessions were conducted on court diversion programs and prosecution diversion programs;▪ Presentations were conducted at annual conferences for the MO Association of Treatment Court Professionals (MATCP) conference and MO Association of Prosecuting Attorneys (MAPA).▪ Expansion of juvenile diversion:<ul style="list-style-type: none">○ Includes working with schools, juvenile offices, and behavioral health treatment providers on diversion programs<ul style="list-style-type: none">▪ 31 Youth Behavioral Health Liaisons positions were added in FY22;▪ Reducing the School to Prison Pipeline video series was conducted to promote juvenile diversion;▪ Parent training for resource knowledge and access to services was provided;▪ Training for school personnel on Behavioral Risk Assessments was provided.▪ Expansion of law enforcement assistance programs:<ul style="list-style-type: none">○ Includes educating first responders on the First Responder Provider Network, expansion of Post Critical Incident Seminars (PCIS), and expansion of first responder peer support programs<ul style="list-style-type: none">▪ 50 clinicians are represented on the First Responder Provider Network;▪ 7 PCIS events have been conducted in a collaboration with the MO State Highway Patrol and DMH;
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Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

- DOC has replicated the PCIS model for DOC staff and has conducted 2 PCIS events;
- Peer support training for law enforcement has been conducted statewide.

Future Status: Continued operation of current community-based programming.

Missouri received a No Cost Extension for the CMS Mobile Crisis Planning Grant. Remaining activities include developing statewide standards/regulations and creating and disseminating a comprehensive mobile crisis response training curriculum. All work will conclude prior to the end of the No Cost Extension grant period in September 2023.

As of April 2023, eighteen BHCCs are operational and four out of the eighteen BHCCs serve youth. At least three additional agencies have advised they are planning to add youth services to their BHCC but no timelines have been provided.

Supported community living (147 contracts) are provided in a community-based and consumer-centered

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

manner.

Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services.

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p><i>Summary of Actions Needed:</i> Implementation of remaining activities associated with CMS Mobile Crisis Planning Grant. Missouri received a No Cost Extension for the CMS Mobile Crisis Planning Grant. Remaining activities include developing statewide standards/regulations and creating and disseminating a comprehensive mobile crisis response training curriculum. All work will conclude prior to the end of the No Cost Extension grant period in September 2023.</p>
<p>F.b Increase availability of on- going community-based services, e.g., outpatient, CMHCs, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.</p>	<p><i>Current Status:</i></p> <p>MO HealthNet's Primary Care Health Home (PCHH) initiative provides intensive care coordination and integrated care management that addresses social determinants of health for a medically complex population for over 50,000 participants annually or an estimated 36,000 per month. MO HealthNet requires each health center to implement the Patient Centered Medical Home (PCMH) model as a means to achieve accessible, high quality primary care that improves the quality of clinician work life and patient outcomes. The MO HealthNet PCHH initiative currently has 43 participating organizations with 208 health center locations that integrate behavioral health consultants into their primary care settings.</p> <p>Missouri Medicaid contracts with CCBHOs to provide comprehensive behavioral health services within designated service areas to provide services for adults with SMI and children and adolescents with SED. CCBHOs are available statewide, with all 114 of the states counties currently covered by a CCBHO.</p> <p>CCBHOs must demonstrate a continued commitment to adopting new evidence-based, best, and promising practices, such as:</p> <ul style="list-style-type: none"> • ACT; • Supported employment; • Supported housing; • Parent-Child Interaction Therapy; • Dialectical Behavior Therapy; • Multi-systemic Therapy; <p>CCBHOs must also adopt with fidelity, a model for providing integrated treatment for co-occurring disorders approved by the Department. ACT is available statewide. There are 25 teams within 9 agencies serving individuals, 9 serve adults, 12 serve TAY, and 4 specialty teams serve parents/children at risk of loss of</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

	<p>custody to young child. One team serves both TAY and adult. As of April 1, 2023, 1,000 individuals are being served.</p> <p>In order to make services more accessible, particularly in rural areas, MHD updated the telemedicine regulation 13 CSR 70-3.330 effective 7/30/2022 to broaden telemedicine coverage and flexibility to include any enrolled provider. Services may be delivered via audio only as well as audio/video modalities.</p> <p>Effective July 1, 2022, MHD implemented a significant provider reimbursement rate increase, raising rates for behavioral health providers to 100% of the Medicare fee schedule. MHD covers behavioral health providers from all disciplines that are licensed in MO (psychologist, psychiatrist, social worker, professional counselor, marital and family therapist, behavior analyst and assistant behavior analyst. MHD covers provisional licensees for each of these disciplines in order to support workforce growth. The intent of the rate increase is to attract additional providers to the network to provide community-based outpatient psychotherapy and counseling services.</p> <p><i>Future Status:</i> The PCHH program expands yearly by natural growth as patients are identified, and this growth has accelerated with Medicaid expansion. The state currently anticipates growth at the rate of 2,500 additional participants annually. Additionally, organizations that have successful performance measure outcomes and have required staffing levels needed for the program, can apply to expand to other clinic locations in their healthcare organization. For example, Missouri gained 8 new PCHH locations statewide in last quarter of 2022.</p> <p>MHD is reviewing January 2023 CMS guidance on interprofessional consultation to identify opportunities to improve timely access to specialty care, including behavioral health services. The collaborative care model may be appropriate for coverage in Missouri, but implementation may be complex due to Missouri’s PCHH and CMHC Health Home programs.</p> <p>In 2022, the CMHC Health Homes worked weekly to identify qualified participants and grew the DMH CMHC Health Care Home program by adding 1,379 participants.</p> <p>Missouri’s 18 BHCCs provide regional crisis services accessible for individuals in severe distress with up to twenty-three consecutive hours of supervised care to assist with deescalating the severity of their crisis by triaging, assessing, and providing immediate resources.</p>
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Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

In 2022, MCR services were expanded to establish a statewide, equitable crisis system of care that is community-based and addresses the needs of individuals experiencing a mental health, suicide, or substance use crisis. The MCR services have been established to ensure access is available to individuals experiencing a behavioral health crisis in the community, whether that’s in their home, workplace, or any other community-based location. Responses are based on a “no wrong door” approach and provided in a timely manner.

The state anticipates FEP as an area for increased interest and attention as additional trainings on FEP evidence based practices are provided for all CCBHOs/CMHCs, standards of practice for providing early psychosis care are rolled out, and the new requirement for collecting data on the number of individuals served who are experiencing FEP is in place. This work will support integration of EBP for FEP practices across the state.

Missouri DSS has partnered with the Missouri Telehealth Network to implement the Rural Citizen’s Access to Telehealth project. The purpose of this project is to increase the use of telehealth in rural areas with a focus on primary care and behavioral health services delivered to MHD participants. This project will provide funding and technical assistance to rural providers (99 of 114 Missouri counties are defined as rural) to implement telehealth (e.g., equipment, software, training in best practices).

Summary of Actions Needed:

For CMHC Health Homes, there is a total of almost 25,000 participants with a future budgeted goal of 31,000 during state fiscal year 2024.

Implement planning, monitoring, and quality improvement projects in collaboration with MCR providers, BHCC providers, and other stakeholders.

The state anticipates increasing the number of YBHLS to ensure there is enough support provided in all of the communities across the state. Expanding this program will be based on the areas indicating the most need and the outcomes of the current program. The length of the response time and the results of the YBHL service are two examples of data points being collected.

Beginning January 2023 – Based on CHCS recommendations, \$5 million in grants will be disbursed by MO Department of Social Services to assist providers in transitioning business models and programs from residential-based to community-based settings.

DSS, MHD, and Missouri Telehealth Network (MTN) will continue to fund telehealth projects for enrolled MHD providers in rural counties. Providers complete a survey to assess readiness, willingness, use, barriers, needs, and interests, meet with MTN representatives to discuss their project and create a project plan, budget,

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

	and timeline to apply for funding.
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	<p><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”¹ The HIT Plan should also describe, among other items, the:</i></p> <ul style="list-style-type: none"> <i>• Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i> <i>• Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i> <p><i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i></p>
Statements of Assurance	

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<p>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period</p>	<p>Missouri has a high level of electronic health record (EHR) adoption among behavioral health providers and continues to implement initiatives to encourage further adoption of HIE needed to achieve the goals of the Demonstration. The State has four Health Information Networks (HINs). In February 2020, the Missouri DSS, MHD received funding from CMS to develop and implement a HIE Onboarding Program. This HIE Onboarding Program provides federal funding to cover some of the onboarding costs for healthcare service providers to participate in HIE with Missouri HINs. The onboarding funding covers some costs related to first-year HIN subscription fees and interface development. The program's goal is to provide significant help to 40 MO HealthNet enrolled hospitals and 1,000 providers currently using EHRs become fully connected to an HIN by September 2021.</p> <p>Through the HIE Onboarding Program, the provider and the HIN are required to implement the following at a minimum:</p> <ul style="list-style-type: none">• Bi-directional query-based exchange between the provider EHR system and the chosen HIN.• An ADT interface, with the requirement for the provider to send ADT data to the chosen HIN.• Providers may request assistance with two additional items:<ul style="list-style-type: none">○ Assistance with public health reporting, including immunizations, syndromic surveillance, electronic case reporting, and registry reporting.○ Ability to receive care management alerts from the chosen HIN. <p>MO HealthNet shares Medicaid claims data with the HINs, making it available to healthcare providers for viewing and consumption into their EHRs to improve care coordination among providers, MO HealthNet and state agencies, including the Missouri DHSS, and the Missouri DMH. Additionally, the State has leveraged HIT to advance care coordination and improve clinical outcomes through its CMHC HCHs, PCHHs and CCBHCs. MCOs are also contractually required to implement HIT initiatives that support behavioral and physical health integration; for example, they are required to have one integrated information system platform for care management and utilization</p>
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>management that provides both physical and behavioral health information, including but not limited to claims data, notes and prior authorizations.</p> <p>Since the State’s last State Medicaid Health Information Technology Plan (SMHP) update, members of the Missouri Medicaid Enterprise (MME) including MO HealthNet, DMH and DHSS have engaged in the following:</p> <ul style="list-style-type: none"> • Development of an enterprise strategy and technical architecture to support the exchange of health information between the state agencies and healthcare service providers through an HIN. • Development and implementation of an HIE platform within the Missouri Medicaid Information System (MMIS) to support connection and bi-directional HIE with HINs. • Procurement of a Medicaid Business Intelligence Solution and Enterprise Data Warehouse that will be capable of supporting bi-directional exchange with HINs and population health management analytics. The solution is currently being implemented. • Development and implementation of a connection between DHSS and Missouri Health Connection (MHC) to support the exchange of public health information between DHSS and Missouri healthcare service providers. • Creation of a working group that includes MME state agencies and the four Missouri HINs to develop and refine Missouri’s strategies for interoperability and state agency participation in bi-directional data exchange with Missouri providers.
<p>Statement 2: Please confirm that your state’s SUD Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what</p>	<p>This HIT Plan is aligned with the State’s broader Medicaid Health IT Plan. MO HealthNet, DHSS, and the DMH have a collaborative agreement to develop and implement health IT and HIE for their shared client base. The departments worked with the Office of Administration ITSD to develop an overall strategy for connecting the State department systems to the HIE for the purpose of sharing clinical and claims data and for exchanging public health information to support State program functions including case management and coordination of care.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

time period.	
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
<p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)² and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts.</p> <p>The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.</p>	<p>The State will review the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B for potential inclusion in the MCO contracts. Currently, MCOs are contractually required, in accordance with Executive Order 07-12, signed by the Governor on March 2, 2007, to support interoperable health information systems and products so long as the maintenance of exchange of health information includes provisions to protect member privacy as required by law.</p>

Prompts	Summary
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Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

To assist states in their health IT efforts, CMS released [SMDL #16-003](#) which outlines enhanced federal funding opportunities available to states “for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers.” For more on the availability of this “HITECH funding,” please contact your CMS Regional Operations Group contact. ³

Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established “No Wrong Door System.”⁴

Closed Loop Referrals and e-Referrals (Section 1)

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
1.1 Closed loop referrals and e- referrals from physician/mental health provider to physician/mental health provider	<p><i>Current State:</i> CCBHOs are required to maintain an HIT system including use of EHRs. Additionally, as of 2016, 96% of CMHCs had EHRs and 80% of public health agencies participated in an HIE. The State has four HINs which support interoperability and closed loop referrals. MHD implemented an HIE Onboarding Program under the HITECH Act. By September 30, 2021, MHD subsidized connections between 93 Medicaid providers representing about 550 provider locations and the HIN of their choice.</p>
	<p><i>Future State:</i> The State continues to encourage provider participation in HIN. Plans are underway to improve data quality, streamline connections, and strengthen Missouri’s HIN ecosystem.</p>
	<p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

<p>1.2 Closed loop referrals and e- referrals from institution/hospital/clinic to physician/mental health provider</p>	<p><i>Current State:</i> In addition to the EHR and HIN activities described in Section 1.1, The DMH maintains an electronic web-based health management tool for care management, care coordination, and population health. This tool provides a comprehensive view of the individuals’ medical and behavioral health including integration of alerts, metabolic trends, patient histories based on Medicaid claims (diagnoses, procedures, pharmacy), hallmark events (ER visits, hospitalizations), and care team members. The tool also provides for customized reporting on any data within the system and provides a dashboard of quality measures for providers to use to identify needed interventions.</p> <p>In addition, MO HealthNet maintains a web based EHR accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. This tool is a HIPAA-compliant portal that enables providers to:</p> <ul style="list-style-type: none"> • 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 PDL and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment; • 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; • Review laboratory data and clinical trait data; and • Determine medication adherence information and calculate MPRs. <p>Additionally, each CMHC HCH must coordinate care and build relationships with regional hospital(s) or hospital system(s) to develop a structure for transitional care planning, including communication of inpatient admissions of CMC HCH participants, and maintain a mutual awareness and collaboration to identify individuals seeking emergency department services who might benefit from connection with a CMHC HCH, and encourage hospital</p>
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>staff to notify the area CMHC HCH staff of such opportunities.</p> <p>The aforementioned Missouri Care Coordination Insights Project will establish and optimize interoperability, connectivity, and exchange of data and insights between hospitals, the Missouri Hospital Association (MHA)/Hospital Industry Data Institute (HIDI), Missouri HINs and key MHD stakeholders. This includes onboarding hospitals not participating in the Medicaid EHR incentive program, but whose providers may exchange health information with Medicaid EHR eligible professionals and hospitals to support hospitals' exchange and sharing of information. It also includes a pilot demonstration project to share ADT alerts and notifications with at least one primary care health home (PCHH) provider network and with one or more of the managed care plans delivering care to Missouri Medicaid participants.</p> <p><i>Future State:</i> Other possible applications of the technology developed under the Missouri Care Coordination Insights Project are being explored include:</p> <ul style="list-style-type: none"> • Developing watchlist capability for state case managers responsible for the health care of children in the state's protective custody, • onboarding stand-alone psychiatric hospitals and developing functionality to help communicate psychiatric treatment capacity and mitigate patient boarding, and • adding alert functionality for patients with history of opioid overdose, SUD, OUD, AUD and substance affected infants. <p><i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project technology.</p>
<p>1.3 Closed loop referrals and e- referrals from physician/mental health provider to community based supports</p>	<p><i>Current State:</i> EHRs have the capability to send this information. The volume of providers utilizing closed loop referrals and e-referrals to community-based supports is unknown. Additionally, health homes provide referrals to community and social services supports which involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, etc. Health home providers monitor continuing Medicaid eligibility using the Family Support Division's (FSD) eligibility website and data base.</p> <p><i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri's HIN ecosystem.</p> <p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
<p>Electronic Care Plans and Medical Records (Section 2)</p>	

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<p>2.1 The state and its providers can create and use an electronic care plan</p>	<p><i>Current State:</i> As described above, the State requires all CMHC HCH and PCHH providers and CCBHOs to implement and use an EHR. Additionally, a 2015-2016 survey of providers revealed 96% of responding CMHCs had adopted EHRs. Additionally, 109 hospitals reported full EHR implementation, only 21 reported partial implementation and 15 were nonresponsive to the survey. MO HealthNet also maintains a web based EHR called CyberAccess, which is accessible to all enrolled Medicaid providers, including CMHCs. At the provider level,</p>
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Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p>CyberAccess offers patient-specific histories, risks, gaps-in-care, reporting, and treatment alerts at the point of care. The goal is to provide a clear understanding of the patient’s previous care and indicators to encourage potential quality of care improvements among all connected partners. MO HealthNet has furthered this effort by sharing Medicaid medical and pharmacy claims data through the HINs for consumption into participating provider EHRs. Combined, these activities have dramatically increased the amount of data available in electronic format among and across settings.</p>
	<p><i>Future State:</i> The State will continue to encourage increased provider adoption of EHRs, including through continued operation of the Medicaid EHR Incentive Program as part of the CMS Promoting Interoperability Program.</p>
	<p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

<p>2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers</p>	<p><i>Current State:</i> As described above, CyberAccess is accessible to all enrolled Medicaid providers, including CMHCs, primary care practices, hospitals 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 issued and transmit a prescription electronically to the enrollee’s pharmacy of choice; (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.</p> <p>Additionally, the Missouri Coalition for Community Behavioral Healthcare has partnered with Netsmart as the state’s care coordination and population health management solutions provider to support the CMHC HCH program. Following the success of Netsmart’s year-long pilot program with facilities including New Horizons, Compass Health, and Truman Behavioral Health, all CMHCs in Missouri began using the Netsmart population health management solution. The population health management solution offers nurse care managers a view of both physical and behavioral patient health data that integrates directly into the provider workflow. Additionally, the solution provides alerts and auto-generated tasks to inform clinical decision making.</p> <p>The Missouri Coalition for Community Behavioral Healthcare is also working with Netsmart on an Enterprise Data Warehouse and Analytics Solution to provide enhanced ability to review data within the existing solution</p>
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Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
	<p>deployments to allow for ad-hoc query capabilities, allowing access to new data sets such as the following:</p> <ul style="list-style-type: none"> • Demographics • Programs and Episodes • Metabolic (vitals, labs, health factors) • Eligibility • Alerts • Staff and organization assignments • Hospitalizations and ER visits • Health Risk Profile information • Claims feeds from data not already directly utilized in CareManager such as Pharmacy information • Daily snapshot of the Population Health metrics at the client level for purposes of historical analysis <p>This solution is currently being piloted with seven agencies.</p> <p><i>Future State:</i> Potential expansion of aforementioned Enterprise Data Warehouse and Analytics Solution to additional agencies pending outcomes of pilot with existing seven agencies.</p> <p><i>Summary of Actions Needed:</i> Analysis of findings from pilot to determine potential plan for expansion to additional agencies.</p>
<p>2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p><i>Current State:</i> As previously described, CCBHOs are required to maintain an HIT system including use of EHRs; CMHCs also have a high rate of EHR adoption. These systems allow access to both youth and adult records.</p> <p>Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation such as assessments, therapy notes, and medication information.</p> <p><i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri’s HIN ecosystem.</p> <p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
<p>2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral</p>	<p><i>Current State:</i> As previously described, CCBHOs are required to maintain an HIT system including use of EHRs; CMCHs also have a high rate of EHR adoption. These systems allow access to both youth and adult records.</p> <p>Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

health system through electronic communications	such as assessments, therapy notes, and medication information.
	<i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri's HIN ecosystem. .

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
	<p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
<p>2.5 Transitions of care and other community supports are accessed and supported through electronic communications</p>	<p><i>Current State:</i> The State’s HINs can provide ADT notification to participating providers. HIDI currently has a core ADT message ingestion and encounter processing framework with established connections to 86 Missouri hospitals through direct and HIE-facilitated connections. It also includes flexible interfaces to support ADT connectivity either directly or through one of Missouri’s HINs and a flexible user-friendly ADT Encounter Notifications Portal delivering predictive analytic alerts and care coordination notifications to designated users at connected hospitals, extensible to targeted non-hospital provider and payer stakeholders.</p> <p><i>Future State:</i> The technology enabled through the aforementioned Missouri Care Coordination Insights Project will expand the use of HIDI’s existing ADT platform through additional onboarding, and the design, development and implementation (DDI) of additional infrastructure to effectively support care coordination needs and interests among MO HealthNet’s stakeholders. The DDI will focus on enhancements to current solution capabilities to included fully automated watchlist processing, and additional outbound modalities to integrate alerts and notifications into clinical workflow. HIDI’s core care alerts and notifications combine the timeliness of ADT messaging with HIDI’s extensive hospital discharge database and applied analytics expertise. Users receive predictive alerts based on validated analytic models to inform care providers prospectively about presenting patients who are highly likely to experience a utilization event. HIDI’s platform allows individual users to modify alert subscription to focus only on populations of interest and gives users the option to both create and submit custom watch lists thus providing MHD and/or its contracted MCOs a mechanism to receive timely notification of care transitions for targeted patient groups. Users are able to customize events of interest to focus on just discharges, just admissions or all transitions of care for a select group of patients.</p> <p><i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project technology.</p>
<p>Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)</p>	
<p>3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure</p>	<p><i>Current State:</i> MO HealthNet and DHSS have conducted internal reviews of patient consent and allowable data uses through the HIN. Additional functionality was added to CyberAccess to filter the claims data to comply with restrictions in federal and state law on sharing certain types of data without additional patient consent beyond the HIPAA-defined consent required for treatment, payment, and operations. Processes are in place to capture consent during the Medicaid enrollment process for all Medicaid participants, which allows Medicaid providers access to clinical data for their patients. Consent is also captured in provider EHRs.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA,	<i>Future State:</i> Continued operation of current programming.
	<i>Summary of Actions Needed:</i> N/A – milestone met.

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
42 CFR part 2 and state laws)	
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	<p><i>Current State:</i> DMH facilities, providers and regional offices are supported by the Customer Information Management, Outcomes, and Reporting (CIMOR) system. CIMOR is an enterprise medical information system that collects and stores a wide range of information used in supporting the DMH business areas, including clinical information (e.g., assessments, screenings), results, follow on diagnoses, and treatment plans. CIMOR shares information with multiple systems and agencies such as DSS/MHD, Medicare and the Social Security Administration.</p> <p>Provider EHRs incorporate all clinical documentation, including intake, assessment and screening tools.</p>
	<p><i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri’s HIN ecosystem.</p>
	<p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	<p><i>Current State:</i> MO HealthNet covers telehealth services. MO HealthNet allows any licensed health care provider, enrolled as a MO HealthNet provider, to provide telehealth services if the services are within the scope of practice for which the health care provider is licensed. The services must be provided with the same standard of care as services provided in person. MCOs are also contractually required to participate in Show-Me ECHO (Extension for Community Healthcare) which uses videoconferencing technology to connect teams of interdisciplinary experts with primary care providers. Show-Me ECHO participants include child and adolescent behavioral health specialist support for primary care; this Child Psych ECHO program integrates medical, pharmacological and psychological considerations into the treatment of the behavioral health patient.</p> <p>In response to the COVID-19 public health emergency (PHE) the State expanded telehealth access, including permitting reimbursement for the delivery of services through audio-only technologies.</p>
	<p><i>Future State:</i> The State has convened a workgroup including representatives from MHD, DMH, DHSS and providers to review telehealth policies post-PHE.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Summary of Actions Needed: Continued operation of telehealth workgroup and implementation of policies in response to workgroup activity and recommendations.

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Prompts	Summary
Alerting/Analytics (Section 6)	
<p>6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment⁵)</p>	<p><i>Current State:</i> The State’s CMHC HCH and PCHH providers monitor individual and population health status and service use to determine adherence to or variance from treatment guidelines. HIT is leveraged to conduct these efforts and outreach is conducted to enrollees at risk of or having already disengaged from treatment.</p> <p>MCOs are also tasked with development of care coordination programming to further assure enrollee treatment engagement.</p> <p><i>Future State:</i> The technology enabled through aforementioned Missouri Care Coordination Insights project supports development, testing and implementation of enhanced HIDI ADT portal features and functionality to allow Medicaid care managers to utilize MHA/HIDI’s predictive alerting and care coordination notifications and new Medicaid-centric predictive analytics models. MHA/HDI’s core care alerts and notifications combine the timeliness of ADT messaging with HIDI’s extensive hospital discharge database and applied analytics expertise. Users receive predictive alerts based on validated analytic models to inform care providers prospectively about presenting patients who are highly likely to experience a utilization event in the near future, such as excessive ED utilization, hospital readmission subject to penalty, etc. HIDI’s platform allows individual users to modify alert subscription to focus only on populations of interest and gives users the option to both create and submit custom watch lists thus providing MHD and/or its contracted MCOs a mechanism to receive timely notification of care transitions for targeted patient groups. Users are able to customize events of interest to focus on just discharges, just admissions or all transitions of care for a select group of patients.</p> <p><i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project.</p>
<p>6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis</p>	<p><i>Current State:</i> The State utilized Community Mental Health Block Grant funds for development of first episode psychosis programming. Participating agencies include CCBHOs, which as previously described have HIT requirements.</p> <p><i>Future State:</i> Continued CCBHO operation of first episode of psychosis programming and associated requirements.</p>

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri

Summary of Actions Needed: N/A – milestone met.

Identity Management (Section 7)

Medicaid Section 1115 SMI/SED Demonstration
 Implementation Plan Missouri

Prompts	Summary
7.1 As appropriate and needed, the care team has the ability to tag or link a child’s electronic medical records with their respective parent/caretaker medical records	<i>Current State:</i> The State’s eligibility and enrollment system can link children and parents on the same case. EHRs have linkage capabilities as well; the volume of providers utilizing this functionality is currently unknown. CCBHOs and CMHCs currently track adult and child behavioral health records in the same EHR that includes all family members receiving services and the ability for appropriate sharing of information among treatment teams.
	<i>Future State:</i> Continued operation of current programming
	<i>Summary of Actions Needed:</i> N/A – milestone met
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	<i>Current State:</i> Provider EHRs capture multiple episodes of care and link episodes of care accordingly.
	<i>Future State:</i> Master patient index (MPI) enhancements are a component of the aforementioned Missouri Care Coordination Insights Project. This includes evaluation and updates to the HIDI Master Patient Index algorithms to utilize the Missouri Department Client Number (DCN) and other identifiers to maximize matching with the Medicaid population.
	<i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project.

Medicaid Section 1115 SMI/SED Demonstration
Implementation Plan Missouri