Letter: MO 11-11 Approval Letter

FILE COPY		
OFFICE	SIGNATURE	DATE
DMCHO/PSB	Mandy J Stamm	10/20/11
DMCHO		10/20/11

Bcc:
Debbie Read
Debbie Anderson
Mary Pat Farkas

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations

October 20, 2011

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

Dear Mr. Kinkade:

Congratulations on being the first State to submit and the first to receive approval of a Health Home State Plan Amendment (SPA) in response to Section 2703 of the Affordable Care Act.

On July 22, 2011, the Centers for Medicare & Medicaid Services (CMS) received Missouri's SPA, transmittal #11-0011, through which the State is implementing Community Mental Health Center-Heath Homes through Section 2703 of the Affordable Care Act.

This SPA is approved October 20, 2011 with an effective date of January 1, 2012. In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers under MO – SPA # 11-0011 during the first 8 fiscal year quarters that the SPA is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

In addition, this approval is based on the State's agreement to implement and comply with CMS' core set of quality measures after CMS reaches a final decision on the core measurement set.

Enclosed is a copy of the CMS 179 form, as well as, the approved pages for incorporation into the Missouri State plan.

I appreciate the significant amount of work Missouri dedicated to getting this SPA approved. I would like to say a special "*Thank You*" to Missouri staff for working diligently in partnership with CMS in addressing the numerous issues involved in the implementation of this health home SPA. I am sure that your program will be a model from which others will learn.

If you have any questions regarding this SPA, please call Sandra Levels at (816) 426-5925.

Sincerely,

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

Enclosure

cc: Ian McCaslin, M.D., MPH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-11

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~October 1, 2011~~ January 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 2703 of the Affordable Care Act and Section 1945 of the Social Security Act

7. FEDERAL BUDGET IMPACT (in thousands):
a. FFY 2012 $ 1,589
b. FFY 2013 $ 3,495

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-H, page 1
Attachment 4.19-B, page 48

9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable):
New material

10. SUBJECT OF AMENDMENT:
Designation of community mental health centers as health homes for individuals with a serious and persistent mental health condition and at least one other chronic condition.

11. GOVERNOR'S REVIEW (Check One)
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jennifer R. Stoll for Ronald J. Levy

13. TYPE NAME: Ronald J. Levy

14. TITLE: Director

15. DATE SUBMITTED: July 22, 2011

16: RETURN TO:
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 22, 2011

18: DATE APPROVED: October 20, 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
James G. Scott

22. TITLE: Associate Regional Administrator For Medicaid and Children's Health Operations

23. REMARKS:
Per and ink changes per State request

FORM HCFA-179 (07-92)

MEDICAID MODEL DATA LAB

Id: MISSOURI
State: Missouri
Health Home Services Forms (ACA 2703)
Page: 1-10

TN#: MO-11-0011 | Superseeds TN#: MO-00-0000 | Effective Date: 01/01/2012 | Approved Date: OCT 2) 2011

Transmital Numbers (TN) and Effective Date

Please enter the numerical part of the Transmital Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.

Supersedes Transmital Number (TN)

00-0000

Transmital Number (TN)

11-0011

Please enter the Effective Date with the format MM/dd/yyyy where MM = two digit month number, dd = the two digit day of the month, and yyyy = the four digit year. Please also include the slashes (/).

Effective Date

01/01/2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

Page 1

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

- [x] Health Home Services

How are Health Home Services Provided to the Medically Needy?

Not provided to Medically Needy

i. Geographic Limitations

Statewide Basis

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

- [x] Two chronic conditions
- [x] One chronic condition and the risk of developing another
- [x] One serious mental illness

from the list of conditions below:

- [x] Mental Health Condition
- [x] Substance Use Disorder
- [ ] Asthma
- [x] Diabetes
- [x] Heart Disease
- [x] BMI Over 25
- [ ] Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

CMHCs will be the state's designated provider for individuals of any age with:

• A serious and persistent mental health condition;
• A mental health condition and one other chronic condition (asthma, cardiovascular disease, diabetes, substance use disorder, developmental disability, overweight (BMI >25);
• A substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, developmental disability (DD), overweight (BMI >25); or
• A mental health condition or a substance use disorder and tobacco use (tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD).

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

iii. Provider Infrastructure

☑ Designated Providers as described in §ection 1945(h)(5)

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

CMHC Health Homes will be physician-led with health teams minimally comprised of a Health Home Director, a Health Home Primary Care Physician Consultant, a Nurse Care Manager(s),and a Health Home Administrative support staff. Optional health team members may also include an individual's treating primary care physician, treating psychiatrist, and mental health case manager, as well as a nutritionist /dietitian, pharmacist, peer recovery specialist, grade school personnel or other representative as appropriate to meet clients' needs (e.g., educational, employment or housing representative). All members of the team will be responsible for ensuring that care is person -centered, culturally competent and linguistically capable. All mandatory Health Home team members' time will be covered by the PMPM rate described in the Payment Methodology section below.

CMHCs will be supported in transforming service delivery by participating in statewide learning activities. Given CMHCs' varying levels of experience with practice transformation approaches, the State will assess providers to determine learning needs. CMHCs will therefore participate in a variety of learning supports, up to and including learning collaboratives, specifically designed to instruct CMHCs to operate as Health Homes and provide care using a whole person approach that integrates behavioral health, primary care and other needed services and supports. Learning activities will be supplemented with monthly practice team calls to reinforce the learning sessions, practice coaching, and monthly practice reporting (data and narrative) and feedback. Learning activities 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 abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. (Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care);
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his/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; and
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.

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Comprehensive care management services are conducted by the Nurse Care Manager, Primary Care Physician Consultant, the Health Home Administrative Support staff and Health Home Director with the participation of other team members and involve:
a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;
b. assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes;
c. assignment of health team roles and responsibilities;
d. development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
e. monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
f. development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Ways Health IT Will Link

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

optical and inpatient services;
- Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee's pharmacy of choice; and
- Review laboratory data and clinical trait data;
- Determine medication adherence information and calculate medication possession ratios (MPR); and
- Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

Care Coordination

Service Definition

Care Coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members. Nurse Care Managers with the assistance of the Health Home Administrative Support staff will be responsible for conducting care coordination activities across the health team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.

Ways Health IT Will Link

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

Health Promotion

Service Definition

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

Ways Health IT Will Link

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

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management. The Health Home Director, Primary Care Physician Consultant, and Nurse Case Manager will all participate in providing Comprehensive Transitional Care activities, including, whenever possible, participating in discharge planning.

Ways Health IT Will Link

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

Individual and Family Support Services (including authorized representatives)

Service Definition

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

Ways Health IT Will Link

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

Referral to Community and Social Support Services

Service Definition

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

Ways Health IT Will Link

Health home providers will monitor continuing Medicaid eligibility using the DFS eligibility website and data base. MO HealthNet and the Department of Mental Health will also develop a process to notify health home providers of impending eligibility lapses (e.g., 60 days in advance).

v. Provider Standards

Initial Provider Qualifications

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

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

vi. Assurances

☑ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

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

☑ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

Using claims data, the state will track avoidable hospital readmissions by calculating ACSC readmissions/1000: (# of readmissions with a primary diagnosis consisting of an AHRQ ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

The State will annually perform an assessment of cost savings using a pre/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. It will also be broken out for each CMHC Health Home. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditure. Savings calculations will be trended for inflation and will truncate the claims of high-cost outliers annually exceeding three standard deviations of the mean. Savings calculations will include the cost of PMPM payments received by Health Home Providers. The assessment will also include the performance measures enumerated in the Quality Measures section.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

To facilitate the exchange of health information in support of care for patients receiving or in need of health home services, the state will utilize several methods of health information technology (HIT).

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

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

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

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

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

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

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

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

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

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Improve Health Outcomes for persons with Mental Illness

Clinical Outcomes

Measure

1. Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.
2. Emergency Department Visits: Preventable/ambulatory care-sensitive emergency room visits [algorithm, not formally a measure]
3. Hospital Readmission: Hospital readmissions within 30 days

Data Source

Measure Specification

1. Claims
2. Claims
3. Claims

1. Numerator = Total # of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years / Denominator = Total mid-year population under age 75. BENCHMARK GOAL: NCQA's most recently published 50th percentile regional rate for Medicaid managed care.
2. Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measure, which is too lengthy to place in the SPA. The algorithm is a nationally recognized method of calculating preventable ED visits. BENCHMARK GOAL: NCQA's most recently published 50th percentile regional rate for Medicaid managed care.
3. Percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology. BENCHMARK GOAL: NCQA's most recently published 50th percentile regional rate for Medicaid managed care.

How Health IT will be Utilized

1. Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual health homes against each other and disseminated by e-mail.
2. Hospital ER visits will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual health homes against each other and disseminated by e-mail.
3. Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual health homes against each other and disseminated by e-mail.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

1. All Members: Medication Adherence to Antipsychotics, Antidepressants, and Mood Stabilizers
2. Care Coordination: Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.

Data Source

1. Pharmacy Claims
2. Claims & Monthly Health Home Report

Measure Specification

1. Numerator = Number of members on that class of medication in the past 90 days with medication possession ratios (MPR) > 80% / Denominator = Number of all members on that class of medication in the past 90 days. BENCHMARK GOAL: >90%.
2. Number of patients contacted (by phone or face-to-face) within 72 hours of discharge / Number of all patients discharged. BENCHMARK GOAL: 80%.

How Health IT will be Utilized

1. The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance
2. The numerator will be aggregated from the monthly health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual health home.

Goal 2:

Reduce Substance Abuse

Clinical Outcomes

Measure

1. Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months.
2. Reduce the proportion of adults (18 and older) who drank excessively in the previous 12 months.

Data Source

1. Annual status report
2. Annual status report

Measure Specification

1. Numerator = Number of adults who report using illicit drugs in the previous 12 months / Denominator = Total number of adults in the past 12 months x 100. BENCHMARK GOAL: 5%.
2. Numerator = Number of adults who report drinking excessively in the previous 12 months / Denominator = Number of all adult in the past 12 months x 100. BENCHMARK GOAL: 9%.

How Health IT will be Utilized

1. Results will be reported in a spreadsheet and benchmark style by individual health home.
2. Results will be reported in a spreadsheet and benchmark style by individual health home.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Goal 3:

Increase patient empowerment and self-management

Clinical Outcomes

Measure

Patient use of personal EHR (Direct Inform, or its successor)

Data Source

CyberAccess or its successor

Measure Specification

Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period / Denominator = Number of patients actively enrolled in the health home at any point during the 90 days x 90. BENCHMARK GOAL: Greater than 0.25.

How Health IT will be Utilized

This is a standard management report available within the CyberAccess tool. Results will be reported by individual health home on the spreadsheet and benchmark style and disseminated all health homes.

Experience of Care

Measure

Satisfaction with services

Data Source

Mental Health Statistics Improvement Program (MHSIP) survey

Measure Specification

SAMHSA National outcome Measures (NOMS) specifications. Numerator = number of MHSIP survey responses with an average score < 2.5 (1= strongly agree, 5 = strongly disagree) across all general satisfaction questions / Denominator = number of MHSIP survey responses. BENCHMARK GOAL: >90%.

How Health IT will be Utilized

Results of the MHSIP survey will be aggregated by health home and across the entire statewide initiative. Final report will benchmark individual health home performance compared to other health homes and the statewide average and identify individual items for performance improvement.

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Goal 4:

Improve coordination of care

Clinical Outcomes

Measure

Care Coordination - Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.

Data Source

Claims and Monthly Health Home Report

Measure Specification

How Health IT will be Utilized

Numerator = Number of patients contacted (phone or face-to-face) within 72 hours of discharge / Denominator = Number of all patients discharged x 100. BENCHMARK GOAL: 80%.

The numerator will be aggregated from the monthly health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual health home.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

Use of CyberAccess per member per month (or its successor) for non-MCO enrollees

Data Source

CyberAccess or its successor

Measure Specification

CyberAccess web hits PMPM Numerator = the number of times cyber access was open a healthcare home number for the 90 day reporting period. Denominator = Number of patients actively enrolled in the health home at any point during the 90 days x 90. BENCHMARK GOAL: One CyberAccess utilization PMPM.

How Health IT will be Utilized

This is a standard management report available within the CyberAccess tool. Results will be reported by individual health home on the spreadsheet and benchmark style and disseminated all health homes

Goal 5:

Improve preventive care

Clinical Outcomes

Measure

Body Mass Index (BMI) Control - Percentage of patients with documented BMI between 18.5-24.9

Data Source

Disease Registry

Measure Specification

Numerator = Number of patients with BMI of 18.5 - 24.9 / Denominator = Number of all patients with a documented BMI x 100. BENCHMARK GOAL: 37%.

How Health IT will be Utilized

The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance.

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

Metabolic Screening - % of members screened in previous 12 months. Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG).

Data Source

Disease Registry

Measure Specification

Number of current enrollees with a documented metabolic screening in the last 12 months / Total enrollees. BENCHMARK GOAL: 80% completion.

How Health IT will be Utilized

The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI healthcare home number registry. Results will be reported in a spreadsheet and benchmark style by individual health home.

Goal 6:

Improve Diabetes Care

Clinical Outcomes

Measure

Adult Diabetes - % of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.

Data Source

Claims and Disease Registry

Measure Specification

Numerator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and having a documented Hba1c in the previous 12 months. BENCHMARK GOAL: >70%.

How Health IT will be Utilized

The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

Preventive - % of members screened in previous 12 months - Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG)

Data Source

Disease Registry

Measure Specification

Numerator = Number of current enrollees with a documented metabolic screening in the last 12 months / Denominator = Total enrollees x 100. BENCHMARK GOAL: 80% completion.

How Health IT will be Utilized

The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI healthcare home number registry. Results will be reported in a spreadsheet and benchmark style by individual health home.

Goal 7:

Improve asthma care

Clinical Outcomes

Measure

1. Pediatric Asthma - % of patients 5-17 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.
2. Adult Asthma - % of patients 18-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.

Data Source

Claims

Measure Specification

1. Numerator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in health home registry. BENCHMARK GOAL: >70%.
2. Numerator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry. BENCHMARK GOAL: >70%.

How Health IT will be Utilized

The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

Members with Asthma: Adherence to prescription medications for asthma and/or COPD.

Data Source

Claims

Measure Specification

Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for asthma/COPD in the past 90 days. BENCHMARK GOAL: >90%.

How Health IT will be Utilized

The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance

Goal 8:

Improve Cardiovascular (CV) Care

Clinical Outcomes

Measure

1. Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least two office visits, with blood pressure adequately controlled (BP < 140/90) during the measurement period
2. CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).

Data Source

1. Claims and Disease Registry
2. Claims and Disease Registry

Measure Specification

1. Numerator = for a given 90 day period number of patients between the age of 18 t0 85 years old identified as having hypertension in health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90 / Denominator = for a given 90 day period number of patients between the age of 18 to 75 years old identified as having hypertension in health home registry who had two documented episodes of care in the previous 12 months. BENCHMARK GOAL: >90%.
2. Numerator = for a given 90 day period number of patients between the age of 18 years or older identified as having cardiovascular disease in health home registry months where the most recent documented LDL level in the previous 12 months is < 100 / Denominator = for a given 90 day period number of patients between the age of 18 years and older identified as having cardiovascular disease in health home registry. BENCHMARK GOAL: >70%.

How Health IT will be Utilized

Thhe medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

1. Members with CVD: Adherence to Meds - CVD and Anti-Hypertensive Meds
2. Members with CVD: Use of statin medications by persons with a history of CAD (coronary artery disease).

Data Source

Measure Specification

1. Claims and Disease Registry
2. Claims and Disease Registry

1. Numerator = number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on that class of medication in the past 90 days. BENCHMARK GOAL: >90%.
2. Numerator = for a given 90 day period number of patients identified as having coronary artery disease in health home registry and a prescription for a Statin / Denominator = for a given 90 day period number of patients coronary artery disease in health home registry. BENCHMARK GOAL: >70%.

How Health IT will be Utilized

The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance

Goal 9:

N/A

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Goal 10:

N/A

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

Comprehensive Care Management

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Service

Care Coordination

Clinical Outcomes

Measure

N/A

Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Experience of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Quality of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Service

Health Promotion

Clinical Outcomes

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Experience of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Quality of Care

Measure
N/A
Data Source
N/A
Measure Specification
N/A
How Health IT will be Utilized
N/A

Service

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)
Measure

Clinical Outcomes

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Service

Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Service

Referral to Community and Social Support Services

Clinical Outcomes

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Experience of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

Quality of Care

Measure

N/A

Data Source

N/A

Measure Specification

N/A

How Health IT will be Utilized

N/A

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures).

Data Source

Claims

Frequency of Data Collection

Annual

ii. Emergency room visits

Description

Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure).

Data Source

Claims

Frequency of Data Collection

Annual

Description

iii. Skilled Nursing Facility admissions

Use of HEDIS 2011 codes for discharges for SNF services (part of inpatient utilization - nonacute care (NON) measure).

Data Source

Claims

Frequency of Data Collection

Annual

i.

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

Hospital admission rates

The State will consolidate data from its fee—for-service MMIS-based claims system and from MCO-generated encounter data for the participating health home sites to assess hospital admission rates, by service (medical, surgical, Maternity, mental health and chemical dependency), for the participating health home sites and for a control group of non-participating sites. The analysis will consider a) the experience of beneficiaries with the clinical conditions of focus during the learning collaborative year (expected to grow from year 1 to year 2), and b) all beneficiaries with SMI or two or more chronic conditions drawn from a list of chronic conditions defined by the State.

ii. Chronic disease management

The State will audit each practice's implementation of chronic disease management, with a special focus on comprehensive care management. Audits will assess: a) documented self-management support goal setting with all beneficiaries identified by the practice site as high risk, b) Practice team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge, c) documentation that there is a care manager in place and d) that the care manager is operating consistently with the requirements set forth for the practices by the State.

iii. Coordination of care for individuals with chronic conditions

The State will assess provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment in the following fashion. The State will measure a) care manager contact during hospitalization, b) practice team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge, c) active care management of High Risk patients, and d) behavioral activation of High Risk patients. The measurement methodologies for these four measures are described in the preceding section.

iv. Assessment of program implementation

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

v. Processes and lessons learned

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

vi. Assessment of quality improvements and clinical outcomes

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

vii. Estimates of cost savings

Page

The Missouri DMH and its statewide CMHC providers have been engaged in care coordination and disease management for general medical conditions in persons with severe mental illness (SMI) since 2004. As a result we are able to model anticipated savings in the section 2703 Health Homes for Chronic Conditions when provided by CMHCs based on actual historic savings in previous projects.

1. Analysis #1 – Cost Savings for New Patients Just Entering CMHC Services: Total Medicaid costs were examined pre- and post-enrollment in CMHC management services. The persons selected were 636 patients who were newly enrolled in Missouri Medicaid's CMHC program. Patients were included if they had 9 months of Medicaid claims in each of the 2 preceding years, a diagnosis of severe mental illness, a history of psychiatric hospitalization or multiple ER visits, and functional limitations as a result of their mental illness. The exact enrollment date for CMHC services varied from client to client, which minimized the impact of bias due to changes in the healthcare delivery system at specific points in time or over the study period. Average total monthly Medicaid costs were calculated for the month of CMHC enrollment, the 24 months prior to enrollment, and the 24 months after enrollment for each client. Linear regression trend lines were then calculated on those pre-CMHC service and post-CMHC service cost data.

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

INTERVENTION SAVINGS OFF TREND

CCIP Clients in CMHC Health Homes
Base Period PMPM (CY2006)
$1,556
Expected Trend
16.67%
Expected Trend PMPM with No Intervention
$1,815.81
Actual Trend PMPM in Performance Period (FY2007)
$1,504.34
Gross PMPM Cost Savings
$311.47
Lives
6,757

Gross Program Savings
$25,254,928
Vendor Fees
$1,301, 563
Net Program Savings
$23,953,365
NET PMPM Program Savings
$295.41
Net Program Savings/(Cost) as percentage of Expected PMPM
16.3%

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

It is important to note that the cohorts used in both the preceding analyses included dual eligibles in the intervention groups, however the analyses did not include the Medicare costs. If the analyses had included Medicare costs, it is believed that there would have been additional proportional savings in these costs as well. Missouri did not explicitly flag which patients were dual eligibles or attempt to model how their inclusion impacted the overall savings. However, approximately 50% of the clients and service will be dual eligible at any given time in Missouri's CMHC programs. Taken together for our proposed § 2703 CMHC Health Home, the State conservatively estimates including the cost of the Health Home Intervention:
- Year 1 will yield 5% Savings over year 0 total costs trended forward
- Year 2 will yield 10% Savings over year 0 total costs trended forward
- Year 3 will yield 15% Savings over year 0 total costs trended forward

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

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

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

3.1 - B: Medically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Health Home Services

i. Geographic Limitations

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

Two chronic conditions
One chronic condition and the risk of developing another
One serious mental illness

from the list of conditions below:

Mental Health Condition
Substance Use Disorder
Asthma
Diabetes
Heart Disease
BMI Over 25
Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

Designated Providers as described in §ection 1945(h)(5)

Team of Health Care Professionals as described in §ection 1945(h)(6)

Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Service Definition

Comprehensive Care Management

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition

Ways Health IT Will Link

v.Provider Standards

vi. Assurances

A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

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

C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving 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).

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Measure

Clinical Outcomes

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 3:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 4:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 7:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 8:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Measure

Quality of Care

Data Source

Measure Specification

How Health IT will be Utilized

Service

Health Promotion

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

Individual and Family Support Services (including authorized representatives)

Measure

Clinical Outcomes

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

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

i. Hospital admission rates

ii. Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v. Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

Attachment 4.19-B

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Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

CMHC Health Home Provider

Description

Overview of Payment Structure: Missouri has developed the following payment structure for designated CMHC Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Missouri. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology for Health Homes is in addition to the existing fee-for-service or Managed Care plan payments for direct services, and is structured as follows:

Clinical Care Management per-member-per-month (PMPM) payment
Missouri will pay for reimbursement of the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Primary Care Nurses, Physician Consultants, and Administrative Support staff) whose duties are not otherwise reimbursable by MO HealthNet.

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 HH services. This Health Home delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care. Additionally:
• The managed care plan will be informed of its members that are in Health Home services and a managed care plan contact person will be provided for each Health Home provider to allow for coordination of care.
• The managed care plan will be required to inform either the Individual's Health Home or MO Health Net of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.
• The CMHC Health Home team will provide Health Home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the CMHC Health Home.

Clinical Care Management per member per month (PMPM) payment:
This reimbursement model is designed to only fund Health Home functionalities that are not covered by any of the currently available Medicaid funding mechanisms. Nurse Care Manager and Primary Care Physician Consultant duties often do not involve face-to-face interaction with Health Home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Missouri's Health Home model includes significant support for the leadership and administrative functions that are required to transform a traditional CMHC service delivery system to the new data-driven, population focused, person centered Health Home requirements.

The criteria required for receiving a monthly PMPM payment is:
A. The person is identified as meeting CMHC health home eligibility criteria on the State-run health home patient registry;
B. The person is enrolled as a health home member at the billing health home provider;
C. The minimum health home service required to merit PMPM payment is that the person has received Care Management monitoring for treatment gaps; or another health home service was provided that was documented by a health home director and/or nurse care manager; and
D. The health home will report that the minimal service required for the PMPM payment occurred on a monthly health home activity report.

Nurse Care Manager
1 FTE/250 enrollees
$105,000 / year
PMPM $35.00
a. Develop wellness & prevention initiatives
b. Facilitate health education groups
c. Participate in the initial treatment plan development for all of their Health Home enrollees
d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases
e. Consult with Community Support Staff about identified health conditions
f. Assist in contacting medical providers & hospitals for admission/discharge
g. Provide training on medical diseases, treatments & medications
h. Track required assessments and screenings
i. Assist in implementing DMH Net health technology programs & initiatives (i.e., CyberAccess, metabolic screening)
j. Monitor HIT tools & reports for treatment
k. Medication alerts & hospital admissions/discharges
l. Monitor & report performance measures & outcomes

Primary Care Physician Consultant
1 hr/enrollee/yr $150/hr
PMPM $12.50
a. Participates in treatment planning
b. Consults with team psychiatrist
c. Consults regarding specific consumer health issues
d. Assists coordination with external medical providers

Health Home Director
1 FTE/500 enrollees $115,000 / year
PMPM$19.17
a. Provides leadership to the implementation and coordination of Healthcare Home activities
b. Champions practice transformation based on Healthcare Home principles
c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities
d. Monitors Healthcare Home performance and leads improvement efforts
e. Designs and develops prevention and wellness initiatives

Administrative Support
1 FTE support staff/500 enrollees
Non-PMPM paid staff training time
Contracted services
PMPM $12.07
a. Referral tracking
b. Training and technical assistance
c. Data management and reporting
d. Scheduling for Health Home Team and enrollees
e. Chart audits for compliance
f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc.
g. Requesting and sending Medical Records for care coordination

TOTAL PMPM = $78.74

• Staff cost is based on a provider survey of all CMHC's statewide in the spring of 2011 regarding the current costs of similar staff and includes fringe, operating & indirect costs.
• All CMHC providers will receive the same single PMPM rate.
• The PMPM will be adjusted annually according to the CPI
• The PMPM method will be reviewed 18 months after the first PMPM payments to determine if the PMPM is economically efficient & consistent with quality of care. Whether to change the PMPM rate to tiered rates will be addressed at the 18 month review.
• Full-time PMPM funded staff will not be allowed to bill any other CMS funding opportunities. Staff for whom PMPM funding only covers a part of their total work time will log their time funded by & dedicated to Section 2703 Health Home Services to assure that no other billing to CMS occurs during that time.
• The PMPM proposed does not cover the full training and technical assistance costs of implementing Health Homes in Missouri. Missouri Foundations, Providers and State agencies are spending over $1,500,000 to fund expert consultation, technical assistance, learning collaboratives, and other training required for Section 2703 Health Home planning, development and implementation.

☐ Tiered?

- **Payment Type: Alternate Payment Methodology**

Provider Type

Not applicable.

Description

Not applicable.

☐ Tiered?