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State/Territory Name: Missouri

State Plan Amendment (SPA) #: 24-0005

This file contains the following documents in the order listed:

MO - Submission Package - MO2023MS0002O - (MO-24-0005) - Health Homes

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

Center for Medicaid & CHIP Services

April 29, 2024

Todd Richardson
Director
MO HealthNet Division
PO Box 6500
Jefferson City, MO 65102

Re: Approval of State Plan Amendment MO-24-0005

Dear Director Richardson,

On February 14, 2024, the Centers for Medicare & Medicaid Services (CMS) received Missouri State Plan Amendment (SPA) MO-24-0005 to implement a Developmental Disabilities Health Home (DD Health Home) for individuals statewide served through the Missouri Department of Mental Health, Division of Developmental Disabilities (DD), who have a qualifying chronic health condition, have or are at risk of developing another condition, and are eligible for Division of DD services.

We approve Missouri State Plan Amendment (SPA) MO-24-0005 with an effective date(s) of July 01, 2024.

For payments made to Health Homes providers under this new Health Homes Program SPA, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 7/1/2024 to 6/30/2026.

The FMAP rate for payments made to health homes providers will return to the state's published FMAP rate at the end of the enhanced match period. The Form CMS-64 has a designated category of service Line 43 for states to report health homes services expenditures for enrollees with chronic conditions.

If you have any questions regarding this amendment, please contact Mandy Strom at mandy.strom@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

MO - Submission Package - MO2023MS0002O - (MO-24-0005) - Health Homes

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2023MS0002O | MO-24-0005 | DD Health Home

CMS-10434 OMB 0938-1188

Package Header

Package ID MO2023MS0002O
SPA ID MO-24-0005
Submission Type Official
Initial Submission Date 2/14/2024
Approval Date 04/29/2024
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Missouri
Medicaid Agency Name: MO HealthNet Division

Submission Component

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

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2023MS0002O | MO-24-0005 | DD Health Home

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SPA ID and Effective Date

SPA ID MO-24-0005

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2024	New
Health Homes Geographic Limitations	7/1/2024	New
Health Homes Population and Enrollment Criteria	7/1/2024	New
Health Homes Providers	7/1/2024	New
Health Homes Service Delivery Systems	7/1/2024	New
Health Homes Payment Methodologies	7/1/2024	New
Health Homes Services	7/1/2024	New
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2024	New

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2023MS0002O | MO-24-0005 | DD Health Home

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Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

The State of Missouri Department of Social Services, MO HealthNet Division, in collaboration with Missouri Department of Mental Health, Division of Developmental Disabilities (DD) intends to implement a Developmental Disabilities Health Home (DD Health Home) for individuals statewide served through DD, who have a qualifying chronic health condition, have or at risk of developing another condition, and are eligible for Division of DD services. The goal of establishing the DD Health Home is to provide care coordination for enrollees while integrating care management of chronic conditions and other identified health risks for population health management, including components of Social Determinants of Health (SDOH) and to ensure the delivery of quality care that is integrated and supports the needs of individuals with intellectual and/or developmental disabilities (IDD) chronic conditions. This SPA establishes requirements for the DD Health Home, which includes population criteria and enrollment criteria, types of Health Home providers, provider infrastructure, supports for providers, services delivery systems, payment methodologies, and Health Home monitoring, quality measurement and evaluation.

DD Health Home implementation is under the authority of Section 2703 of the Patient Protection and Affordable Care Act of 2010 (1945 of the Social Security Act).

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2024	$1906200
Second	2025	$22874400

Federal Statute / Regulation Citation

1945 of the Social Security Act

Section 2703 of the Patient Protection and Affordable Care Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
Fiscal Impact for DD HH SPA FINAL 02.13.2024	2/14/2024 8:36 AM EST	

Submission - Summary

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Superseded SPA ID	N/A		

Governor's Office Review

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

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

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MO - Submission Package - MO2023MS0002O - (MO-24-0005) - Health Homes

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MO2023MS0002O | MO-24-0005 | DD Health Home

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User-Entered

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

DD Health Home

Executive Summary

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

The overall goal of the DD Health Home is to support population health management for the identified Health Home population.

The DD Health Home is designed to coordinate care for individuals with identified health risks and chronic health conditions eligible for Division of DD services. Care coordination encompasses the whole person as outlined in his or her person-centered plan. The DD Health Home provides consultation and care coordination which includes addressing needed medical/health care, developmental disabilities habilitation including behavioral supports, community-based crisis prevention and response, mental health and substance use disorder treatment, social and other services and supports. The DD Health Home promotes wellness, healthy lifestyles and preventative care. The process centers around educating the person and their support systems on chronic health conditions and identified health risk management with the overall goal to improve health outcomes for the individuals served.

The providers of DD Health Home services are DD Targeted Case Management (TCM) and/or DD HCBS certified or accredited waiver providers. The DD Health Home provider shall include, employ, contract with, or otherwise have access to an interdisciplinary team specializing in medical/healthcare, developmental disabilities habilitation, behavioral health care, social work, and other care providers. An integral part of the DD Health Home model is the incorporation of the Health Home plan of care into the individual's person-centered plan.

General Assurances

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

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Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | MO2023MS0002O | MO-24-0005 | DD Health Home

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- (•) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

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Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Home Services

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

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

Health Homes Population and Enrollment Criteria

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Population Criteria

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

- [ ] Two or more chronic conditions
- [x] One chronic condition and the risk of developing another

Specify the conditions included:

- [ ] Mental Health Condition
- [ ] Substance Use Disorder
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] BMI over 25
- [x] Other (specify):

Name	Description
Individuals shall have a chronic condition of Intellectual and/or Developmental Disability; and have or be at risk of developing one of the following conditions: Diabetes, Asthma, Cardiovascular Disease (CVD) or Hypertension, (continued in next box)	Developmental Disability: Adults and youth who meet the MO State statute definition of Developmental Disability RsMO 630.005(9). "Developmental disability", a disability - Which is attributable to: Intellectual disability, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or Any other mental or physical impairment or combination of mental or physical impairments; and is manifested before the individual attains age twenty-two; and Is likely to continue indefinitely; and Results in substantial functional limitations in two or more of the following areas of major life activities: Self-care; receptive and expressive language development and use; learning; self-direction; capacity for independent living or economic self-sufficiency; mobility; and reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated.
Chronic Obstructive Pulmonary Disease (COPD), Overweight (Body Mass Index (BMI) >25, Dementia, Dependent on a ventilator and/or One of the Fatal Five Plus conditions or one or more chronic conditions (continued in next box)	See above box.
that could lead to one of the Fatal Five Plus conditions: Pulmonary Aspiration, Bowel Obstruction, Gastroesophageal Reflux Disease	See above box.

Name	Description
(GERD), Seizures, Sepsis, Dehydration (continued in next box)	
Tobacco Use, Diagnosis of Autism Spectrum Disorder, or Using the Health Risk Screening Tool that identifies potential risk for individuals with a Healthcare Level of 3 or greater (see below criteria).	See above box.

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

The Health Risk Screening Tool (HRST) is a tool used to provide early detection of health risks and destabilization.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

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

- ○ Opt-In to Health Homes provider
- ○ Referral and assignment to Health Homes provider with opt-out
- ◉ Other (describe)

Name:

Referral and assignment to Health Homes provider with option to opt-out or option to opt-in

Description:

Individuals eligible for DD Health Home services as identified by the state will be auto-assigned to eligible providers based on qualifying conditions. Individuals may also opt-in if they are identified as being potentially eligible for DD Health Home services by other means such as providers, families, guardians, and support coordinators. The state will make the final determination on whether the individual qualifies for DD Health Home services. Upon enrollment, individuals assigned to a DD 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 provide a brief description of:

• DD Health Home services;
• Describe the process for individuals to opt-out of DD Health Home; and
• Have the option to change DD Health Home providers by selecting another DD Health Home provider.

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Health Homes Providers

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Types of Health Homes Providers

☑ Designated Providers

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

☐ Physicians
☐ Clinical Practices or Clinical Group Practices
☐ Rural Health Clinics
☐ Community Health Centers
☐ Community Mental Health Centers
☐ Home Health Agencies
☑ Case Management Agencies

Describe the Provider Qualifications and Standards

MO DD TCM Providers and MO DD HCBS waiver providers will serve as the Designated providers for the DD Health Home. All designated providers will be required to meet State qualifications as a DD Health Home provider.

☐ Community/Behavioral Health Agencies
☐ Federally Qualified Health Centers (FQHC)
☑ Other (Specify)

Provider Type	Description
MO DD HCBS Providers	Accredited or certified MO DD HCBS waiver providers will serve as the designated providers for the DD Health Home. All designated providers will be required to meet State qualifications as a DD Health Home provider.

Health Homes Providers

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- [ ] Teams of Health Care Professionals
- [ ] Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The DD Health Home provider infrastructure will include designated providers working with the DD Health Home team as described below. DD Health Homes will be required to meet the standards and requirements included in the State Plan and other State issued guidance and requirements for delivering the DD Health Home model.

The state plans to designate TCM and accredited and/or certified HCBS Waiver Providers as DD Health Home providers. To become a DD Health Home provider, applicants will be required to meet state defined DD Health Home requirements and have experience in working with the individuals with IDD and understand their needs in order to support the participant with their overall quality of life.

The DD Health Home team will include a Health Home Director, Nurse Care Manager (NCM), Physician Consultant (Advanced Practice Registered Nurse (APRN) as a substitute), Specialized Healthcare Consultant and DD Health Home Facilitator. Specialized Healthcare Consultant includes one or more of the following: Behavioral Health Consultant, dietician, occupational therapist, physical therapist, or speech language pathologist.

The Health Home Director is responsible for championing continued practice transformation designed to integrate physical and behavioral health, prevention, and wellness; managing DD Health Home enrollments, discharges, and transfers; overseeing the daily operations of the DD Health Home, including overseeing the completion and submission of required monthly DD Health Home reports to the State; and, if appropriately credentialed, participating in health education activities; and oversight of monitoring for care management gaps via population health.

The Physician Consultant/APRN as a substitute for the Physician Consultant establishes organizational priorities for disease management and improving health status; participates in case consultation with interdisciplinary teams; helps educate clinical and direct care staff on the nature, course, and treatment of chronic diseases; and develops collaborative relationships between the organization and treating Primary Care Physicians, between Primary Care Physicians and Psychiatrists, and between the organization and other health care professionals and facilities.

The NCM is responsible for overseeing the health trends of the entire population of individuals; following-up on identified trends impacting the health of the population; addressing high utilizers; participating in health education activities, including topics on smoking cessation, disease prevention, and medication adherence; and completing medication reconciliations for DD Health Home individuals post hospital discharge.

The Specialized Healthcare Consultant focuses on managing a population of individuals versus specialty care; supports the care team and the individual in identifying and behaviorally intervening to improve and manage the individual's physical health condition; assists with high utilizers; assist with medication adherence, DD Health Home healthcare goal adherence, self-management support/goal setting, and facilitate staff trainings. It also allows the DD Health Home to have flexibility in offering additional consultation from a variety of healthcare professionals for special populations.

The DD Health Home Facilitator tracks individual enrollments, transfers and discharges; facilitate information exchange; track individual's hospitalizations, discharges and ER visits; identifies high utilizers, serves as a rater for applicable HRSTs, track screening completions including Metabolic Screening (MBS) and ensures entry of MBS data; IT support functions; and support general DD HH team operations.

DD Health Home providers shall be physician led with an individual's interdisciplinary team minimally comprised of the DD Health Home team. Additional team members may include the individual's treating primary care physician, as well as other representatives as appropriate to meet the individual's needs. All members of the individual's team will be responsible for ensuring that care is person-centered, culturally competent, and linguistically capable.

The per member per month rate described in the Payment Methodology section includes the DD Health Home Director, Physician Consultant/ APRN, NCM, Specialized Healthcare Consultant and DD Health Home Facilitator.

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

Supports for Health Homes Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

The state will monitor DD Health Home providers through monthly reporting and biennial provider designation reviews to ensure that Health Home services are being provided that meet the DD Health Home provider standards and CMS' health home core functional requirements. In addition, the MO DD Health Homes will be supported as the state continually assesses the DD Health Homes to determine training needs. DD Health Homes will participate in a variety of centralized learning supports including: learning collaboratives, educational webinars, peer led training and education, one-on-one training and technical assistance, and community resource trainings.

Other Health Homes Provider Standards

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

Initial Provider Qualifications for DD Health Home
In addition to being a DD service provider of TCM or DD HCBS Waiver services, each DD 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. Must be enrolled in Missouri's Medicaid program and agree to comply with all Medicaid program requirements;
b. DD Health Home providers can either directly provide, or subcontract for the provision of DD Health Home services. The DD Health Home remains responsible for all DD Health Home program requirements, including services performed by the contractor.
c. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practices 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 provider leadership in collaboration with the State have presented the state-developed PowerPoint Introduction to Missouri's DD Health Home initiative to provider staff and board of directors;
d. Meet the state's minimum access requirements as follows: Prior to implementation of Health Home service coverage, provide assurance of enhanced individual 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 and DMH information technology systems to conduct care coordination and prescription monitoring for Medicaid individuals;
f. Utilize the department's identified system to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and other items as required by the department;
g. Routinely use an electronic health management tool to determine individualized health risks (i.e.: HRST);
h. Routinely use an electronic management tool to determine problematic prescribing patterns;
i. Conduct wellness interventions as indicated based on the individual's level of risk;
j. Agree to convene regular, ongoing, and documented internal DD Health Home team meetings to plan and implement goals and objectives of ongoing practice transformation;
k. Agree to participate in CMS and state-required evaluation activities;
l. Agree to develop required reports describing DD Health Home activities, efforts and progress in implementing DD Health Home services;
m. Maintain compliance with the terms and conditions as a DD Health Home provider or face termination as a provider of DD Health Home services; and
n. Present a proposed DD Health Home service delivery model the department determines will have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the proposed Health Home, Medicaid caseload, percentage of caseload with eligible chronic conditions of individuals and other factors to be determined by DMH.

Ongoing Provider Qualifications for DD Health Home
Each DD Health Home must also:
a. Continue to have a strong, engaged leadership personally committed to and capable of leading the DD Health Home through the transformation process and sustaining transformed DD Health Home processes as evidenced by successful participation in the leadership training and learning collaboratives developed for DD Health Home;
b. Coordinate care and build relationships with regional hospital(s) or hospital system(s) to develop a structure for transitional care planning, including communication of inpatient admissions of Health Home individuals, and maintain a mutual awareness and collaboration to identify individuals seeking emergency department services who might benefit from connection with a Health Home, and encourage hospital staff to notify the area Health Home staff of such opportunities;
c. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
d. Demonstrate development of fundamental Health Home functionality through an assessment process to be applied by DMH;
e. Demonstrate significant improvement on clinical indicators specified by and reported to DMH;
f. Submit data reports as required by DSS and/or DMH;
g. Provide DD Health Home services that demonstrate overall cost effectiveness;
h. Participate in technical assistance conference calls and webinars as requested by DSS and/or DMH;
i. Meet standards as determined by DMH.

Name	Date Created	
No items available		

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Health Homes Service Delivery Systems

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

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

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MO - Submission Package - MO2023MS0002O - (MO-24-0005) - Health Homes

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MO2023MS0002O | MO-24-0005 | DD Health Home

CMS-10434 OMB 0938-1188

Package Header

Package ID MO2023MS0002O
SPA ID MO-24-0005
Submission Type Official
Initial Submission Date 2/14/2024
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Payment Methodology

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

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [x] Capabilities of the team of health care professionals, designated provider, or health team
      - [ ] Other
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided All DD Health Home providers will receive the same PMPM rate.

- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

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

Health Homes Payment Methodologies

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Rate Development

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

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

Comprehensive Description

Comprehensive Description
Overview of Payment Structure: Missouri has developed the following payment structure for designated MO DD Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Missouri. Failure to meet such requirements is grounds for revocation of Health Home' status and termination of payments.

Clinical Care Management Per-Member-Per-Month (PMPM) payment:
Cost Assumptions/Factors Used to Determine Payment
Missouri will pay DD Health Homes the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Health Home Director, Physician Consultant/ APRN, NCM, Specialized Healthcare Consultant, and DD Health Home Facilitator), whose duties are not otherwise reimbursable by MO HealthNet. In addition, the DD Health Home PMPM will include Health Home specific training, technical assistance, administration, and data analytics.

Staff cost is based on the Bureau of Labor Statistics data.

All DD Health Home providers will receive the same PMPM rate.

The PMPM method will be reviewed periodically to determine if the rate is economically efficient and consistent with quality of care.

Clinical Care Management Standards
Managed Care: All Health Home payments including those for MO HealthNet individuals enrolled in managed care plans will be made directly from MO HealthNet to the Health Home provider. As a result of the additional value managed care plans will receive from MO HealthNet direct paid Health Home services, the managed care plan is not required to provide care coordination or case management services which would duplicate the CMS reimbursed Health Home services. This Heath Home delivery design and payment methodology will not result in any duplication of payment between Health Home and managed care. The managed care plan will be informed of its members that are in Health Home services and a managed care plan contact person will be provided for each Health Home provider to allow for coordination of care.

- The managed care plan will be required to inform either the individual's Health Home or MO HealthNet of any inpatient admission or discharge of a Health Home member the plan learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.
- The DD Health Home team will provide Health Home services in collaboration with managed care organization 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 DD Health Home.

Minimum Criteria for Payment:
The criteria required for receiving the PMPM payment is:

- The person is identified as meeting MO DD Health Home eligibility criteria on the state-run Health Home health information technology platform;
- The person is enrolled as a DD Health Home individual at the billing Health Home provider and is enrolled in only one Health Home at a time;
- The minimum DD Health Home service required to merit payment of the PMPM is that the individual has received Care Management monitoring for care management gaps that was documented or another Health Home service was provided that was documented; and
- The Health Home will report that the minimal service required for the PMPM rate payment occurred on a monthly Health Home attestation report.

Except as otherwise noted in the plan, state-developed PMPM rates are the same for both governmental and private providers of Health Home services. The department's PMPM rate is published on the website at: https://dmh.mo.gov/dev-disabilities/health-home and is effective for services provided on or after July 1, 2024.

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Assurances

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

Describe below how non-duplication of payment will be achieved

Health Home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e., DD TCM, DD HCBS Waivers, managed care, other delivery systems including waivers, any future Health Home state plan benefits, and other state plan services). In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home individuals are not receiving similar services through other Medicaid-funded programs.

The below listed services will continue to be necessary for individuals served under Waivers.
Functions of case managers:

i. Determine Waiver eligibility;
ii. Comprehensive assessment to determine unmet needs related to Waiver services;
iii. Services planning and services provided under the Waiver;
iv. Waiver services authorization;
v. Service monitoring.

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

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

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

Optional Supporting Material Upload

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Health Homes Services

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Service Definitions

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

Comprehensive Care Management

Definition

Comprehensive care management services include:
- Determining level of participation in care management services based upon individualized information provided through the Health Risk Screening Tool (HRST), Health Risk Support Plans (HRSP), and other individual information;
- Assessment of preliminary service needs which includes reviewing and identifying gaps in the overall person-centered plan which may include the HRSP and Behavior Support Plan (BSP),;
- DD Health Home development of individual DD health care goals, preferences and optimal clinical outcomes;
- Assigning health team roles and responsibilities;
- Developing guidelines for health teams to follow across risk levels or health conditions;
- Monitoring of individual and population health status and service use to determine adherence to or variance from DD health care goals and identified service needs identified in the overall person-centered plan; and
- Developing and disseminating reports that indicate the individual's progress toward meeting outcomes for individual satisfaction, health status, service delivery and costs.
- Care management monitoring for care management gaps utilizing population health management.

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

The state maintains various Health Information Technology (HIT) systems that will be used to improve service delivery and care coordination across the care continuum.

DMH maintains an electronic events management system for reporting of critical incidents and other events that meet criteria defined by DMH DD.

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers. The tool is a HIPAA-client portal that enables providers to:
- Download paid claims data submitted for the 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 the 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 the 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 issues and transmit a prescription electronically to the enrollee's pharmacy of choice; and
- Review laboratory data and clinical trait data;
- Determine medication adherence information and calculate medication possession ratios (MPR); and
- Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses

- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
DD TCM and accredited or certified DD HCBS Waiver providers.	DD TCM and accredited or certified DD HCBS Waiver providers.

Health Homes Services

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Care Coordination

Definition

Care Coordination is the implementation of the overall individual person-centered plan with active individual and family involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.
Care coordination is designed to be delivered in a flexible manner best suited to the individual's preferences and to support goals that have been identified by developing linkages and skills in order to allow the individual to reach their full potential and increase their independence in obtaining and accessing services. Specific activities include but are not limited to:

- Participating in hospital discharge processes to support the individual's transition to the community;
- Communicating and consulting with the individual and providers through face-to-face and collateral contacts; and
- Facilitating regularly scheduled interdisciplinary team meetings to review person-centered plans and assess progress toward identified goals.

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

DMH maintains an electronic events management system for reporting of critical incidents and other events that meet criteria defined by DMH DD.

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers.
The tool is a HIPAA-client portal that enables providers to:

- Download paid claims data submitted for the 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 the individual's care and receive best practice information;
- Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for the individual 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 individual's pharmacy of choice;
- Review laboratory data and clinical trait data;
- Determine medication adherence information and calculate medication possession ratios (MPR); and
- Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
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- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
DD TCM and accredited or certified DD HCBS Waiver providers.	DD TCM and accredited or certified DD HCBS Waiver providers.

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Health Promotion

Definition

Health promotion services shall minimally consist of educating and engaging the individual in making decisions that promote independent living skills and lifestyle choices that achieve the following goals:

- Good health;
- Proactively managing chronic conditions;
- Identifying risk factors early; and
- Screening for emerging health problems.

Health promotion services include but are not limited to:

- Promoting the individual's education of their chronic conditions;
- Developing self-management plans with the individual;
- Conducting medication reviews and regimen compliance;
- Providing support to the individual for improving social networks and health-promoting lifestyle interventions, including but not limited to: Preventative health practices for the I/DD population, nutritional counseling, obesity reduction and prevention and increasing physical activity; and
- Assisting the individual to participate in the overall person-centered plan process with an emphasis on person-centered empowerment and the development of health literacy skills to help the individual understand and self-manage chronic health conditions.

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

DD Health Home has access to an integrated electronic health risk solution. The integrated electronic health risk solution is used to provide early detection of health risk and destabilization, and is intended to empower the individual and other interdisciplinary team members with information to effectively oversee the health and welfare of the individual. The integrated electronic health risk solution is interactive, individualized applications to empower users to address areas of health risk and destabilization in areas such as functional activities, behavioral, physiological, safety, and frequency of services. The Health Home works with the individual to address the identified areas of health risk and destabilization, service gaps, and support effective individualized service planning to mitigate risk and improve overall health outcomes.

The integrated electronic health risk solution provides training and service considerations that are tailored specifically to the needs of the individual, and empower the team with knowledge of how to address areas of risk identified.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
DD TCM and accredited or certified DD HCBS Waiver providers.	DD TCM and accredited or certified DD HCBS Waiver providers.

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

Definition

Comprehensive transitional care services include but are not limited to:

- Facilitating the individual's transition between care levels, such as a hospital, nursing facility and residential supports, or when opting for a new Health Home provider;
- Collaborating and establishing relationships with the individual's physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the overall person-centered plan. Specific focus is on increasing the individual's 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;
- Communicating with and educating the individual and providers located at the setting from which the individual is transitioning, and at the setting to which the individual is transitioning;
- Ensuring the individual's prompt access to follow-up care after discharge (e.g., care record from discharge entity, medication reconciliation, reviewing person-centered plan to assure access to needed community services, appointment scheduling); and
- Providing care coordination services designed to streamline person-centered plans, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use.

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

MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of a new admission of any Medicaid individual and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. DMH DD would immediately notify the Health Home provider of the admission, which would enable the Health Home provider to:

- Perform the required continuity of care coordination between inpatient and outpatient, which includes DD HCBS waiver services; and
- Active participation in discharge planning to ensure consistently meeting goals identified in the overall person-centered plan and to avoid readmission.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
DD TCM and accredited or certified DD HCBS Waiver providers.	DD TCM and accredited or certified DD HCBS Waiver providers.

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Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services are intended to assist the individual to facilitate and maintain quality of life and explore community options to promote overall quality of life through health stabilization and improved health outcomes. Activities include but are not limited to:

- Educating and guiding in self-advocacy support with the individual;
- Increasing the individual's health literacy skills and ability to self-manage their care;
- Identifying resources for the individual to address the gaps identified in the overall person-centered plan to improve his or her overall health and ability to function within his or her families and in the community;
- Educating the individual on the importance of obtaining and adhering to medications and other prescribed treatments; and
- Assisting the individual with developmental disabilities for whom primary services needs are more directly related to treatment (e.g., treatment for a mental health condition or serious and persistent mental illness) and/or particular healthcare condition(s), referring and coordinating with the approved care management entity for the MO CMHC Health Care Home or MO Primary Care Health Home for services more directly related to those aforementioned conditions.

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

The DD Health Home has access to an integrated electronic health risk solution. The integrated electronic health risk solution has the capability to be interoperable with other health information technology. The information maintained in this integrated electronic health risk solution may be used to provide information related to the early detection of health risk and destabilization.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
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- [ ] Social Workers
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- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
DD TCM and accredited or certified DD HCBS Waiver providers.	DD TCM and accredited or certified DD HCBS Waiver providers.

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Referral to Community and Social Support Services

Definition

Referral to Community and Social Support Services involves identifying gaps in the overall person-centered plan that are connecting the individual to community based resources and referrals that support Social Determinants of Health (SDOH). It also includes identifying resources to reduce barriers that will promote the individual's overall quality of life through health stabilization and improved overall health outcomes.

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

The DD Health Home has access to an integrated electronic health risk solution. The integrated electronic health risk solution has the capability to be interoperable with other health information technology. The information maintained in this integrated electronic health risk solution may be used to provide information related to the early detection of health risk and destabilization.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
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Provider Type	Description
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Health Homes Patient Flow

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

•Individuals eligible for DD Health Home services and identified by the state will be auto-assigned to eligible providers. Individuals may also opt-in if they are identified as being potentially eligible for DD Health Home services by other means such as providers, families, guardians, and support coordinators. The state will make the final determination on whether the individual identified qualifies for DD Health Home services. Upon enrollment, individuals assigned to the DD Health Home will be informed by the state via U.S. mail and other methods as necessary of all available DD Health Homes throughout the state. The notice will describe the individual's choice in selecting a DD Health Home as well as provide a brief description of DD Health Home services, and describe the process for individual's to opt-out of receiving services from the assigned DD Health Home provider and select another service provider from the available DD Health Home providers throughout the state at any time. Individuals who have been auto assigned to a DD Health Home provider may also opt out of the DD 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 DD Health Home.
•Once enrolled, a Nurse Care Manager (NCM) will be assigned to assist in improving health and wellness goals.
•Once an individual is assigned to the DD Health Home, the DD Health Home provider completes a chart review of the individual. Once the chart review is completed, the DD Health Home completes the DD Health Home screen, including components of SDOH. The NCM meets with the individual to review the results of the screen and their chronic disease management history, and to discuss wellness, health, and healthcare goals.
•The DD Health Home team collaborates with the individual to develop healthcare goals which are incorporated into the individual's DD Health Home Plan.
•The individual's Primary Care Physician (PCP) is notified of enrollment in the DD Health Home. If the individual does not have a PCP, the DD Health Home provider works to connect them with one.
•The DD Health Home team carries out assigned responsibilities related to DD Health Home goals, including, but not limited to, wellness, health status, chronic disease management, and identified SDOH resources.
•The department's identified system enables NCMs to identify if individuals fail to fill prescribed medications for chronic health conditions; if individuals with hypertension, diabetes, and cardiovascular disease have lab values which exceed desired levels; and track progress in controlling BMI levels, tobacco use, and metabolic screening values.
•When goals are achieved, the individual may be discharged or transferred to the CMHC Health Home or Primary Care Health Home for continued care with the option of returning to the DD Health Home, if needed.

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Health Homes Monitoring, Quality Measurement and Evaluation

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Monitoring

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

The state will annually conduct a methodology which establishes estimated cost savings for the health home population on the basis of reductions in utilization for key targets identified by the program.

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

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

The IntellectAbilities Integrated Health Supports System includes an integrated health risk solution used to provide early detection of health risks and destabilization as well as standardized electronic Health Risk Support Plan (HRSP) templates. Completed HRSPs will support the team with identification of implementation strategies to mitigate risk and improve health outcomes.

As Missouri implements its DD Health Home models, the state will also be working toward the development of a single data portal to facilitate information exchange, performances measures documentation and calculation and aggregate state reporting to CMS. The state will also continue to refine a process for Health Information Exchange (HIE) between DD Health Home and primary care practices.

The following is a summary of HIT currently available for DD 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 HIE for comprehensive transitional care services.

Care Management and Care Coordination HIT:
DMH maintains an electronic events management system for reporting of critical incidents and other events that meet criteria defined by DMH DD.

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers. The tool is a HIPAA-client portal that enables providers to:

- Download paid claims data submitted for the individual 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 the individual's care and receive best practice information;
- Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for the individual 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 issues 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 and Individual and Family Support Services HIT:
Health Promotion –
DD Health Home has access to an integrated electronic health risk solution. The integrated electronic health risk solution is used to provide early detection of health risk and destabilization, and is intended to empower the individual and other interdisciplinary team members with information to effectively oversee the health and welfare of the individual. The integrated electronic health risk solution is interactive, individualized applications to empower users to address areas of health risk and destabilization in areas such as functional activities, behavioral, physiological, safety, and frequency of services. Health Home work with the individual to address the identified areas of health risk and destabilization, service gaps, and support effective individualized service planning to mitigate risk and improve overall health outcomes.

The integrated electronic health risk solution provides training and service considerations that are tailored specifically to the needs of the individual, and empower the team with knowledge of how to address areas of risk identified.

Individual and Family Support Services -
The DD Health Home has access to an integrated electronic health risk solution. The integrated electronic health risk solution has the capability to be interoperable with other health information technology. The information maintained in this integrated electronic health risk solution may be used to provide information related to the early detection of health risk and destabilization.

Comprehensive Transitional Care HIT:
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 individual and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. DMH DD would 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 individuals in need of DD 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, DD Health Home will continue to implement or develop memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.

Referral to Community and Social Support Services HIT:
The DD Health Home has access to an integrated electronic health risk solution. The integrated electronic health risk solution has the capability to be interoperable with other health information technology. The information maintained in this integrated electronic health risk solution may be used to provide information related to the early detection of health risk and destabilization.

DD 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 DD Health Home providers of impending eligibility lapses (e.g., 60 days in advance).

Specific HIT Strategies for DD Health Home Customer Information Management, Outcomes and Reporting (CIMOR) – DD Health Home will continue to utilize The DD Information System for routine functions (e.g., contract management, billing, benefit eligibility, etc.). In addition, DD Health Home enrollment data in the DD Information System will be cross referenced with MO HealthNet inpatient pre-authorization data to enable the automated real-time reporting of inpatient authorizations to the appropriate DD Health Home provider.

Data Warehouse and Reporting System – The department's identified system will support data warehousing and reporting for the DD Health Home.

Specific HIT Strategies for Prescribing Practices – DD Health Home will utilize an electronic health management tool to receive aggregate and individual identification and reporting of potentially problematic prescribing patterns.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MO2023MS0002O | MO-24-0005 | DD Health Home

Package Header

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Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- [x] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

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