Table of Contents

State/Territory Name: Missouri

State Plan Amendment (SPA) #: 25-0021

This file contains the following documents in the order listed:

MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th St.
Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

April 27, 2026

Joshua Moore
Director, MO HealthNet Division
Missouri Department of Social Services
P. O. Box 6500
Jefferson City, MO 65109

Re: Approval of State Plan Amendment MO-25-0021 Missouri-2 Health Home Services

Dear Joshua Moore,

On October 15, 2025, the Centers for Medicare and Medicaid Services (CMS) received Missouri State Plan Amendment (SPA) MO-25-0021 for Missouri-2 Health Home Services. Missouri is amending its approved Primary Care Health Home (PCHH) state plan to add a community health worker and an optional behavioral health assistant as members of the care team to be paid under the per member per month (PMPM) payment. Missouri is also increasing the PCHH reimbursement rate by $10.82 PMPM.

We approve Missouri State Plan Amendment (SPA) MO-25-0021 with an effective date(s) of October 01, 2025.

If you have any questions regarding this amendment, please contact Rhonda Gray at 667-290-8850 or rhonda.gray@cms.hhs.gov.

Sincerely,

Nicole McKnight

Acting Director, Division of Program Operations

Center for Medicaid & CHIP Services

MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

CMS-10434 OMB 0938-1188

Package Header

Package ID	MO2025MS0005O	**SPA ID**	MO-25-0021
Submission Type	Official	**Initial Submission Date**	10/15/2025
Approval Date	04/27/2026	**Effective Date**	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Missouri	**Medicaid Agency Name:**	Department of Social Services

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

Package Header

Package ID MO2025MS0005O
SPA ID MO-25-0021
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Initial Submission Date 10/15/2025
Approval Date 04/27/2026
Effective Date N/A
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SPA ID and Effective Date

SPA ID MO-25-0021

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
1945 Health Home Intro	10/1/2025	MO-19-0003
1945 Health Home Population and Enrollment Criteria	10/1/2025	MO-19-0003
1945 Health Home Providers	10/1/2025	MO-19-0003
1945 Health Home Payment Methodologies	10/1/2025	MO-23-0014
1945 Health Home Services	10/1/2025	MO-19-0003
1945 Health Home Monitoring, Quality Measurement and Evaluation	10/1/2025	MO-24-0027

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives

Missouri is amending its approved Primary Care Health Home (PCHH) state plan to add a community health worker and an optional behavioral health assistant as members of the care team to be paid under the per member per month (PMPM) payment. Missouri is also increasing the PCHH reimbursement rate by $10.82 PMPM. Missouri's PCHH was originally implemented 1/1/2012 and its integrated team are concept has shown and continues to show success in meeting the following goals: 1) reduction in avoidable hospitalizations, 2) reduction in emergency department visits, 3) improvement in clinical measures such as hypertension, hemoglobin A1C, and cholesterol levels, 4) positive impact to quality of life for participants and providers, 5) reduction in healthcare costs associated with avoidable use of healthcare services. Missouri's PCHH works with primary care providers throughout the state in the provision of team-based care to qualifying individuals enrolled in their health homes. Current care teams include a health home director, nurse care manager, behavioral health consultant and care coordinator who are paid through the PCHH per- member-per-month payment. This amendment includes the addition of a community health worker (CHW) and an optional behavioral health assistant as members of the care team to be paid under the PMPM. Other clinic staff work in collaboration with the PCHH team such as physicians, nurse practitioners, clinic managers, pharmacists, nutritionists, information technology, etc.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2026	$3067057
Second	2027	$3234361

Federal Statute / Regulation Citation

Section 1945 of Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

1945 Health Home Intro

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

CMS-10434 OMB 0938-1188

Package Header

Package ID	MO2025MS0005O	**SPA ID**	MO-25-0021
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Superseded SPA ID	MO-19-0003		
	User-Entered		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Home state plan option under Section 1945 of the Social Security Act.

Name of 1945 Health Home Program

Missouri-2 Health Home Services

Executive Summary

Provide an executive summary of this Health Home program including the goals and objectives of the program, the population, providers, services and service delivery model used

Missouri is amending its approved Primary Care Health Home (PCHH) State Plan Amendment to add a community health worker and an optional behavioral health assistant as members of the care team to be paid under the PMPM. This SPA is also increasing the PCHH reimbursement rate by $10.82 PMPM. The PCHH was originally implemented 1/1/2012 and its integrated team care concept has shown and continues to show success in meeting the following goals:
- Reduction in avoidable hospitalizations
- Reduction in emergency department visits
- Improvement in clinical measures such as hypertension, hemoglobin A1C, and cholesterol levels

-Positive impact to quality of life for participants and providers
-Reduction in healthcare costs associated with avoidable use of healthcare services
Missouri's PCHH works with primary care providers throughout the state in the provision of team-based care to qualifying individuals enrolled in their health homes. Current care teams include a health home director, nurse care manager, behavioral health consultant and care coordinator who are paid through the PCHH per- member-per-month payment. This amendment includes the addition of a community health worker (CHW) and an optional behavioral health assistant as members of the care team to be paid under the PMPM. Other clinic staff work in collaboration with the PCHH team such as physicians, nurse practitioners, clinic managers, pharmacists, nutritionists, information technology, etc.

General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Home providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home services.
- [x] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Home providers.
- [x] The state provides assurance that FMAP for 1945 Health Home services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [x] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health home enrollee will be claimed.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

1945 Health Home Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

CMS-10434 OMB 0938-1188

Package Header

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

1945 Health Home Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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Population Criteria

The state elects to offer Health Home services to individuals with:

☑ Two or more chronic conditions

Specify the conditions included:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☐ Diabetes
☑ Heart Disease
☑ BMI over 25
☑ Other (specify):

Name	Description
Developmental Disabilities	Developmental disabilities present additional challenges to people trying to manage chronic physical and behavioral health conditions. Autism Spectrum Disorder and Attention-Deficit/Hyperactivity Disorder are neurodevelopmental disorders that may each count separately as two or more chronic conditions.
Substance Use Disorder (SUD)	Substance use diagnosis counts towards eligibility of two or more conditions. Restricted to primary care organizations that have at least one clinician prescribing and managing medication-assisted treatment (MAT). If SUD is one of two qualifying conditions, the individual is receiving MAT or other behavioral health/SUD services through PCHH.
Tobacco Use	Tobacco use places individuals at risk of asthma, diabetes, and cardiovascular disease and counts as one of two chronic conditions.
Asthma	Asthma (adult) and COPD with each diagnosis counting separately towards eligibility.
Heart Disease	Heart disease category is comprised of multiple conditions, including cardiovascular disease, ischemic vascular disease, hypertension, hyperlipidemia, congestive heart failure, with each diagnosis counting towards eligibility of two or more chronic conditions.

Name	Description
BMI over 25	For adults, BMI of 25-29.9; for children/youth, BMI at 85th to 94th percentile for age. Either of these count as one chronic condition.
Mental Health Condition	Anxiety disorders and/or depressive disorders, with each diagnosis counting separately as two or more chronic conditions.

☑ One chronic condition and the risk of developing another

Specify the conditions included:

☐ Mental Health Condition

☐ Substance Use Disorder

☑ Asthma

☑ Diabetes

☐ Heart Disease

☐ BMI over 25

☑ Other (specify):

Name	Description
Chronic Pain	Chronic Pain is pain that lasts past the time of normal tissue healing. Risk stratification for severity of pain as well as for worsening condition and/or opioid dependency will be incorporated into eligibility. Qualified participant eligibility shall be limited to chronic non-cancer neck and back pain, chronic pain post trauma (for example, motor vehicle collision), and others as determined medically necessary through a prior approval process. Chronic pain places the individual at risk for developing another chronic condition.
Obesity	Adult BMI at 30 or greater and child/youth BMI at 95th percentile or greater counts as one qualifying condition. This condition places the individual at risk for developing another chronic condition.
Asthma (pediatric)	Pediatric asthma counts as one qualifying condition and places the individual at risk of developing another chronic condition.
Diabetes	Diabetes counts as one qualifying condition and places the individual at risk for chronic conditions such as cardiovascular disease, mental health conditions, depression, anxiety, and BMI over 25.

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

Description of “At Risk” Criteria:
As noted above, chronic pain, obesity, pediatric asthma, and diabetes are all standalone chronic conditions that place individuals at risk of developing another chronic condition.

☐ One serious and persistent mental health condition

1945 Health Home Population and Enrollment Criteria

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User-Entered

Enrollment of Participants

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

- (•) Opt-In to a Health Home provider
- ( ) Referral and assignment to a Health Home provider with opt-out
- ( ) Other (describe)

Describe the process used:

MO HealthNet routinely identifies potential enrollees who already have a relationship with a PCHH organization but are not enrolled in PCHH and shares this list with PCHH providers. The state may send information to potentially eligible individuals about PCHH providers in their geographic area so they can contact the PCHH and ask about the program. PCHH providers also mine systems to identify potential enrollees. Program overview and patient agreement to participate is provided to potential enrollees by PCHH providers. Once an individual is enrolled, the PCHH will notify other healthcare providers (e.g. specialists) about the goals and types of PCHH services the participant will be receiving, as well as encourage their participation in care coordination. Other individuals with qualifying chronic conditions who don't use a PCHH provider as their primary care provider may request to enroll. Potentially eligible individuals may be informed about and referred to a PCHH provider by a hospital or emergency department. These processes are ongoing.

This view was generated on 4/29/2026 11:12 AM EDT

MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

1945 Health Home Providers

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

CMS-10434 OMB 0938-1188

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Types of Health Home Providers

☑ Designated Providers

Indicate the Health Home Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians

☑ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

see Other Provider Standards below

☑ Rural Health Clinics

Describe the Provider Qualifications and Standards

see Other Provider Standards below

☐ Community Health Centers

☐ Community Mental Health Centers

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

☑ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

see Other Provider Standards below

☑ Other (Specify)

Provider Type	Description
Primary care clinics operated by hospitals	see Other Provider Standards below

1945 Health Home Providers

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☐ Teams of Health Care Professionals

☐ Health Teams

1945 Health Home Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Designated providers of primary care health home services will be federally qualified health centers (FQHCs), rural health clinics (RHCs), clinical practices/clinical group practices, and primary care clinics operated by hospitals. All designated providers will be required to meet state qualifications.

Practice sites will be physician-led and shall form a health team comprised of a primary care physician (i.e., family practice, internal medicine, or pediatrician), nurse practitioner, or physician assistant; a licensed nurse or medical assistant; behavioral health consultant; care coordinator, community health worker, behavioral health assistant and health home director. In addition, other optional team members may include a nutritionist, diabetes educator, pharmacist, asthma educator, referral coordinator, community resource coordinator and others as appropriate and available. Optional team members are identified for inclusion at the request of the patient, responsible caregiver. The designated provider is responsible for locating and conducting outreach to optional team members. Optional team members will not be included in the review to determine selection of primary care health homes. All members of the team will be responsible for ensuring that care is person-centered. The Health Home Director, Nurse Care Manager, Behavioral Health Consultant/Behavioral Health Assistant, Care Coordinator, Community Health Worker's and Physician Champion's time will be covered under the PMPM rate. and optional team members may be covered if included in additional care coordination services portion of PMPM as described in the Payment Methodology section below.

Community Health Workers (CHW):
CHW's have unique expertise and there are specific responsibilities they are well suited to assume on a PCHH and care team. With the appropriate training, CHWs are able to provide services/assistance to patients:

- Conduct outreach to actively engage patients in health care and preventative services to allow closure of care gaps, improved patient clinical outcomes, and optimization of the cost-effective use of health care resources (Patient and Family Support, Care Coordination)
- Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the practice (Care Coordination)
- Provide education on health conditions and strategies to implement treatment and care plan goals, including both clinical and non-clinical needs (Health Promotion)
- Identify community resources (i.e. social services, workshops, etc.) for patients to maximize health and wellness (Referral to community and support services)
- Navigate and coordinate patient access to individual and family support, including referral to community social supports (Patient and family support)
- Assist with referral and tracking for both clinical and non-clinical needs (Care Coordination)
- Provide assistance with enabling services such as transportation, food, housing, etc. (Care Coordination)
- Educate, coordinate and provide access to chronic disease management including self-management support, and patient self/home disease monitoring (Health promotion/Patient and family support)
- Co-lead health education groups and implement wellness and prevention initiatives (Health promotion)
- Assist with medication or treatment adherence (Health promotion/Transitions of care)
- Facilitate goal setting with patients and assess how a self-management plan is progressing (Health promotion)
- Problem-solve obstacles to comply with a given treatment (Care management/Health promotion)

Behavioral Health Assistants (BHAs) have experience working in a behavioral health setting at minimum and receive additional training for the work in this program. The BHA will be responsible for:

- Administer Brief Age-Appropriate Preventative health screening for behavioral health, substance use, health risk behaviors, and social risk factors (Care Management)
- For patients with positive screening results on brief screeners administer more comprehensive screeners to identify whether patient needs education, health/wellness coaching, healthy behavior reinforcement or referral for further assessment (Care Management)
- Provide patient education, health/wellness coaching, healthy behavioral reinforcement, self-management goal prioritization and follow-up, care plan goal setting support/follow-up, high utilizer patient engagement, navigation support for patient being referred for assessment for need of higher level of services, assist with patient reminders for patients receiving brief interventions and short term therapy services: Please note can be provided by qualified mental/behavioral health profession using standing orders, care paths/protocols, enhanced training, oversight by licensed behavioral health clinician (Health Promotion)
- Referral from licensed behavioral health staff to behavioral health assistants for patients stable and in need of support but not in need of the level of services from a licensed behavioral health staff (Health Promotion/Patient and Family Support)

Behavioral Health Consultants (BHCs) are licensed behavioral health clinicians (e.g., LCSW, LPC, PhD) and are responsible for:

- Collaborative and Case conferences with primary care providers to identify care paths for high quality patient care in outpatient primary care (Care Coordination)
- Curbside consults with primary care clinicians by BHC (Health Promotion)
- Brief interventions to address the medical conditions and related behavioral health factors/conditions that affect the health and wellbeing of the person (Health Promotion/ Patient and Family Support)
- Brief coaching for substance use and as needed referral to determine if person needs substance use treatment. (Health Promotion)
- Provide patient education, health/wellness coaching, healthy behavioral reinforcement, self-management goal prioritization and follow-up, care plan goal setting support/follow-up, high utilizer patient engagement, navigation support for patient being referred for assessment for need of higher level of services. (Health Promotion)
- For patients with positive screening results on brief screeners administer more comprehensive screeners to identify whether patient needs education, health/wellness coaching, healthy behavior reinforcement or referral for further assessment (Health Promotion/ Referral to community and Support Services)

- For patients in need of a referral for further assessment to determine the level of services and assessment (Referral and Support Services)
- Supervision of Behavioral Health Assistants and provide consultation on individuals managed by BHAs
- Assessments and assistance of primary care clinicians regarding behavioral health diagnosis and substance use. (Care Coordination)

Care Coordinators (CCs) have experience working in a healthcare setting at minimum and are responsible for:
- Assist with appointment scheduling and tracking individual's services (Care Coordination)
- Assist with referral tracking and feedback (Care Coordination)
- Assist with performance improvement and data management. (Care Coordination)
- Process enrollment/discharge/transfer forms (Care Coordination)
- Reminding enrollees about keeping appointments, filling prescriptions, follow-up on self-management goals, etc. (Referral to Community and Support Services)
- Requesting and sending medical records for care coordination (Care Coordination)

Nurse Care Managers (NCMs) have an RN or LPN license and are responsible for:
- Communicate and collaborate with PCP, PCHH team, and other members of the care team to incorporate patient interactions with nurse care manager into the delivery of patient centered care for the PCHH enrollees (Care Coordination)
- Participate in pre-visit planning and care team huddles/communication for enrollee visits with Provider (Care Management)
- Participate in the treatment/patient-centered care plan self-management goal development, ongoing patient engagement towards progress, and plan update for PCHH enrollees in collaboration with PCP, PCHH team, and other care team members to ensure plan is patient centered and driven by the patient. Single patient plan should be documented in patient record in the practice Electronic Health Record and allow review and update by NCM, PCHH team, and other care team members working with the patient (Health Promotion)
- Build trusting relationships with PCHH enrollees and serve as a point of contact by conducting care coordination, care management, case management, and population health management for assigned panel of enrollees and contribute to management of all PCHH enrollees through collaboration with PCP, PCHH team, and other members of the care team
- Conduct proactive transitions of care with enrollees who have had inpatient and/or emergency department visits post discharge. Contact and medication reconciliation should be performed with enrollee with information communicated to patient PCP for guidance on any needed home medication regiment modifications, timing of patient follow-up visit to practice, and any other treatment instruction (Comprehensive transitional Care)
- Participate in contacting and engaging enrollees who are high utilizers of inpatient and/or emergency department to lead to modifying behaviors to reduce inappropriate usage and increase engagement with care in the outpatient setting (Comprehensive transitional Care)
- Identify, track, and manage enrollee care gaps, medication adherence, utilization of inpatient, emergency department, urgent care, specialists, personal care services using HIT tools, population health management tools, scorecards, and workflows to support enrollee active engagement in the PCHH program and high-quality patient centered care that is effective and cost effective (Care Management)
- Participate in monitoring, reporting, and improvement of performance measures and outcomes
- Participate in the process to identify potential enrollees for the PCHH program
- Collaborate with MCO case managers for enrollees that are a member of a MCO as needed to best coordinate care and reduce duplication of services. If a patient is discharged from health home, they transition to MCO case manager for continuity of services for patient (Care Coordination)
- Utilize MHD health technology programs & initiatives (i.e. CyberAccess)
- Develop, conduct, and facilitate enrollee/practice staff education and training regarding prevention, management, and treatment of chronic conditions, wellness topics, and age-appropriate preventative services (Health Promotion)

Health Home Directors have preferred qualifications of RN with healthcare administration experience and are responsible for:
- Provide leadership for the implementation and coordination of health home activities
- Manage PCHH enrollments, discharges, and transfers
- Overseeing the daily operations of the PCHH, including coordinating activities of other health home staff
- Monitor health home performance and leads improvement efforts
- Champion practice transformation based on health home principles
- Provide training and technical assistance for PCHH staff
- Oversee data management and reporting
- Ensure PCHH staff are trained in and following procedures as outlined in the SPA and code of regulations
- Implement workflows and processes to optimize the effectiveness of the PCHH team in improving health outcomes for PCHH enrollees
- Liason with clinic leadership to ensure PCHH is integrated within the clinic staff
- Provide clinic staff training and education and workflows to ensure full practice is working towards patient-centered care practices.

Supports for Health Home Providers

Describe the methods by which the state will support providers of Health Home services in addressing the following components

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

Description

Designated health homes will be supported in transforming service delivery by participating in training and technical assistance activities that will be delivered in a variety of modalities including live in-person, virtual, and/or on demand with individual PCHH providers and groups of PCHH providers. Given providers' varying levels of experience with practice transformation approaches, the State will assess providers to determine learning needs. Health homes will therefore participate in a variety of learning supports, up to and including learning networks/collaboratives, specifically designed to instruct organizations to operate as Health Homes and provide care using a whole person approach that integrates behavioral health, primary care and other needed services and supports. Training and technical assistance activities will be supplemented with periodic calls to reinforce the T/TA, practice transformation, and monthly practice reporting and feedback.

Other Health Home Provider Standards

The state's requirements and expectations for Health Home providers are as follows

1. In addition to being a Federally Qualified Health Center, Rural Health Clinic, clinical practice/clinical group practice, or primary care clinic operated by a hospital, each primary care health home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each primary care health home:
a. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals, defined as receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), furnished uncompensated care by the provider, or furnished services at either no cost or reduced based on a sliding scale. Patient percentage requirements will be determined by the state;
b. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated by through the application process and agreement to participate in learning activities, including in-person sessions and regularly scheduled virtual meetings and/or phone calls;
c. Meet state requirements for patient empanelment (i.e., each patient receiving primary care health home services must be assigned to a primary care clinician);
d. Meet the state's minimum access requirements. Prior to implementation of primary care health home services and on an ongoing basis, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week clinical advice;
e. Have a formal and regular process for patient input into services provided, quality assurance, access and other practice aspects;
f. Have completed EMR implementation and been using the EMR as its primary medical record solution, to eprescribe, and to generate, or support the generation of through a third party such as a data repository, clinical quality measures relevant to improving chronic illness care and prevention for at least six months prior to the beginning of primary care health home services;
g. Actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for Medicaid participants;
h. Actively utilize population health management tools for care coordination and care gap identification for Medicaid participants;
i. Utilize electronic health record and population health management tool that tracks and measures care of individuals and PCHH provider population;
j. Within three months of primary care health home service implementation, have developed and maintain a relationship with regional hospital(s) or system(s) to ensure a process for transitional care planning, to include communication of inpatient and emergency department admissions of PCHH participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a PCHH site to establish services, and in addition motivate hospital staff to notify the primary care health home's designated staff of such opportunities; the state will assist in obtaining hospital/primary care health home MOU if needed;
k. Agree to convene regular, ongoing and documented internal primary care health home team meetings to plan and implement goals and objectives of practice transformation;
l. Agree to participate in CMS and state-required evaluation activities;
m. Agree to develop required reports describing primary care health home activities, efforts and progress in implementing primary care health home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of primary care health home service staff time and activities);
n. Maintain compliance with all of the terms and conditions as a primary care health home provider or face termination as a provider of primary care health home services; and
o. Present a proposed health home delivery model that the state determines to have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the PCHH, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

2. Ongoing Provider Certification Requirements
a. Each practice must:
1. Conduct quality improvement activities to address gaps and opportunities for improvement identified during and after the application process;
2. Demonstrate development and maintenance of fundamental medical home functionality through an assessment process to be applied by the state;
3. Demonstrate significant improvement on clinical outcome and process indicators specified by and reported to the state, and
4. Achieve NCQA Patient-Centered Medical Home recognition under most current standards by month 18 from the date at which supplemental payments commence; or meet equivalent/equitable recognition standards approved by the state as such standards are developed.

3. Health home organizations that want to enroll individuals with substance use disorder must include at least one eligible prescribing clinician to prescribe and manage medication assisted treatment.

4. Organizations that want to enroll people with chronic pain diagnoses must, at a minimum, regularly participate in interactive video conferences on chronic pain that include pain management specialists who will provide guidance on the management of people with a chronic pain diagnosis. When possible, organizations are encouraged to directly collaborate with a pain management specialist on the management of these individuals. A pain management specialist is defined as a licensed physician (MD or DO) who is board certified in anesthesiology or pain management.

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MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

CMS-10434 OMB 0938-1188

Package Header

Package ID MO2025MS0005O
SPA ID MO-25-0021
Submission Type Official
Initial Submission Date 10/15/2025
Approval Date 04/27/2026
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Superseded SPA ID MO-23-0014
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Payment Methodology

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

☑ Fee for Service

☐ Individual Rates Per Service

☑ Per Member, Per Month Rates

☑ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

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

☑ Other

Describe below

See description in Rate Development section below.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

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

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's per-member-per-month rate was set as of October 1, 2025 and is effective for services provided on or after that date.

☐ PCCM (description included in Service Delivery section)

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

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

1945 Health Home Payment Methodologies

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Package ID	MO2025MS0005O	**SPA ID**	MO-25-0021
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Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

10/1/2025

Website where rates are displayed

https://mydss.mo.gov/media/pdf/pchh-member-month-rates

1945 Health Home Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Comprehensive Description

Missouri's Primary Care Health Home (PCHH) program provides coordinated, person-centered care to Medicaid beneficiaries with chronic conditions through an interdisciplinary care team. Designated providers include Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), clinical/group practices, and primary care clinics operated by hospitals. Providers deliver the six Health Home services in accordance with Section 1945 of the Social Security Act.

Care Management PMPM Rate

Health Home providers meeting State and Federal requirements will be paid a per member per month (PMPM) rate of $80.19, effective October 1, 2025. The PMPM rate reflects the cost of delivering Health Home services and is based on:
- Staffing costs for care team members responsible for service delivery; and
- Program support costs necessary to deliver Health Home services, including care coordination infrastructure and related activities.

Staffing costs are developed using statewide salary data, including Missouri-specific data and Bureau of Labor Statistics data, and include fringe benefits. Staffing ratios reflect the number of enrollees served per staff position. Program support costs are based on provider cost reports, cost proposals, and actual program expenditures.

Unit of Service

A unit of service is defined as one reimbursable unit per member per month (PMPM).
To be reimbursed for a reimbursable unit of service, providers must, at a minimum, deliver one of the six required Health Home services during the service month.
Once an individual is enrolled in the Health Home program, the provider must attest to the provision of at least one of the six Health Home services to receive the PMPM payments for each month in which a qualifying service is provided.

Provider Payment

The State pays providers a PMPM rate based on the number of enrolled beneficiaries who have an attested service each month. Providers will receive the full PMPM payment for each enrolled individual for a given month when:
- The individual is enrolled in the Health Home program; and
- The provider delivers and documents, through attestation and health records, at least one Health Home service during the month.

Service Documentation

Providers must document all Health Home services in the beneficiary's record and provide attestation for those services to the state. Documentation must support:
- The type of Health Home service delivered; and
- That the service was provided during the service month.

Providers must maintain documentation sufficient to support payment and comply with Medicaid recordkeeping requirements.

Verification and Oversight

The State conducts ongoing monitoring to ensure that PMPM payments correspond to the delivery of Health Home services. Providers are required to attest to service delivery and maintain documentation supporting the provision of services. The State verifies enrollee Medicaid eligibility on the last day of the service month prior to payment to the provider. The State reviews provider-reported data and cost information to ensure services are delivered in accordance with program requirements.

Rate Review and Rebasing

The State periodically reviews Health Home rates to ensure they are consistent with efficiency, economy, and quality of care.
The review includes:
- Provider cost reports: PCHH cost exclusion amounts
- Provider expenditure data;
- Staffing costs; and
- Program expenditures.
Based on this review, the State will adjust the PMPM rate, as appropriate, to ensure that rates remain sufficient to support quality services. Any rate changes will be implemented through a State Plan Amendment.

Managed Care Considerations

Health Home services are reimbursed directly by the State and are not included in managed care capitation payments. Managed care plans are not responsible for providing services that duplicate Health Home services for conditions addressed through the Health Home program. The State ensures that payment for Health Home services does not duplicate payment for services included in managed care rates and requires coordination between managed care plans and Health Home providers to support appropriate service delivery.

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Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

Managed Care: All Health Home payments including those for MO HealthNet (MHN) participants enrolled in managed care plans will be made directly from MHN to the Health Home provider. As a result of the additional value that managed care plans will receive from MHN direct paid Health Home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the CMS reimbursed health home services (i.e. the conditions for which an individual was enrolled in the Health Home). This Health Home delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care. The managed care plan will be informed of its members that are in Health Home services and a managed care plan contact person will be provided for each Health Home provider to allow for coordination of care.

- The managed care plan will be required to inform either the individual's Health Home or MO Health Net of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.
- The PCHH team will provide Health Home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the PCHH.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Medicaid-Funding-Questions 25-0021	2/25/2026 4:49 PM EST	

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MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

CMS-10434 OMB 0938-1188

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Superseded SPA ID	MO-19-0003		
	User-Entered		

Service Definitions

Provide the state's definitions of the following Health Home services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive care management services involve:
- assessing preliminary and ongoing service needs,
- contribute to development, person-centered treatment/care plans,
- monitoring individual health status
- population health management
- patient activation in care

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including primary care practices. 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; and
g. Determine medication adherence information and calculate medication possession ratios (MPR); and
h. Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

PCHH practices also utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral platforms.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Comprehensive care management is provided by licensed behavioral health professionals, and by trained behavioral health assistants, supervised by licensed behavioral health professionals.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Comprehensive care management is provided by nurse care managers.

☑ Nurses

Description

Comprehensive care management is provided by nurses.

- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [x] Pharmacists

Description

Comprehensive care management is provided by pharmacists.

- [x] Social Workers

Description

Comprehensive care management is provided by social workers.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [x] Dieticians

Description

Comprehensive care management is provided by dietitians.

- [x] Nutritionists

Description

Comprehensive care management is provided by dietitian nutritionists.

- [x] Other (specify)

Provider Type	Description
Community Health Worker	Comprehensive care management is provided by community health workers.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

Package Header

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Superseded SPA ID	MO-19-0003		
	User-Entered		

Care Coordination

Definition

Care Coordination includes:
- Assist with and coordination of appointment scheduling/reminders
- Assist with referral process and follow-up monitoring
- Connection and navigation assistance across settings of care i.e. hospital, specialist, between primary care, behavioral health, and community settings to assist with linkages to care.
- Hospital and ED discharge planning process
- Coordination and follow-up for needed services
- Population health management and quality improvement
- Coordination with access to care barriers

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including primary care practices. 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; and
g. Determine medication adherence information and calculate medication possession ratios (MPR); and
h. Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

PCHH practices also utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral platforms.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  Care coordination is provided by Licensed behavioral health professionals and trained behavioral health assistants, supervised by licensed behavioral health professionals.

- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

  Description

  Care coordination is provided by nurse care managers.

- [x] Nurses

  Description

  Care coordination is provided by nurses.

- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [x] Pharmacists

  Description

  Care coordination is provided by pharmacists.

- [x] Social Workers

  Description

  Care coordination is provided by social workers.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners

Dieticians

Description

Care coordination is provided by dietitians.

Nutritionists

Description

Care coordination is provided by dietitian nutritionists.

Other (specify)

Provider Type	Description
Community health workers	Appropriately trained community health workers provide care coordination activities as members of the care team.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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	User-Entered		

Health Promotion

Definition

Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.

Health promotion services also assist patients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PCHH practices utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral systems to assist with health promotion. EMR have built in patient education information available for download for patient and health promotion information can be provided by patient portal and/or text messaging campaigns.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  Health promotion activities are provided by licensed behavioral health professionals and behavioral health assistants supervised by licensed behavioral health professionals.
- [x] Nurse Practitioner
  Description
  Health promotion activities are provided by advanced practice registered nurses.
- [x] Nurse Care Coordinators
  Description
  Health promotion activities are provided by nurse care managers.
- [x] Nurses
  Description
  Health promotion activities are provided by nurses.
- [ ] Medical Specialists
- [x] Physicians
  Description
  Health promotion activities are provided by physicians.
- [x] Physician's Assistants
  Description
  Health promotion activities are provided by physician assistants.
- [x] Pharmacists
  Description
  Health promotion activities are provided by pharmacists.
- [x] Social Workers
  Description
  Health promotion activities are provided by social workers.
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Community health workers	Health promotion activities are provided by community health workers.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care from inpatient to other settings includes:
- Encourage shift from reactive care & treatment to proactive delivery of care
- Care coordination & collaboration with other members of the care team, including providers, nurses, social workers, pharmacists, & discharge planners, to continue implementation of patient-driven treatment/care plan
- Assistance with transitions of care between settings of care i.e. inpatient, emergency department, specialist, and from pediatric to adult care
- Transitional care including follow-up from inpatient admissions and emergency department visits with medication reconciliation

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay.

MO HealthNet and the Department of Mental Health provide a daily data transfer listing all new hospital admissions and discharges. This information is transferred to the state's data analytics contractor which matches it to a list of all persons assigned and/or enrolled in a healthcare home. The contractor notifies the PCHH of the admission, which enables the PCHH to:

a. Use the hospitalization episode to locate and engage persons in need of PCHH services;
b. Perform the required continuity of care coordination between inpatient and outpatient; and
c. Coordinate with the hospital to discharge and avoid readmission as soon as possible.

PCHH practices also utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral platforms to assist with transitional care from inpatient to other settings.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists
  Description
  Comprehensive transitional care is provided by behavioral health professionals and behavioral health assistants, supervised by behavioral health professionals.
- [x] Nurse Practitioner
  Description
  Comprehensive transitional care is provided by advanced practice registered nurses.
- [x] Nurse Care Coordinators
  Description
  Comprehensive transitional care is provided by nurse care managers.
- [x] Nurses
  Description
  Comprehensive transitional care is provided by nurses.
- [ ] Medical Specialists
- [x] Physicians
  Description
  Comprehensive transitional care is provided by physicians.
- [x] Physician's Assistants
  Description
  Comprehensive transitional care is provided by physician assistants.
- [x] Pharmacists
  Description
  Comprehensive transitional care is provided by pharmacists.
- [x] Social Workers
  Description
  Comprehensive transitional care is provided by social workers.
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [x] Dieticians
  Description

Comprehensive transitional care is provided by dietitians.

☑ Nutritionists

Description

Comprehensive transitional care is provided by dietitian nutritionists.

☑ Other (specify)

Provider Type	Description
Community health workers	Comprehensive transitional care is provided by community health workers.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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	User-Entered		

Individual and Family Support (which includes authorized representatives)

Definition

Members of the care team act as patient and family supports by assisting patients in obtaining resources to help support them in attaining the highest level of health and functioning in their families & communities, including:

- Obtaining and adhering to medications and other treatments
- Obtaining and maintaining eligibility for healthcare
- Disability benefits
- Case management referral & coordination for individuals with developmental disabilities

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PCHH practices utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral platforms to aid individual and family support activities.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists	**Description** Individual and family support services are provided by behavioral health professionals and behavioral health assistants, supervised by behavioral health professionals.
☑ Nurse Practitioner	**Description** Individual and family support services are provided by advanced practice registered nurses.
☑ Nurse Care Coordinators	**Description** Individual and family support services are provided by nurse care managers.
☑ Nurses	**Description** Individual and family support services are provided by nurses.
☐ Medical Specialists	
☑ Physicians	**Description** Individual and family support services are provided by physicians.
☑ Physician's Assistants	**Description** Individual and family support services are provided by physician assistants.
☑ Pharmacists	**Description** Individual and family support services are provided by pharmacists.
☑ Social Workers	**Description** Individual and family support services are provided by social workers.
☐ Doctors of Chiropractic	
☐ Licensed Complementary and alternative Medicine Practitioners	
☑ Dieticians	**Description** Individual and family support services are provided by dietitians.
☑ Nutritionists	**Description** Individual and family support services are provided by dietitian nutritionists.
☑ Other (specify)	

Provider Type	Description
Community health workers	Individual and family support services are provided by community health workers.

1945 Health Home Services

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Referral to Community and Social Support Services

Definition

Referral to community and social support services involves providing the following assistance to individuals:
- Referral and coordination for individuals receiving home and community-based services;
- Providing information on available community resources available to individuals to best meet their health care needs; and
- Assessing, coordination, and referral to address barriers to access to care and treatment plan achievement such as difficulty with transportation, housing, food, employment, education, legal etc.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

PCHH providers will be encouraged to monitor continuing Medicaid eligibility using the DFS eligibility website and data base. MO HealthNet will also refine processes to notify primary care health home providers of impending eligibility lapses (e.g., 60 days in advance). PCHH practices also utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral platforms to aid referral to community and social support services.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Referrals to community and social support services are provided by licensed behavioral health professionals and behavioral health assistants, supervised by licensed behavioral health professionals.

☑ Nurse Practitioner

Description

Referrals to community and social support services are provided by advanced practice registered nurses.

☑ Nurse Care Coordinators

Description

Referrals to community and social support services are provided by nurse care managers.

☑ Nurses

Description

Referrals to community and social support services are provided by nurses.

☐ Medical Specialists

☑ Physicians

Description

Referrals to community and social support services are provided by physicians.

☑ Physician's Assistants

Description

Referrals to community and social support services are provided by physician assistants.

☑ Pharmacists

Description

Referrals to community and social support services are provided by pharmacists.

☑ Social Workers

Description

Referrals to community and social support services are provided by social workers.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☑ Dieticians

Description

Referrals to community and social support services are provided by dietitians.

Nutritionists

Description

Referrals to community and social support services are provided by dietitian nutritionists.

Other (specify)

Provider Type	Description
Community health workers	Referrals to community and social support services are provided by community health workers.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

Package Header

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Health Home Patient Flow

Describe the patient flow through the state's Health Home system. Submit with the state plan amendment flow-charts of the typical process a Health Home individual would encounter

MO HealthNet queries state system to identify potential enrollees for the PCHH program and sends to PCHH provider if they already have a relationship with that provider organization. PCHH providers also query their EHR systems for this purpose. PCHH staff contact potential enrollees to explain PCHH. If an individual meets eligibility criteria and decides to enroll in the PCHH program, an enrollment form will be submitted. The PCHH team provides at least one of six health home services each month throughout the individual's enrollment in the program to assist them in improving their health/wellness outcomes and goals . PCHH services are free, participation is optional, and choosing not to enroll will have NO impact on their current services. Please see attached patient flow. An individual can decide at any time to be discharged or transfer to another health home.

Name	Date Created	
MO HealthNet Primary Care Health Home Flow Chart 8.25	9/16/2025 9:20 AM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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MO - Submission Package - MO2025MS0005O - (MO-25-0021) - Health Homes

1945 Health Home Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Home Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

The State will annually perform an assessment of cost savings using a pre-/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. It will also be broken out for each primary care health home. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditures. Savings calculations will be trended for inflation, and will truncate the claims of high-cost outliers annually exceeding three standard deviations of the mean. Analyses are run with and without high-cost outliers. Analyses exclude managed care members and dual eligible individuals. Savings calculations will include the cost of PMPM payments received by primary care health home providers. The assessment will also include the performance measures enumerated in the Quality Measures section.

Describe how the state will use health information technology in providing Health Home services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

To facilitate the exchange of health information in support of care for patients receiving or in need of primary care health home services, the state will utilize several methods of health information technology (HIT). Following is a summary of HIT currently available for primary care health home providers to conduct comprehensive care management, care coordination, health promotion and individual and family support services. Also included is a description of the state's process to improve health information exchange (HIE) for comprehensive transitional care services. Missouri continues to work toward the development of a single data portal to facilitate information exchange, measures documentation and calculation and state reporting to CMS. The state continues to refine a process for HIE between CMHCs and primary care practices.

1. HIT for Comprehensive Care Management and Care Coordination – MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including primary care practices, CMHCs, and schools. The tool is a HIPAA-compliant portal that enables providers to:
a. Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
b. View dates and providers of hospital emergency department services;
c. Identify clinical issues that affect an enrollee's care and receive best practice information;
d. Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
e. Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
f. Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice;
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.

PCHH practices also utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral platforms

2. HIT for Health Promotion and Individual and Family Support Services –
PCHH providers are required to have patient portals in their electronic medical records system which also make various types of information available to enrollees.

3. HIT for Comprehensive Transitional Care – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health have developed a daily process to notify each healthcare home provider of all authorized admissions, which enables the primary care health home provider to:

a. Use the hospitalization episode to locate and engage persons in need of primary care health home services;
b. Perform the required continuity of care coordination between inpatient and outpatient; and
c. Coordinate with the hospital to discharge and avoidable admission as soon as possible.

4. Referral to Community and Social Support Services – Primary care health home providers are encouraged to monitor continuing Medicaid eligibility using the FSD eligibility website and data base. Primary care health home providers can also access information about impending eligibility lapses (e.g., 60 days in advance). PCHH practices also utilize electronic health records, population health management tools ,HIE, state immunization registry, and/or electronic community referral platforms

5. Data Warehouse and Reporting System – The Missouri Primary Care Association maintains a data warehouse for the purpose of functioning as a patient registry for the primary care health home providers and generating quality measures to support clinical quality improvement. Patient demographics and clinically authenticated patient care data from the health home EMRs and practice management systems are included in the data set to support the required measures. MPCA generates aggregate reports to support quality improvement, best practice identification, and benchmarking. PCHH providers can download care gap reports that identify patients in need of services.

1945 Health Home Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MO2025MS0005O | MO-25-0021 | Missouri-2 Health Home Services

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Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Home providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- [x] The state provides assurance that it will identify measureable goals for its Health Home model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- [x] The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

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