Table of Contents

State/Territory Name: MO

State Plan Amendment (SPA) #: 16-0002

This file contains the following documents in the order listed:

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

Division of Medicaid and Children's Health Operations

July 5, 2016

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

Dear Mr. Kinkade:

The Centers for Medicare & Medicaid Services (CMS), Kansas City Regional Office, has completed its review of Missouri State Plan Amendment (SPA) Transmittal Number #16-002. This SPA was submitted on March 23, 2016, for the purpose of adding additional chronic care conditions as qualifying conditions for Primary Care Health Home participants.

The original approval package forwarded to the state contained incorrect SPA Pages. SPA #16-002 was approved on June 21, 2016, with an effective date of April 1, 2016, as requested by the state. CMS has enclosed a copy of the CMS 179 Summary form, as well as, the corrected approved pages for incorporation into the Missouri State Plan.

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

Sincerely, 7/5/2016

Megan K. Buck
Acting Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: Megan K. Buck -A

Enclosures

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

Health Home State Plan Amendment

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

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 1

Submission Summary

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

MO-16-0002

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

MO-11-0015

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

CONVERTED Missouri-2 Health Home Sevices - in process

State Information

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

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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

The primary contact for this submission package.

Name:	Joseph Parks, M.D
Title:	Director, MO HealthNet Division
Telephone number:	(573) 751-6884
Email:	Joe.Parks@dss.mo.gov

The secondary contact for this submission package.

Name:	
Title:	
Telephone number:	
Email:	

The tertiary contact for this submission package.

Name:	
Title:	
Telephone number:	
Email:	

Proposed Effective Date

04/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
Data conversion from previous Medicaid Model Data Lab.
Supersedes Transmittal Number: 00-0000

Transmittal Number: 11-0015

This State Plan Amendment is in Attachment 3.1-H of the State Plan, except for the Payment Methodologies section, which is in Attachment 4.19-B of the State Plan.

Attachment 3.1-H of the above entry: Page 2

Attachment 4.19-B Page 49

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 907137.00
Second Year	2017	$ 1226301.00

Federal Statute/Regulation Citation

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

Governor's Office Review

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

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 2

Submission - Public Notice

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

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

Indicate how public notice was solicited:

- [ ] **Newspaper Announcement**
- [ ] **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
  Date of Publication:
  _____ (mm/dd/yyyy)
- [ ] **Email to Electronic Mailing List or Similar Mechanism.**
  Date of Email or other electronic notification:
  _____ (mm/dd/yyyy)
  Description:
- [ ] **Website Notice**
  Select the type of website:
  - [ ] Website of the State Medicaid Agency or Responsible Agency
    Date of Posting:
    _____ (mm/dd/yyyy)
    Website URL:
  - [ ] Website for State Regulations
    Date of Posting:
    _____ (mm/dd/yyyy)
    Website URL:
  - [ ] Other
- [ ] **Public Hearing or Meeting**
- [ ] **Other method**

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

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21,

2016
Attachment 3.1-H Page Number: 3

Submission - Tribal Input

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

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

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

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

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 4

Submission - SAMHSA Consultation

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

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

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 5

Health Homes Population Criteria and Enrollment

Population Criteria

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

☑ **Two or more chronic conditions**

Specify the conditions included:

- [x] **Mental Health Condition**
- [x] **Substance Abuse Disorder**
- [x] **Asthma**
- [x] **Diabetes**
- [x] **Heart Disease**
- [x] **BMI over 25**

Other Chronic Conditions	
Developmental Disabilities	

Additional description of other chronic conditions:
Other Chronic Conditions Covered:
• Developmental Disabilities
• (NEW) Mental Health Conditions: (Depression, Anxiety)
• (NEW) Substance Abuse Disorder (restricted to organizations that have at least one clinician certified to provide medication-assisted treatment)

- [x] **One chronic condition and the risk of developing another**

Specify the conditions included:

- [x] **Mental Health Condition**
- [x] **Substance Abuse Disorder**
- [x] **Asthma**
- [x] **Diabetes**
- [x] **Heart Disease**
- [x] **BMI over 25**

Other Chronic Conditions	
Developmental Disabilities	

Specify the criteria for at risk of developing another chronic condition:
Description of "At Risk" Criteria:
1. Tobacco use (tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD).
2. Diabetes (Diabetes is considered an at-risk behavior for chronic conditions such as CVD and BMI over 25).
3. (NEW) Obesity (considered an at-risk behavior for chronic conditions such as CVD and DM).
4. (NEW) Pediatric asthma (considered an at-risk behavior for higher rates of school absenteeism; inadequate sleep leading to short attention, impulsivity, emotional liability, hyperactivity, irritability, cognitive and speech-language problems, and poor academic outcomes; and anxiety, depression, and other emotional and behavioral problems)

Additional description of other chronic conditions:
Other Chronic Conditions Covered: Developmental Disabilities

- [ ] **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

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

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

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

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

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

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

○ **Opt-In to Health Homes provider**

Describe the process used:

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

Describe the process used:
Individuals eligible for primary care health home services and identified by MO HealthNet as being existing users of a PCHH organization will be auto-assigned to PCHH providers based on qualifying conditions. Individuals enrolled will be informed via US mail. The notice will describe PCHH services, as well as the process to opt out of receiving PCHH services or change PCHH providers, and that these decisions will not impact their existing services. Once an individual is enrolled, the PCHH will notify other healthcare providers (e.g. specialists) about the goals and types of PCHH services the participant will be receiving, as well as encourage their participation in care coordination. Other individuals with qualifying chronic conditions who don't use a PCHH provider as their primary care provider may request to enroll. Potentially eligible individuals may be informed about and referred to a PCHH provider by a hospital or ED. Eligibility for PCHH services will be identifiable through the state's comprehensive Medicaid EHR.

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

○ **Other**

Describe:

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

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

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan**

will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

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

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

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 6

Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

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

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☑ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☑ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

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

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

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

Describe the Provider Qualifications and Standards:

☑ **Other (Specify)**

Provider	
Name: Primary care clinics operated by hospitals	

Provider Qualifications and Standards:

☐ **Teams of Health Care Professionals**

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

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

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

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

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

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

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

Provider Infrastructure

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

Practice sites will be physician-led and shall form a health team comprised of a primary care physician (i.e., family practice, internal medicine, or pediatrician) or nurse practitioner, a licensed nurse or medical assistant, behavioral health consultant, a nurse care manager and the practice administrator or office manager. The team is supported as needed by the care coordinator and health home director. In addition, other optional team members may include a nutritionist, diabetes educator, public school personnel and others as appropriate and available. Optional team members are identified for inclusion at the request of the patient, responsible caregiver or by the care manager. The designated provider is responsible for locating and conducting outreach to optional team members. Optional team members will not be included in the review to determine selection of primary care health homes. All members of the team will be responsible for ensuring that care is person-centered, culturally competent and linguistically capable. The Health Home Director, Nurse Care Manager, Behavioral Health Consultant, and Care Coordinator’s time will be covered under the PMPM rate described in the Payment Methodology section below.

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

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
1. In addition to being a Federally Qualified Health Center, Rural Health Clinic, clinical practice/clinical group practice, or primary care clinic operated by a hospital, each primary care health home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each primary care health home:
a. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals, defined as receiving medical assistance from Medicaid or the Children’s Health Insurance Program (CHIP), furnished uncompensated care by the provider, or furnished services at either no cost or reduced based on a sliding scale. Patient percentage requirements will be determined by the state;
b. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated by through the application process and agreement to participate in learning activities, including in-person sessions and regularly scheduled phone calls;
c. Meet state requirements for patient empanelment (i.e., each patient receiving primary care health home services must be assigned to a physician);
d. Meet the state’s minimum access requirements. Prior to implementation of primary care 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. Have a formal and regular process for patient input into services provided, quality assurance, access and other practice aspects;
f. Have completed EMR implementation and been using the EMR as its primary medical record solution, to

eprescribe, and to generate, or support the generation of through a third party such as a data repository, clinical quality measures relevant to improving chronic illness care and prevention for at least six months prior to the beginning of primary care health home services;
g. Actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for Medicaid participants;
h. 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;
i. Within three months of primary care 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 primary care 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 primary care health home site, and in addition motivate hospital staff to notify the primary care health home's designated staff of such opportunities; the state will assist in obtaining hospital/primary care health home MOU if needed;
j. Agree to convene regular, ongoing and documented internal primary care 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 primary care health home activities, efforts and progress in implementing primary care health home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of primary care health home service staff time and activities);
m. Maintain compliance with all of the terms and conditions as a primary care health home provider or face termination as a provider of primary care health home services; and
n. Present a proposed healthcare 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 primary care 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 Certification Requirements
a. Each practice must:
1. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
2. Demonstrate development of fundamental medical home functionality at 6 months and 12 months through an assessment process to be applied by the state;
3. Demonstrate significant improvement on clinical outcome and process indicators specified by and reported to the state, and
4. Submit an application for NCQA recognition by month 18 from the date at which supplemental payments commence and either:
i. Attain NCQA 2011 PPC-PCMH recognition at least at Level 1, or
ii. Attain NCQA 2014 PCMH recognition at least at Level 1, or
5. Meet equivalent recognition standards approved by the state as such standards are developed.

3. For health home organizations that want to enroll individuals with substance abuse disorder, at least one physician at each applicable practice site must qualify* and apply for a waiver** under the Drug Addiction Treatment Act of 2000 (DATA 2000).
*Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified physicians may apply for waivers to treat opioid dependency with approved buprenorphine products in any settings in which they are qualified to practice, including an office, community hospital, health department, or correctional facility. A "qualifying physician" is specifically defined in DATA 2000 as one who is:
• Licensed under state law (excluding physician assistants or nurse practitioners)
• Registered with the Drug Enforcement Administration (DEA) to dispense controlled substances
• Required to treat no more than 30 patients at a time within the first year
• Qualified by training and/or certification
Also, in order to maintain a waiver, a physician must be capable of referring patients to counseling and other services.

**To qualify for a waiver, a licensed physician (M.D. or D.O.) must meet any one or more of the following criteria and provide supporting documentation for all that apply:
• Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties
• Hold an addiction certification from the American Society of Addiction Medicine (ASAM)

• Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association
• Have completed required training for the treatment and management of patients with opioid use disorders. This involves not less than eight hours of training through classroom situations, seminars at professional society meetings, electronic communications, or training otherwise provided by ASAM and other organizations.
• Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment. The physician's participation should be confirmed in a statement by the sponsor of the approved medication to Department of Health and Human Services (HHS).
• Have other training or experience that the state medical licensing board (of the state in which the physician will provide maintenance or detoxification treatment) considers a demonstration of the physician's ability to treat and manage patients with opioid dependency.
• Have completed other training or experience that HHS considers a demonstration of the physician's ability to treat and manage patients with an opioid dependency. The criteria of HHS for this training or experience will be established by regulation.

Health Homes Service Delivery Systems

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

☑ **Fee for Service**
☐ **PCCM**

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

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

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

☐ **Fee for Service**

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

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part**

of a team of health care professionals will be different from those of a regular PCCM.

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

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

☐ **The current capitation rate will be reduced.**

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

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

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

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

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

○ **Yes**

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

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

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

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

○ **No**

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

☐ **Fee for Service**

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

☐ **Other**

Description:

☐ **Other Service Delivery System:**

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

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

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 8

Health Homes Payment Methodologies

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

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

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

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

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

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

☐ **Other: Describe below.**

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

☑ **Per Member, Per Month Rates**

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

Rate Basis/Development

Overview of Payment Structure: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's per-member-per-month rate was set as of January 1, 2016 and is effective for services provided on or after that date. Rates are published here:
http://dss.mo.gov/mhd/cs/health-homes/pdf/pchh-per-member-per-month-rates.pdf.
. 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 PCHH the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Nurse Care Managers, Behavioral Health Consultants, Care Coordinators and Health Home Directors) whose duties are not otherwise reimbursable by MO HealthNet. In addition, PCHH Health Homes receive payments related to Health Home specific training, technical assistance, administration, and data analytics.

- Staff cost is based on a provider survey of all PCHH statewide and includes fringe, operating & indirect costs.
- All PCHH providers will receive the same PMPM rate.
- The PMPM method will be reviewed periodically to determine if the rate is economically efficient and consistent with quality of care.

Clinical Care Management Standards

Managed Care: All Health Home payments including those for MO HealthNet (MHN) participants enrolled in managed care plans will be made directly from MHN to the Health Home provider. As a result of the additional value that managed care plans will receive from MHN direct paid Health Home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the CMS reimbursed health home services. This Health Home delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed

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

Minimum Criteria for Payment
The criteria required for receiving the PMPM rate payment is:
A. The person is identified as meeting PCHH 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 payment of the PMPM is that the person has received Care Management monitoring for treatment gaps; or another health home service was provided that was documented 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.

☐ **Incentive payment reimbursement**

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

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

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

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

☐ **Tiered Rates based on:**

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

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

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

☐ **Rate only reimbursement**

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

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

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

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

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 9

Submission - Categories of Individuals and Populations Provided Health Homes Services

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

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

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

Comprehensive Care Management

Definition:
Comprehensive care management services 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 by the care manager of health team roles and responsibilities;
d. development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
e. monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
f. development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices and schools. The tool is a HIPAA-client portal that enables providers to:
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.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Rural health clinics, FQHCs, Primary care clinics operated by hospitals, Primary care pra

Description

Care Coordination

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:
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.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Rural health clinics, FQHCs, Primary care clinics operated by hospitals, Primary care pra

Description

Health Promotion

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

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
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 three years;
b. Cardiac and diabetic risk calculators;
c. Chronic health condition information awareness;
d. A drug information library; and
e. The functionality to create a personal health plan and discussion lists to use with healthcare providers.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Rural health clinics, FQHCs, Primary care clinics operated by hospitals, Primary care pra

Description

Health Homes Services (2 of 2)

Category of Individuals

CN individuals

Service Definitions

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

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

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay.

MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the state's data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a healthcare home. The contractor would then immediately notify the healthcare home provider of the admission, which would enable the primary care health home provider to:
a. Use the hospitalization episode to locate and engage persons in need of primary care health home services;
b. Perform the required continuity of care coordination between inpatient and outpatient; and
c. Coordinate with the hospital to discharge and avoid readmission as soon as possible.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Rural health clinics, FQHCs, Primary care clinics operated by hospitals, Primary care pra

Description

Individual and family support, which includes authorized representatives

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

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

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Rural health clinics, FQHCs, Primary care clinics operated by hospitals, Primary care pra

Description

Referral to community and social support services, if relevant

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

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

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Rural health clinics, FQHCs, Primary care clinics operated by hospitals, Primary care pra

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

MO HealthNet provides PCHH organizations with a monthly list of people potentially eligible for PCHH. PCHH providers also query their EHR systems for this purpose. PCHH staff contact them to explain PCHH, and that they will be assigned a Nurse Care Manager (NCM) to assist them in improving their health/wellness goals, that these services are free, participation is optional, and choosing not to enroll will have NO impact on their currents services. Enrollment forms are submitted for interested individuals.

Once enrolled, the NCM meets with participants to review history and health status, and to discuss wellness, health, and self-management goals. A care plan including these topics is developed with input from the participants.

The NCM (or behavioral health consultant) attempts to see all PCHH participants when they come for visits or other services. When patients do not have appointments, PCHH staff contact them by phone or secure email and/or monitor them (CyberAccess review, check on referrals, share targeted educational information, and review reports provided by MO HealthNet that show recent ER visits or hospitalizations, high utilization of ERs or excessive hospitalizations, and opportunities for care coordination with other program (e.g. home & community-based services or developmental disabilities). Staff members also provide needed coordination, referral, and follow-up for other services such as specialty care, ongoing behavioral health care, and community resources.

PCHHs often offer health/wellness classes (e.g. smoking cessation or nutrition), and encourage PCHH enrollees to participate. NCMs provide transition of care coordination and attempt contact within 72 hours of hospital discharge or ER visit to do a medication reconciliation and ensure appropriate follow-up care.

If patients achieve their goals and their chronic conditions are well-controlled, they may be discharged from PCHH to the provider’s general patient-centered medical home.

☐ **Medically Needy eligibility groups**

- ○ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**
- ○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**
  - ○ **All Medically Needy receive the same services.**
  - ○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016

Transmittal Number: MO-16-0002 Supersedes Transmittal Number: MO-11-0015 Approved Effective Date: Apr 1, 2016 Approval Date: June 21, 2016
Attachment 3.1-H Page Number: 10

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

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

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

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

services. Also included is a description of the state's process to improve health information exchange (HIE) for comprehensive transitional care services. As Missouri implements its primary care 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.

1. HIT for Comprehensive Care Management and Care Coordination – MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including primary care practices, CMHCs, and schools. The tool is a HIPAA-compliant portal that enables providers to:
a. Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
b. View dates and providers of hospital emergency department services;
c. Identify clinical issues that affect an enrollee's care and receive best practice information;
d. Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
e. Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
f. Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice; 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. Primary care 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 three 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.
Primary care health home providers are also required to have patient portals in their electronic medical records system which also make various types of information available to enrollees.
3. HIT for Comprehensive Transitional Care – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health have developed a daily process to notify each healthcare home provider of all authorized admissions, which enables the primary care health home provider to:
a. Use the hospitalization episode to locate and engage persons in need of primary care health home services;
b. Perform the required continuity of care coordination between inpatient and outpatient; and
c. Coordinate with the hospital to discharge and avoidable admission as soon as possible.
4. Referral to Community and Social Support Services – Primary care health home providers will be encouraged to monitor continuing Medicaid eligibility using the FSD eligibility website and data base. Primary care health home providers can also access information about impending eligibility lapses (e.g., 60 days in advance).

5. Data Warehouse and Reporting System – The Missouri Primary Care Association maintains a data warehouse for the purpose of functioning as a patient registry for the primary care health home providers and generating quality measures to support clinical quality improvement. Patient demographics and clinically authenticated patient care data from the health home EMRs are included in the data set to support the required measures. MPCA also hosts a web-based reporting platform for users. Each health center's data is available to the health center for individual report generation at all levels, health center, site, provider, and patient, to assist

with care management. MPCA generates aggregate reports to support quality improvement, best practice identification, and benchmarking.

Quality Measurement

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

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

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

Evaluations

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

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

Hospital Admissions

Measure:

Hospital Admissions

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

Numerator: total number of inpatient discharges. Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year. Refer to the codes in Table IU.A to identify total inpatient discharges. Use the guidelines and formulas outlined in the technical speciation published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014) to report inpatient discharges.

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

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

Emergency Room Visits

Measure:

Emergency Room Visits

Measure Specification, including a description of the numerator and denominator.
The rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.

Numerator: Count the total number of ED visits for Health Home enrollees that Medicaid paid for during the measurement year, following the technical specifications published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014).

Denominator: Health Home enrollee months
Data Sources:
MMIS claims and encounter data; Health Home enrollment data.
Frequency of Data Collection:

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

Skilled Nursing Facility Admissions

Measure:

Skilled Nursing Facility Admissions

Measure Specification, including a description of the numerator and denominator.
The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months. This measure applies to Health Home enrollees age 18 and older.

Numerator: Identify all admissions to nursing facilities following the technical specifications published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014). An enrollee may be counted more than once in the numerator if the individual had more than one admission to a nursing facility followed by a discharge to the community during the measurement year.

Denominator: Number of Health Home enrollee months.
Data Sources:
MMIS claims and encounter data; Health Home enrollment data.
Frequency of Data Collection:

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

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

Hospital Admission Rates

The State will consolidate data from its fee-for-service MMIS-based claims system and from MCO-generated encounter data for the participating Primary care health home sites to assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency), for the participating Primary care health home sites and for a control group of non-participating sites. The analysis will consider:
1. 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
2. All beneficiaries with 2 or more chronic conditions, or 1 chronic condition and at risk for a second, drawn from a list of chronic conditions defined by the State.

(text continued from Estimate of Cost Savings below)

II. EMERGENCY ROOM UTILIZATION IMPACT:
A. Assumed reduction in hospital emergency room utilization is 23.4857% for Medicaid patients in primary care health homes (PCHHs).
B. Assume that an MHD ER visit is at least as costly as the average hospital outpatient visit.
C. Assume that an MHD participant would have at least 1 ER visit annually if not assigned to a Health Home.
D. For the months of June thru August 2011, the following MHD O/P hospital amounts were shown on the monthly FSD / MHD managerial reports:
June 2011: $ 45,239,283 hospital outpatient payments for 104,082 recipients, = $ 434.65 average O/P visit cost.
July 2011: $ 52,051,110 hospital outpatient payments for 114,477 recipients, = $ 454.69 average O/P visit cost.
August 2011: $ 57,679,060 hospital outpatient payments for 122,824 recipients, = $ 469.61 average O/P visit cost.
Average MHD hospital O/P cost per visit = $ 452.98 for June - August 2011.

(text continued in Chronic Disease Management below)

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:
1. Documented self-management support goal setting with all beneficiaries identified by the practice site as high risk;
2. Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge;
3. Documentation that there is a care manager in place; and
4. That the care manager is operating consistently with the requirements set forth for the practices by the State.

(Estimate of Cost Savings text continued from Hospital Admission Rates above)

E. Effective October 1, 2011, radiology services will be paid on a fee schedule instead of the hospital outpatient percentage methodology. Estimated impact on total outpatient costs = $50,000,000 reduction on an annual SFY basis. Based on hospital O/P payments above, estimated O/P payments for an entire SFY without the radiology fee schedule conversion = $206,625,937. Percentage reduction in future total O/P costs would = 24.20%. Average MHD hospital O/P cost per visit reflecting future reduction in hospital outpatient radiology costs = $343.37.
F. Assumed number of MHD Health Home assigned patients =25,372
G. i. $ 343.37 average cost per MHD hospital ER / OP visit, multiplied by 25,372 estimated MHD HH patients,= $ 8,711,919 estimated MHD cost of ER visits for Health Home patients prior to PCHH services.
ii. $ 8,711,919 estimated cost of ER for MHD HH patients, times 23.4857% average I/P cost reduction, = $ 2,046,055 estimated Medicaid ER cost savings.

(text continued in Coordination of Care for Individuals with Chronic Conditions below)

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 as follows:
1. The State will measure:
a. Care manager contact during hospitalization,
b. Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge,
c. Active care management of High Risk patients, and
d. Behavioral activation of High Risk patients.
2. Measurement methodologies for these 4 measures are described in the preceding section.

(Estimate of Cost Savings text continued from Chronic Disease Management above)

III. MHD HEALTH HOME COST IMPACT, NET OF HEALTH HOME PMPM PAYMENTS:
A. Estimated I/P hospital cost savings for MHD Health Home patients = $ 18,444,810
B. Estimated ER cost savings for MHD Health Home patients =$ 2,046,055
C. Assume number of MHD Health Home assigned patients =25,372
D. i. Tentative Primary Care Health Home PMPM = $58.87
ii. Tentative Primary Care Health Home PMPY = $706.44
iii. Annual Primary Care PMPM cost = $(17,923,796)
E. Primary Care Health Home estimated annual savings net of PMPM costs =$2,567,070
F. Total estimated pre-PCHH costs = $ 136,025,063
G PCHH savings as a percentage of pre-PCHH costs = 1.89%

(text continued in Assessment of Program Implementation below)

Assessment of Program Implementation
The State will monitor implementation in 2 ways.
1. First, a Primary care health homes Work Group comprised of Dept. of Social Services and Dept. 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 transition to monthly meetings 6 months into implementation.
2. Second, the 2 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.

(Estimate of Cost Savings text continued from Coordination of Care for Individuals with Chronic Conditions above)

IV. NOTE ON MEDICAID INPATIENT COST PER DAY:
The average Medicaid inpatient cost per day of $1,672.62 in I. C. above is from historical hospital cost report data prior to the current state fiscal year. It is greater than the average Medicaid inpatient per diem of $967.55 for SFY 2012. The Medicaid cost per day is used to calculate the inpatient costs and estimated savings in section I above because MHD reimburses the "Medicaid shortfall," or the difference between a hospital's Medicaid I/P cost and its I/P per diem rate, through Direct Medicaid add-on payments that are calculated every state fiscal year. The savings in Medicaid inpatient hospital I/P costs attributable to Primary Care Health Homes would occur in 2 phases: the 1st phase would be the per diem payments avoided in the short term; the 2nd phase would be Direct Medicaid add-on payments avoided in the long term.

Processes and Lessons Learned
The aforementioned work group, as well as the Steering Committee of the Missouri Medical Home Collaborative will approach the Primary care 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 Primary care health homes Work Group and the Collaborative Steering Committee by practice representatives, the State will assess what elements of its practice transformation strategy are working – and which are not. Critical attention will be paid to a) critical success factors, some of which have already been identified in the literature, and b) barriers to practice transformation.

Assessment of Quality Improvements and Clinical Outcomes
The State will use 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 primary care health homes. For registry and claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. For registry-based measures for which national Medicaid benchmark data is available for Medicaid managed care plans, comparisons will be made to regional and national benchmarks, even though such benchmarks are not specific to persons with chronic conditions.

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

If no, describe how cost-savings will be estimated.
I. INPATIENT UTILIZATION IMPACT:

A. Assumed reduction in hospital inpatient utilization is 15.4125% for Medicaid patients in primary care health homes (PCHHs).
B. Estimated average inpatient days per MHD patient admission. =3 days.
C. Average estimated Medicaid inpatient cost per day, including Medicaid share of hospital provider tax assessment, =$ 1,672.62
D. Assumed number of MHD Health Home assigned patients =25,372
E. Assume that an MHD participant would have at least 1 hospital I/P admission annually if not assigned to a Health Home.
F. i. $ 1,672.62 times 3 days average per admission = $ 5,017.86 average cost of Medicaid inpatient admission.
ii. 25,372 estimated MHD Primary Care Health Home patients, times $ 5,017.86 average Medicaid I/P admit cost, =$ 127,313,144 estimated MHD cost of hospital I/P admissions for Health Home patients prior to PCHH services.
iii. $ 127,313,144 estimated cost of hospitalization for MHD HH patients, times 15.4125% average I/P cost reduction, =$ 19,622,138 estimated Medicaid I/P hospital cost savings.
G. Assume that achieving gross Medicaid inpatient hospital cost savings for health home patients requires additional or "replacement" costs for increased utilization of other services such as physicians and pharmacy. Prior actuarial review found replacement cost factor of 6% to achieve hospital I/P cost reductions
H. $19,622,138 estimated gross Medicaid I/P hospital cost savings, net of 6% replacement cost factor = $18,444,810 estimated net Medicaid I/P cost savings.

(text continued in Hospital Admission Rates above)

PRA Disclosure Statement