The MO HealthNet Division (MHD) is attempting to develop shared savings with Health Home providers, if actual savings is eventually realized through the Health Home implementation. This would take place on a retrospective basis and only if approved by the Centers for Medicare and Medicaid Services (CMS). One aspect of shared savings involves Medicare-Medicaid "dual" eligible patients. The following draft proposal, "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," is MHD's first step to requesting CMS approval for shared savings for dual patients. It is being posted for public review and comments which will be shared in summary with CMS. Please email your comments no later than May 25, 2012 to Karen.A.Purdy@dss.mo.gov.

Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

Managed FFS Demonstration Proposal

A. Executive Summary

One-page summary of proposed demonstration design that should include the following overview chart:

The state of Missouri MO HealthNet Division (MHD) previously applied for and received formal approval from the Centers for Medicare and Medicaid Services (CMS) to implement two Health Home programs under Section 2703 of the Affordable Care Act (ACA).

The goals of the Missouri Health Home program include the following:

- reduce inpatient hospitalization admissions, readmissions and inappropriate emergency department (ED) visits;
- improve coordination and transitions of care to improve patient outcomes;
- implement and evaluate the Health Home model as a way to achieve accessible, high quality holistic health care;
- demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model, and
- support practice sites by increasing available resources and thereby improve quality of clinician work life.

Missouri's two Health Home programs were implemented in January 2012 following the approval of two State Plan Amendments (SPAs) and provide care coordination services to eligible Medicaid beneficiaries that meet the SPA clinical criteria, including those beneficiaries who are dually eligible for Medicare and Medicaid. The first approved SPA, the Community Mental Health Center (CMHC) Health Home program, targets Medicaid beneficiaries, including duals, who have serious mental illness (SMI) or mental illness in combination with another chronic condition. The second approved SPA, the Primary Care (PC) Health Home program targets Medicaid beneficiaries, including those dually eligible for Medicare and Medicaid, who have specific somatic chronic conditions.

These initiatives promise to be successful in improving the care of beneficiaries and reducing costs to both Medicare and Medicaid. Under this proposed financial alignment demonstration program, Missouri proposes that Medicare agree to share with the state the savings that Medicare realizes as a result of the state's investment in the two Health Home programs. The state anticipates that the savings calculation that Medicare will use will mirror the methodology used by Medicaid.

The matrix below provides information on key aspects of the demonstration proposal, which are discussed in more detail within this application.

Target Population (All full benefit Medicare-Medicaid enrollees/subset/etc.)	There are **12,230** adult, full benefit Medicare-Medicaid enrollees (out of the **42,634** beneficiaries eligible for Health Homes) participating in the MO HealthNet Health Home program based on meeting the clinical criteria for the CMHC Health Home program or the Primary Care Health Home program.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	There are **168,229** statewide full benefit Medicare-Medicaid enrollees in MO HealthNet.
Total Number of Beneficiaries Eligible for Demonstration	The total number of MO HealthNet beneficiaries eligible to participate in both of the Health Home programs equal **42,634** Medicaid beneficiaries, including **12,230** that are dually eligible for Medicare and Medicaid.
Geographic Service Area (Statewide or listing of pilot service areas)	The Health Home programs are statewide initiatives that are available to all eligible beneficiaries who receive care in Health Homes. Health Home services are available in all geographic areas within Missouri.
Summary of Covered Benefits	Through both of the Health Home programs, eligible beneficiaries receive state plan Medicaid services plus the following support services, as needed: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care (including appropriate follow-up from inpatient to other settings), Individual and Family Support Services (including authorized representatives), and Referral to Community and Social Support Services.
Financing Model	Designated Health Homes receive a Per Member Per Month (PMPM) payment from the State of Missouri for providing the services described above. Providers continue to receive fee-for-service payments for all other services provided to individuals who are dually eligible for Medicare and Medicaid. Additionally providers are eligible to share with the state any net savings achieved through the provision

	of Health Home services. Potential shared savings distribution levels are adjusted based on Health Home performance on quality measures. CMS has approved the Missouri's payment methodology under Section 2703 of the ACA in two separate State Plan Amendments. Missouri seeks to share with CMS savings that the Health Homes generate as a result of the state's investment in the Health Homes.
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates – Section D asks for more detailed information)	Missouri engaged stakeholders in mid-2011 in the development of its Health Home program under Section 2703 of the ACA in coordination with the Missouri Medical Home Collaborative (MMHC) which received input from multiple state provider associations, medical groups, professional organizations, insurers and beneficiary advocates. The state held over 25 advisory committee meetings with and continues to engage various consumer, advocacy, and provider organizations in the design, implementation and performance of the Health Home programs.
Proposed Implementation Dates(s)	The state implemented the CMHC Health Homes on January 1, 2012 and the Primary Care Health Homes was implemented in a phased process between January 1, 2012 and April 1, 2012. The state proposes to commence the demonstration immediately effective upon demonstration approval by CMS, but no later than October 1, 2012. The implementation of the shared savings arrangement with Medicare will begin on the date of implementation.

*B. **Background***

i. Discussion of overall vision and/or rationale for proposed demonstration, including the barriers to integration to be addressed by the model and how they relate to the current financing and delivery system for Medicare-Medicaid Enrollees. State may include description of how it has tried to overcome these barriers in the past (e.g., through other CMS demonstrations, the use of SNPs, etc.) as applicable.

The goal of this demonstration project is to provide integrated care management and support services to individuals who are dually eligible for Medicare and Medicaid and served by Missouri's Health Home programs. Missouri believes that these services will lead to improved delivery and quality of care, and reduced costs to both Medicare and Medicaid for the participating population.

In Medicare, there are approximately 3.2 million individuals dually eligible for Medicare and Medicaid under age 65 with a Medicare per member per month (PMPM) cost of $639 and a Medicaid PMPM cost of $485. These high costs are due in part to beneficiary burden of illness, and also due to the highly fragmented and often uncoordinated care that these beneficiaries receive. In addition, disparate funding sources and payer systems contribute to the less-than-optimally effective treatment being provided to individuals who are among the most vulnerable served by both Medicare and Medicaid. Untreated or poorly treated medical and/or behavioral illness is a major cause of unnecessary expenditures leading to avoidable ED visits and avoidable hospitalizations.

In an attempt to address these systemic issues and overcome the barriers to high quality care, Missouri requested and received approval from CMS for two separate State Plan Amendments (SPAs) to allow provision of Health Home services to MO HealthNet participants, including individuals dually eligible for Medicare and Medicaid. The two Health Home programs are:

- The Community Mental Health Center (CMHC) Home Health program designed for individuals with serious mental illness (SMI) or a combination of mental health issues and another chronic condition. There are currently 29 CMHCs participating in the Missouri CMHC Health Home program.
- The Primary Care (PC) Health Home program designed for patient with complex chronic conditions. There are currently 24 Primary Care Health Home organizations in the state, with most operating multiple Health Home sites.

Please see Attachment G for a list of all of the Community Mental Health Centers participating in the CMHC Health Home program and Attachment H for a list of all of the organizations participating in the Primary Care Health Home program.

Both of these Health Home programs provide an alternative approach to the delivery of health care services that promises better patient experience, better patient outcomes and lower costs than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home (PCMH) model, but has been customized to meet the specific needs of low-income patients with chronic medical conditions. Both the CMHC Health Home program and the Primary Care Health Home program rely upon the same care model and offer the same core services. The programs differ, however, in terms of the eligibility criteria, the members of the care team, the care team goals, the measures used to assess progress towards those goals, and the amount of the PMPM payment.

The Missouri Department of Mental Health (DMH) oversees Health Home services for individuals with serious mental illness (SMI) provided by Community Mental Health Centers while the Missouri HealthNet Division (MHD) oversees Primary Care Health Home services for individuals with predominantly somatic chronic conditions. Both of these Health Home programs offer participants the standard Medicaid benefit package supplemented with comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referrals to community and social support services. Individuals receiving additional waiver services through a home and community-based services (HCBS) waiver or other state waiver program will continue to receive these services, with the expectation that the Health Homes will assist the beneficiary in coordinating such services as appropriate.

Specific performance goals for Health Homes include:

- reduce inpatient hospitalization admissions, readmissions and inappropriate emergency department (ED) visits;
- improve coordination and transitions of care to improve patient outcomes;
- implement and evaluate the Health Home model as a way to achieve accessible, high quality holistic health care;
- demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model, and
- support practice sites by increasing available resources and thereby improve quality of clinician work life.

These programs currently serve and plan on continuing to serve all categorically needy Medicaid participants who meet the programs' eligibility requirements, including those who are dually

eligible for Medicaid and Medicare. Individuals, who reside in a nursing facility, receive hospice services, or who are enrolled in a Medicare Advantage Plan, the PACE program or a Special Needs Plan are not eligible to participate in either Health Home program.

Missouri seeks to share with CMS savings that the Health Homes generate as a result of the state's investment in the Health Homes. Missouri will, in turn, share these savings with providers to incentivize and reward improvements in service delivery and quality of care. Missouri will accomplish this goal by offering providers performance incentive payments if there are cost savings that result from provision of Health Home services. To avoid incentivizing clinically inappropriate reductions in service as a way to reduce costs, the amount of the incentive payment will be determined by the individual Health Home's performance on clinical process outcome indicators. In this manner, participating Health Homes are incentivized to reduce costs, but only while maintaining or improving the quality and clinical outcomes of the care provided. The shared savings incentive payments will be paid in each subsequent year based on the savings and performance realized in the prior year.

ii. Detailed description of the Medicare-Medicaid enrollee population that would be eligible to participate in the proposed demonstration (including completion of the chart below) as well as those that would be specifically excluded.

Missouri proposes to provide integrated care management and support services for eligible beneficiaries. The eligibility criteria for each of the programs are as follows.

- The CMHC Health Home Program will enroll non-institutionalized, categorically needy individuals including those who are dually eligible for Medicare and Medicaid who also have:
    - serious mental illness (SMI);
    - a mental health condition and one other chronic condition (asthma, cardiovascular disease, diabetes, substance use disorder, developmental disability, overweight (BMI >25);
    - a substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, developmental disability (DD), overweight (BMI >25); or
    - a mental health condition or a substance use disorder and tobacco use (tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD).

The Primary Care Health Home Program will enroll non-institutionalized, categorically needy individuals including those who are dually eligible for Medicare and Medicaid who also have:

- two chronic conditions, or

- one chronic condition and the risk of developing another from the following list: asthma, diabetes, heart disease, BMI over 25 or a developmental disability.

There are currently 168,229 dual eligibles in the State of Missouri. Of the total dual eligibles population, 12,230 are currently enrolled in a Health Home program with 5,869 participating in the CMHC Health Home program and 6,361 participating in the Primary Care Health Home. Individuals were initially identified by the state for enrollment through review of paid claims history. While individuals that are dually eligible for Medicare and Medicaid who are receiving Home and Community Based wavier services are eligible to participate in the program, individuals who are receiving services in institutionalized setting are not eligible to participate in the Health Home programs. Table One below details the current enrollment in the Health Home programs.

Table One: Current Enrollment in Health Home Programs

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Total number of beneficiaries in the state eligible to participate in either Health Home program	42,634	0	TBD
Total number of beneficiaries who are dually eligible for Medicare and Medicaid that are eligible to participate in either Health Home program	12,230	0	TBD
Overall total enrollment in Health Homes	37,720	0	2,433
Total Enrollment in the CMHC Health Homes Program	17,262	0	714
Individuals enrolled in the CMHC Health Homes Program with Serious Mental Illness	17,262	0	714
Total Enrollment in the Primary Care Health Homes Program	20,458	0	TBD

Individuals Enrolled in the Primary Care Health Homes Program with 2 chronic conditions	20,458	0	TBD
Individuals Enrolled in the Primary Care Health Homes Program with 1 chronic condition and at risk for another	0	0	TBD
Individuals age 65+ enrolled in either Health Homes program	3,541	0	1,127
Individuals age 65+ enrolled in the CMHC Health Homes program	709	0	TBD
Individuals age 65+ enrolled in the Primary Care Health Homes program	2,832	0	TBD
Individuals under age 65 enrolled in either Health Homes program	33,375	0	1,306
Individuals under age 65 enrolled in the CMHC Health Homes program	16,553	0	TBD
Individuals under age 65 enrolled in the Primary Care Health Homes program	16,822	0	TBD
Duals enrolled in the CMHC Health Home program	5,869	0	TBD
Duals enrolled in the PC Health Home program	6,361	0	TBD
Total number of dual eligible enrolled in both Health Home programs	12,230	0	TBD

C. Care Model Overview

i. Description of proposed delivery system/programmatic elements, including:

The Missouri Health Home model builds on the PCMH model as a means to achieving accessible, high quality care for low-income patients with chronic conditions. The model emphasizes patient-centered care planning, the use of a patient registry, claims and EMR data analytics to stratify health risk, and the provision of care management, care coordination and transitional care services as a means of improving the quality of patient care and health outcomes. While the CMHC Health Homes and the Primary Care Health Home programs differ in terms of their respective eligibility criteria, goals and measures and the amount of the PMPM payment, both programs rely upon the same care model and serve the same core functions.

The core functions of the Missouri Health Home programs include,

1. **Comprehensive Care Management.** Comprehensive care management services are provided by the Nurse Care Manager, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), with the participation of other team members and the support of Health Home Administrative Support staff and the Health Home Director. The 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 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.

2. **Care Coordination.** Care Coordination is the implementation of the individualized treatment plan (with active beneficiary involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up

monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members. Nurse Care Managers, with the assistance of the Health Home Administrative Support staff, are responsible for conducting care coordination activities across the health team. The primary responsibility of the Nurse Care Manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.

3. **Health Promotion**. 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, providing support for improving social networks and providing health-promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist clients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Health Home Director, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), and Nurse Care Manager each participate in providing Health Promotion activities.

4. **Comprehensive Transitional Care (including appropriate follow-up from inpatient to other settings).** In conducting comprehensive transitional care, a member of the care 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 care 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 beneficiary and family member ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management. The Health Home Director, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), and Nurse Care Manager all participate in providing Comprehensive Transitional Care activities, including, whenever possible, participating in discharge planning.

5. **Individual and Family Support Services (including authorized representatives)**. Individual and family support services activities include, but are not limited to: advocating for individuals and families, and assisting with obtaining and adhering to

medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to help 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 is to increase health literacy, ability to self-manage care and to facilitate participation in the ongoing revision of their care/treatment plan. For individuals with developmental disabilities (DD), the care team will refer to and coordinate with the approved DD case management entity for services more directly related to habilitation services and for services more directly related a particular healthcare condition. Nurse Care Managers will provide this service.

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

Geographic Distribution: The Health Home programs are currently operating statewide and will continue to do so under this demonstration. Missouri will continue to contract with Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and primary care clinics operated by hospitals to provide Health Home services. All designated providers are currently and will continue to be required to meet state qualifications. The MO HealthNet Division and the Missouri Department of Mental Health reviewed applications submitted by eligible provider entities in the state and selected sites upon the merits of the applications while ensuring appropriate geographic distribution. There are a total of 24 Primary Care Health Homes, including mostFQHCs in the state. There are 29 CMHCs participating in the CMHC Health Home program. This widespread participation enables the state to serve individuals eligible for the program residing in every county within Missouri.

Practice sites are and will continue to be physician or nurse practitioner-led and have care teams comprised of a primary care physician (i.e., family practice, internal medicine or nurse practitioner, a licensed nurse or medical assistant, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), a nurse care manager and the practice administrator or office manager. Beneficiaries participate in the development of their care plans and are encouraged to be active in the management of their care. The team is supported as needed by the Care Coordinator and the 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 beneficiary, responsible caregiver or by the Care Manager. The designated provider is responsible for locating and conducting outreach to optional team members. All members of the team will be responsible for ensuring that the care provided is person-centered, culturally competent and linguistically capable. The Health Home Director, Nurse Care Manager, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), and Care Coordinator's time will be covered under the appropriate PMPM rates for the CMHC Health Homes and the Primary Care Health Homes as described in the Payment Methodology section below. The standard benefits package of direct services provided by the primary care practices and the CMHCs will continue to be paid through fee-for-service arrangements, as will payments for all other services provided outside of the Health Home.

Health Home sites are and will continue to 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 continue to assess providers to determine learning needs. Each Health Home organizations is required to have at least one site participating in a learning collaborative, specifically designed to help practices transform into Health Homes and provide care using a whole-person approach that integrates primary care, behavioral health, and other needed services and supports. Learning activities are and will continue to be supplemented with monthly practice team calls to reinforce the learning sessions, practice coaching, and monthly practice reporting (data and narrative) and feedback. The learning collaborate has been funded by the Missouri Foundation for Health and the Health Care Foundation of Greater Kansas City.

Enrollment methodology: For the purposes of initial enrollment into the Health Home programs, Missouri used the state's comprehensive Medicaid electronic health record and claims data to identify individuals who were eligible for either the CMHC Health Home program or the Primary Care Health Home program and were currently receiving services from Health Home providers. These individuals were automatically enrolled into the appropriate Health Home program and auto-assigned to their existing providers. Upon enrollment, individuals assigned to a Health Home were informed by the state via U.S. mail and other methods as necessary of the Health Home program, the individual's ability to select a different Home Health provider at any time and are provided a listing of all available Health Homes throughout the state. The notice also describes how an individual may opt out of participating in the Health Home program at any time.

Going forward, beneficiaries who were not auto-enrolled in Health Homes but are receiving services from Health Home providers may be referred to the program by their providers. When referring a beneficiary to the Health Home program, the Health Home submits an application to the state on behalf of the beneficiary for review and approval. Once the application is approved, the state notifies the individual using the same notification process described above. Additionally individuals with qualifying chronic conditions who are not currently receiving services at a Health Home may request to be part of a Health Home by contacting the state. Potentially eligible individuals receiving services in the ED or as an inpatient of a hospital with a memorandum of understanding (MOU) with a participating Health Home will be notified by the hospital about the Health Home program and referred to an appropriate Health Home provider.

When an eligible individual is assigned to a Health Home provider, the provider will receive communication from the state regarding a beneficiary's enrollment in the Health Home program. The Health Home will notify other treatment providers (e.g., primary care and specialists such as OB/GYNs) about the goals and types of Health Home services as well as encourage participation in care coordination efforts.

In order to qualify as a Health Home, provider candidates were required to meet the following criteria by the date of application submission:

- have a substantial percentage (not less than 25%) of their patient panel enrolled in MO HealthNet or be uninsured;
- provide a Health Home that is capable of overall cost effectiveness;
- have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process;
- have patient panels assigned to each primary care clinician;
- actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for MO HealthNet participants;
- 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;
- meet the minimum access requirements of third-next-available appointment within 30 days and same-day urgent care;
- have completed Electronic Medical Record (EMR) implementation and been using the EMR as its primary medical record solution for at least six months prior to the beginning of health home services, and
- agree to participate in a learning collaborative program.

ii. Description of proposed benefit design and how the model will align the full array of

Medicare and Medicaid services, including discussion of who will be accountable for managing the full range of services.

Individuals dually eligible for both Medicare and Medicaid participating in either the CMHC Health Home program or the Primary Care Health Home Program will continue to have access to the full range of services to which they are entitled through both Medicare and the Medicaid State Plan through the traditional fee-for-service payment model. This comprehensive package of covered services will be managed and coordinated by the beneficiary's Health Home care team.

iii. Description of whether the program will add new supplemental benefits and/or other ancillary/supportive services (e.g., housing, non-emergency transportation, etc.) or modify existing services.

In addition to the core services offered through traditional fee-for-service Medicare and Medicaid, the Health Homes offer participants comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services in exchange for a per member per month fee paid by the state. These services will improve the overall provision of care to the member and will provide greater ongoing beneficiary support.

iv. Discussion of how evidence-based practices will be employed as part of the overall care model.

Both the Primary Care Health Home program and the CMHC Health Home program are built upon the foundation of the evidence-based Chronic Care Model (CCM) for improving the quality of care for individuals with chronic conditions. Developed by the MacColl Institute, the Chronic Care Model (CCM) outlines the basic elements that should to be included at each level of the health care system in order to foster high quality care at a lower cost.

In addition to relying on an evidence-based architecture, the Health Home programs require all participating Health Homes to have at least one site participate in the ongoing Learning Collaboratives. The learning collaborative is designed to facilitate practice transformation and introduce Health Home providers to evidence-based strategies to support their care of individuals with chronic conditions. Health Homes participate in both face-to-face learning sessions, and on monthly webinars, and also have access to online resources, including reports that profile clinical performance using practice-reported clinical data.

Finally, the measures of clinical performance that the Health Home providers are required to report on throughout the demonstration are evidence-based and many of them have national Medicaid benchmark data available. These clinical performance measures will be used to determine the amount of savings that the providers may share in with the state, if the practice is able to generate savings.

v. As applicable, description of how the proposed model fits with:

(a) current Medicaid waivers and/or State plan services available to this population; Under the demonstration, individuals dually eligible for Medicare and Medicaid will continue to access all of the services traditionally offered through fee-for-service Medicare and Medicaid. However, if enrolled in a Health Home program that was created through a state plan amendment, the beneficiary will receive additional Health Home services and the Health Home providers will be responsible for assisting the beneficiary in managing and coordinating all of the beneficiary's usual benefits.

If beneficiaries are eligible for home and community-based waiver services, they may both access Health Home services and continue to receive services through the existing waivers without an impact to their eligibility. Currently the state serves beneficiaries who are dually eligible for Medicare and Medicaid in the following waivers: Comprehensive Waiver (a waiver to establish and maintain a community based system of care for individuals with mental retardation and developmental disabilities that includes a comprehensive array of services that meets the individualized support needs of individuals in a community setting), Community Support Waiver, Autism Waiver, Partnership for Hope Waiver, AIDS Waiver, Medically Fragile Adult Waiver, Aged and Disabled Waiver and Independent Living Waiver. Finally, an Adult Day Care Waiver is currently pending approval from CMS.

(b) existing managed long-term care programs;

Missouri does not currently operate a managed long-term care program.

(c) existing specialty behavioral health plans;

Missouri does not currently contract with specialty behavioral health plans.

(d) integrated programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs;

Beneficiaries receiving care through a Special Needs Plan or through a Program for All-inclusive Care for the Elderly (PACE) are not eligible to participate in the Health Home programs.

(e) other State payment/delivery efforts underway (e.g., bundled payments, multi-payer initiatives, etc.) and

Missouri is currently participating in the multi-payer Missouri Medical Home Collaborative and it is through this involvement that Home Homes are eligible and are participating in a Learning Collaborative. Missouri does not currently have any other state payment reform efforts underway that will have any impact on the individuals who are dually eligible for Medicare and Medicaid and enrolled in a Health Home program.

(f) other CMS payment/delivery initiatives or demonstrations (e.g., health home, accountable care organizations, Multipayer advanced primary care practice demonstrations, demonstration to reduce preventable hospitalizations among nursing home residents, etc.).

Missouri does not currently participate in any CMS payment/delivery initiatives or demonstrations that will have any impact on the individuals who are dually eligible for Medicare and Medicaid and enrolled in a Health Home program.

D. Stakeholder Engagement and Beneficiary Protections

i. Discussion of how the State engaged internal and external stakeholders during the planning process and incorporated input into its demonstration proposal. Please be as specific as possible and include dates/descriptions of all meetings, workgroups, advisory committees, focus groups, etc. that were held to discuss proposed demonstration with relevant stakeholders. CMS may ask States to provide additional detail (e.g., summary of stakeholder input, agendas and attendee lists for meetings, etc.) as necessary.

Missouri has actively engaged both internal and external stakeholders, including consumers throughout the planning and implementation process of the Health Home programs. The state described its planning efforts in multiple forums involving consumer, provider, and health plans stakeholders. CMS Regional Office, state agency representatives, employer, foundation, and health service researchers were also participants. The Missouri Medical Home Collaborative (MMHC) Council played a central role in the early stakeholder engagement process, with large meetings occurring in November and December of 2010, and in January and June of 2011. A list of attendees from the initial November 2010 meeting is provided in Attachment D. The MMHC created a Steering Committee to focus upon the detailed planning activity. This group has met five times to date, including in March, May, June, and November of 2011, and January of 2012. The initial membership list is provided in Attachment E.

In addition, provider organizations played an intensively active role in program design and implementation, participating in standing work groups and working closely in collaboration with state agency staff. These work groups continue to meet on a regular basis with state staff. Separate work groups continue to operate for the Primary Care and CMHC Health Home programs, chaired by MO HealthNet Division and Department of Mental Health staff respectively.

Finally, the state has presented to many other bodies on its Health Home planning and implementation work. A list of these organizations and some detail regarding their composition is provided in Attachment F.

ii. ***Description of protections (e.g., continuity of care, grievances and appeals processes, etc.) that are being established, modified, or maintained to ensure improved beneficiary experience and access to high quality health and supportive services necessary to meet the beneficiary's needs.***

To ensure that beneficiaries are satisfied with the services provided by the Health Home, the program provides beneficiaries with the freedom to choose their Health Home providers, change their Health Home providers at any time and to opt out of the Health Home program entirely at any time without penalty. Upon enrollment, individuals assigned to a Health Home will be informed by the state via U.S. mail and other methods as necessary of all available Health Homes throughout the state. The notice will describe beneficiary choice in selecting a Health Home and clearly describe the process for changing Health Home providers and for opting out of the Health Home program at any time without jeopardizing eligibility and coverage of existing Medicaid and Medicare services.

Additionally if a beneficiary applies for participation in a Health Home and the state denies the request, or if at any time any MO HealthNet services have been denied, reduced or terminated, beneficiaries have the right to request a State Fair Hearing. The state is responsible for communicating this right to beneficiaries in a letter outlining the hearing and appeals process. In the denial notice sent to beneficiaries, the state informs them of the opportunity to request a hearing by either writing to the MO HealthNet Division, Participant Services Unit, P.O. Box 3535, Jefferson City, MO 65 102-3535 or by calling the Participant Services Unit at 1-800-392-2161 toll free or (573)751-6527 at the beneficiary's own expense. The beneficiary must contact the Participant Services Unit within 90 days of the date on the denial letter in order to exercise the right to a fair hearing.

Once the beneficiary has requested a hearing, the state will provide him/her with a hearing form designed to gather information about the request. Once the state receives the completed hearing form, the state will schedule a hearing. Hearings are held on the phone. Beneficiaries may either go to the local Family Support Division office for the hearing or have the hearing from your home. The beneficiary is allowed have anyone present at the hearing that he/she would like. The beneficiary may also choose to have another person speak for him/her at the

hearing. Asking for a hearing will not affect the beneficiary's eligibility. Beneficiaries will receive the hearing decision in the mail. If the beneficiary does not agree with the decision, then he/she may ask for an appeal.

iii. ***Description of the state's plans for continuing to gather and incorporate stakeholder feedback on an ongoing basis during implementation and throughout the demonstration, including how the State will inform beneficiaries (and their representatives) about this demonstration. Discuss how information will be provided in languages other than English and in alternative formats for individuals with disabilities.***

Personnel from the MO HealthNet Division and the Department of Mental Health will invite provider, consumer advocate and private payer representatives on the Steering Committee of the Missouri Medical Home Collaborative to review practice data submissions and analysis by the Missouri Foundation for Health, as well as the status of practice transformation activities in conjunction with the learning collaborative. The Steering Committee will meet every six months to review the performance of the Health Homes. The state is willing to consider including beneficiaries who are dually-eligible for Medicare and Medicaid as members of the Steering Committee, as well as CMS representatives, at the request of CMS.

This demonstration project will benefit from Missouri Department of Social Service's (MO DSS) experience working as the state entity for Medicaid in Missouri. MO DSS has experience in producing materials that are understandable and accessible to Medicaid beneficiaries, and are Section 508 compliant. MO DSS is aware of the requirements that include methods of communicating with enrollees who do not speak English as a first language, accommodating enrollees with physical disabilities, different learning styles and capacities, and enrollees who are visually and hearing impaired. All MO DSS enrollees and potential enrollees are informed that information is available in alternative formats and how to access those formats. Currently, MO HealthNet's beneficiary website includes materials for Health Home participants in both English and Spanish. In-person and telephonic interpreter vendors, as well as written translation vendors, are provided. American Sign Language (ASL) interpreters and Braille materials are provided. Notices include language clarifying that oral interpretation is available for all prevalent languages and how to access such services.

The process by which the State will inform beneficiaries (and their representatives) about this demonstration is described in the immediately preceding response.

E. Financing and Payment

i. Description of proposed State-level payment reforms, including identification of the financial alignment model(s) that will be used.

In addition to existing fee-for-service or managed care plan payments for direct services, Missouri currently offers Health Home providers a per member per month clinical management fee to fund Health Home functionalities that are not covered by any of the currently available Medicaid or Medicare funding mechanisms. These fees are made available for beneficiaries served both through the Medicaid fee-for-service and managed care programs.

Additionally the state offers approved Health Homes performance incentive payments if there are cost savings as a result of the Health Home program. To avoid incentivizing clinically inappropriate reductions in service as a way to reduce costs, the amount of the incentive payment will be determined by the individual Health Home's performance on clinical process outcome indicators. In this manner, participating Health Homes are incentivized to reduce costs, but only while maintaining or improving the quality and clinical outcomes of the care provided. The shared savings incentive payments will be paid in each subsequent year based on the savings and performance realized in the prior year.

Through this demonstration project, Missouri seeks to partner with Medicare to create a similar shared saving arrangement such that if any savings accrue to Medicare as a result of the Health Home programs, then Medicare will share such savings with the Missouri, which in turn will share those savings with the Health Home providers.

ii. In either financial alignment model, describe how payments will be made to providers, including proposed payment types (e.g., full-risk capitation, partial cap, administrative PMPM); financial incentives; risk sharing arrangements; etc. as applicable.

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

Missouri pays approved Health Homes a clinical care management per-member-per-month (PMPM) payment to reimburse the costs of staff primarily responsible for delivery of services not covered by other reimbursement (Primary Care Nurses, Primary Care Physician Consultant

(for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), and Administrative Support staff) whose duties are not otherwise reimbursable by MO HealthNet. This reimbursement model is designed to only fund Health Home functionalities that are not covered by any of the currently available Medicaid or Medicare funding mechanisms. Nurse Care Manager and Behavioral Health Consultant (for the Primary Care Health Home program) or Primary Care Physician Consultant (for the CMHC Health Home program) duties often do not involve face-to-face interaction with Health Home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Missouri's Health Home model includes significant support for the leadership and administrative functions that are required to transform traditional Primary Care and CMHC service delivery systems to the new data-driven, population-focused, person-centered Health Home requirements.

The criteria required for a Primary Care Health Home to receive a monthly PMPM payment is:

A. a dually eligible individual is identified as meeting Primary Care Health Home eligibility criteria on the state-run Health Home patient registry;
B. the beneficiary is enrolled as a Health Home member at the billing Health Home provider;
C. the minimum Health Home service required to merit PMPM payment is that the beneficiary has received care management monitoring for treatment gaps; or another Health Home service was provided and documented by a Health Home Director and/or a nurse care manager; and,
D. the Health Home will report and thereby confirm that the minimal service required for the PMPM payment occurred on a monthly Health Home activity report.

The per-member per-month payment is $58.87 for the Primary Care Health Home program and is based on the following structure of personnel and responsibilities:

Team Member	FTE/Cost	PMPM	Team Member Role
Nurse Care Manager	1 FTE/250 enrollees $105,000/year	$35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Primary care health home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support

Team Member	FTE/Cost	PMPM	Team Member Role
			Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases, treatments & medications h. Track required assessments and screenings i. Assist in implementing MHD health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes
Behavioral Health Consultant	1 FTE/750 enrollees $70,000/year	$7.78	a. screening/evaluation of individuals for mental health and substance abuse disorders b. brief interventions for individuals with behavioral health problems c. behavioral supports to assist individuals in improving health status and managing chronic illnesses d. The behavioral health consultant both meets regularly with the primary care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal "curbside " manner as part of the daily routine of the clinic e. Integration with Primary Care i. Support to Primary Care physician/teams in identifying

Team Member	FTE/Cost	PMPM	Team Member Role
			and behaviorally intervening with patients who could benefit from behavioral intervention. ii. Part of front line interventions with first looking to manage behavioral health needs within the primary care practice. iii. Focus on managing a population of patients versus specialty care f. Intervention i. Identification of the problem behavior, discuss impact, decide what to change ii. Specific and goal directed interventions - Use monitoring forms - Use behavioral health "prescription" - Multiple interventions simultaneously g. Education i. Handouts ii. "Teach back" strategy iii. Tailored to specific issue h. Feedback to PCP i. Clear, concise, BRIEF ii. Focused on referral question iii. Description of action plan iv. Plan for follow-up
Primary Care Health Home Director **Administrative**	1 FTE/2500enrollees $90,000/year Non-PMPM paid	$8.87	a. Provides leadership to the implementation and coordination of Health Home activities b. Champions practice transformation based on Health Home principles c. Develops and maintains working relationships with primary and

Team Member	FTE/Cost	PMPM	Team Member Role
support	staff training time Contracted services		specialty care providers including inpatient facilities d. Monitors Health Home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives referral tracking f. Training and technical assistance g. Data management and reporting h. Non-PMPM paid staff training time
Care Coordination	1 FTE/750 enrollees $65,000/year	$7.22	a. Referral tracking b. Training and technical assistance c. Data management and reporting (can be separated into second part time function) d. Scheduling for Primary Care Health Home team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending Medical Records for care coordination
TOTAL PMPM		**$58.87**	

The criteria required for a CMHC Health Home to receive a monthly PMPM payment are the same as those for a Primary Care Health Home. The PMPM payment, however, differs and is $78.74 based on the following structure of personnel and responsibilities:

Team Member	FTE/Cost	PMPM	Team Member Role
Nurse Care Manager	1 FTE/250 enrollees $105,000/year	$35.00	m. Develop wellness & prevention initiatives n. Facilitate health education groups o. Participate in the initial treatment plan development for all of their Health

			Home enrollees p. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases q. Consult with Community Support Staff about identified health conditions r. Assist in contacting medical providers & hospitals for admission/discharge s. Provide training on medical diseases, treatments & medications t. Track required assessments and screenings u. Assist in implementing DMH Net health technology programs & initiatives (i.e., CyberAccess, metabolic screening) v. Monitor HIT tools & reports for treatment w. Medication alerts & hospital admissions/discharges x. Monitor & report performance measures & outcomes
Primary Care Physician Consultant	1 hr/enrollee/year $150/hr	$12.50	a. Participates in treatment planning b. Consults with team psychiatrist c. Consults regarding specific consumer health issues d. Assists coordination with external medical providers
Health Home Director	1 FTE/500 enrollees $115,000/year	$19.17	a. Provides leadership to the implementation and coordination of Health Home activities b. Champions practice transformation based on Health Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Health Home performance and leads improvement efforts e. Designs and develops prevention and

			wellness initiatives
Administrative Support	1 FTE support staff/500 enrollees Non-PMPM paid staff training time Contracted services	$12.07	h. Referral tracking i. Training and technical assistance j. Data management and reporting k. Scheduling for Health Home team and enrollees l. Chart audits for compliance m. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. n. Requesting and sending medical records for care coordination
TOTAL PMPM		**$78.74**	

The PMPM proposed does not cover the full training and technical assistance costs of implementing Health Homes in Missouri. Missouri Foundations, providers and state agencies are spending over $1,500,000 to fund expert consultation, technical assistance, learning collaboratives, and other training required for Section 2703 Health Home planning, development and implementation. The state is not seeking finding for these costs, but only the opportunity to share in any savings that are realized by the Medicare program as a result of the investment. Missouri does, however, request the following:

- CMS provision of reports to Health Homes that could be used by Health Homes to inform their engagement of dually eligible beneficiaries served by Health Homes. Missouri specifically requests that the reports that are being produced for practices participating in the MAPCP demonstration also be made available to Missouri Health Homes.
- CMS provision of data files that can be used by the state for analysis, as well as funding for an analyst to work with such data.

Managed Care: All Health Home payments including those for MO HealthNet participants enrolled in managed care plans will be made directly from MO HealthNet to the Health Home provider. As a result of the additional value that managed care plans will receive from MO HealthNet directly paid Health Home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the MO HealthNet-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. Additionally:

- The managed care plan will be informed of its members that are simultaneously enrolled in a Health Home program and a managed care plan contact person will be provided for each Health Home provider to support coordination of care activity.
- The managed care plan will be required to inform either the individual's Health Home or MO Health Net within 24 hours 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.
- The Health Home team will provide Health Home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in either the CMHC Health Home program or the Primary Care Health Home program.

F. Expected Outcomes

i. Description of the ability of the State to monitor, collect and track data on key metrics related to the model's quality and cost outcomes for the target population, including beneficiary experience, access to care, utilization of services, etc., in order to ensure beneficiaries receive high quality care and for the purposes of the evaluation.

The ultimate goal of the Health Home project is to offer better, more coordinated care to beneficiaries in a way that reduces costs. In order to evaluate Health Home performance and ensure that beneficiaries are, in fact, receiving high quality care, Missouri has implemented a quality process using select quality measures described below in Section F (ii) to assess quality process improvements and clinical outcomes. This evaluation process is designed to:

1. evaluate the Health Home model as a means to delivering accessible, high quality integrated care, and
2. ensure that the Health Homes shared savings incentive has not resulted in clinically inappropriate reductions in service as a way to reduce costs.

As described in response to the question that follows, Missouri has developed a comprehensive measurement set to assess Health Home performance at both the provider and aggregate program level. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, and at the aggregate level for all participating Health Homes. For registry and claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. For registry-based measures for which national Medicaid and Medicare benchmark data are available for Medicaid and Medicare

Advantage managed care plans, comparisons will be made to regional and national benchmarks, even though such benchmarks are not specific to persons with chronic conditions.

The Primary Care and CMHC Health Homes Work Groups, as well as the Steering Committee of the Missouri Medical Home Collaborative, will approach the Health Home transformation process for the participating providers 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, and feedback provided to the Health Homes Work Groups and the Collaborative Steering Committee by practice and consumer advocate representatives, Missouri will assess what elements of its Health Home 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.

ii. List potential improvement targets for measures such as potentially avoidable hospitalizations, 30-day readmission rates, etc.

Primary Care Health Home Clinical Performance Measures:

Missouri has already begun using the following measures to assess the progress of the Primary Care Health Home program:

Goal #1: Improve Health Outcomes for persons with Chronic Conditions:

- **Ambulatory Care-Sensitive Condition Admissions:** age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 65 years and over 75 years. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Emergency Department Visits:** Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measure. The algorithm is a nationally recognized method of calculating preventable ED visits. The state will identify hospital ED visits through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Hospital Readmission:** Missouri will calculate the percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.

- **Care Coordination:** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from the primary care provider. The state will rely on a combination of claims data and EMR data submitted by the practices in their monthly primary care health home reports. The state's benchmark goal is to have 80% of hospital-discharged members have telephonic or face-to-face contact with a care manager made within three days of discharge and performed medication reconciliation with input from PCP.

Goal #2: Improve Behavioral Healthcare:

- **Reducing illicit drug use:** Missouri will calculate the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days. The state will rely on EMR data submitted by the practices in their monthly Primary Care Health Home reports. the state's benchmark goal is to have less than 7.1% of adults reporting use of any illicit drug during the past 30 days. This goal is consistent with the Healthy People 2020 goal.
- **Reducing Excessive Alcohol Consumption:** Missouri will calculate the proportion of adults (18 and older) reporting excessive drinking in the previous 30 days. The state will rely on EMR data submitted by the practices in their monthly Primary Care Health Home reports. The state's benchmark goal is to have less than 25.3% of adults reporting excessive drinking during the past 30 days. This goal is consistent with the Healthy People 2020 goal.
- **Screening for Depression:** Missouri will calculate the percentage of patients 18 years of age and older receiving depression screening through the use of a standardized screening instrument within the measurement period. The state will rely on EMR data submitted by the practices in their monthly Primary Care Health Home reports. The state's benchmark goal is to have 90% of adults receiving depression screening through the use of a standardized screening instrument within the measurement period.
- **Screening for Substance Abuse:** Missouri will calculate the percentage of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary. The state will rely on EMR data submitted by the practices in their monthly reports. The state's benchmark goal is to have 90% of adults receiving screening for substance abuse using a standardized tool with a follow-up plan documented, as necessary.

Goal #3: Increase Patient Empowerment and Self-Management:

- **Patient Use of Personal Electronic Health Records (EHRs) or practice EMR patient portal:** Missouri will use CyberAccess or its successor or information from the practices' EMR patient portals to determine the extent to which patients use their personal electronic health records. The state will calculate the measures using the following formula: Numerator = Number of times Direct Inform was used (patients online EHR

record was opened) in a 90 day period. Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90. The benchmark goal is greater than 25% use.

- **Satisfaction with Services:** Missouri will rely on responses from CG-CAHPS 1.0 Adult Primary Care Surveys Adult Questions #6, 17, 19, and 20 and calculate patient satisfaction scores using the following formula:
    - Numerator = number questions with response of 3-usually or 4-always;
    - Denominator = total number of questions with any answer.

  Results of the CAHPS survey will be aggregated by Primary Care Health Home and across the entire statewide initiative. Final report will benchmark individual Primary Care Health Home performance compared to other Primary Care Health Homes and the statewide average and identify individual items for performance improvement. The state's benchmark goal is satisfaction greater than 80%.

Goal #4: Improve Coordination of Care:

- **Care Coordination:** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within three days of discharge and performance medication reconciliation with input from PCP. The state's benchmark goal is 80% of members**.**
- **Use of CyberAccess per member:** Missouri will calculate number of times that CyberAccess was opened per member per month using the standard management report available within the Cyber Access tool. The state's benchmark goal is one CyberAccess utilization per member each month.

Goal #5: Improve Preventive Care:

- **Body Mass Index (BMI) Control:** Missouri will calculate the percentage of patients with documented BMI between 18.5 and 24.9. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is 80% of patients having a BMI within the healthy range.
- **Adult Weight Screening and Follow-Up:** Missouri will calculate the percentage of patients aged 18 years or older with a calculated BMI in the past three months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the EMR to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is 80% of patients with a BMI outside of parameters with a documented follow-up plan.

Goal #6: Improve Diabetes Care:

- **Adult Diabetes:** Missouri will calculate the percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%. Missouri will use data analytics of the diagnostic and service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >60% of treatment is within guidelines of care.
- **Blood Pressure (BP) Management in Diabetes Patients**: Missouri will calculate the percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg. Missouri will use data analytics of the diagnostic and service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >65% had a blood pressure reading within the recommended range.
- **Adherence to Prescription Medications for Persons with Diabetes**: Missouri will calculate the percentage of members on medication for diabetes in the past 90 days with a medication possession ratio (MPR) > 80%. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >90% of care is provided consistent with treatment guidelines.

Goal #7: Improve Asthma Care:

- **Adult Asthma** - Missouri will calculate the percentage of patients 18 to 50 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >70% of care is provided consistent with treatment guidelines.
- **Adherence to Prescription Medications for Persons with Asthma**: Missouri will calculate the percentage of adherence to prescription medications for asthma and/or COPD. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >90% of care is provided consistent with treatment guidelines.

Goal #8: Improve Cardiovascular Disease (CVD) Care:

- **Hypertension:** Missouri will calculate the percentage of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least two office visits, with blood pressure adequately controlled (BP < 140/90) during the measurement

period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >50%.

- **Coronary Artery Disease (CAD)**: Missouri will calculate the percentage of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100). Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor. The state's benchmark goal is >70% of patients will have their lipid level adequately controlled.
- **Adherence to Prescription Medications for Persons with CVD**: Missouri will calculate the percentage of adherence to CVD medications and anti-hypertensive medications. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >90% of care provided is consistent with treatment guidelines.

CMHC Health Home Clinical Performance Measures:

Missouri has already begun using the following measures to assess the progress of the CMHC Health Home program:

Goal #1: Improve Health Outcomes for Persons with Mental Illness

- **Ambulatory Care-Sensitive Condition Admissions:** age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 65 years and over 75 years. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Emergency Department Visits:** Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measure. The algorithm is a nationally recognized method of calculating preventable ED visits. The state will identify hospital ED visits through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Hospital Readmission:** Missouri will calculate the percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.

- **Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers:** Missouri use data analytics of the diagnostic & service utilization information in administrative claims to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. Specifically, Missouri will calculate the percentage of patients maintaining adherence to Antipsychotics, Antidepressants and Mood Stabilizer medications using the following formula: Numerator = number of members on that class of medication in the past 90 days with medication possession ratios (MPR) > 80% / Denominator = number of all members on that class of medication in the past 90 days. The state's benchmark goal is greater than 90% medication adherence.
- **Care Coordination:** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within three days of discharge and performed medication reconciliation with input from the primary care provider (PCP). The state will rely on a combination of claims data and EMR data submitted by the practices in their monthly Health Home reports. The state's benchmark goal is to have 80% of hospital-discharged members have telephonic or face-to-face contact with a care manager made within three days of discharge and performed medication reconciliation with input from PCP.

Goal #2: Reduce Substance Abuse

- **Reduce illicit drug use:** Missouri will calculate the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months. The state will rely on annual status reports submitted by the practices and use the following formula: Numerator = number of adults who report using illicit drugs in the previous 12 months / Denominator = total number of adults in the past 12 months x 100. The state's benchmark goal is to have fewer than 5% of adults reporting use of any illicit drug during the past 12 months.
- **Reduce Excessive Alcohol Consumption:** Missouri will calculate the proportion of adults (18 and older) reporting excessive drinking in the previous 12 months. The state will rely on annual status reports submitted by the practices and use the following formula: Numerator = number of adults who report drinking excessively in the previous 12 months /Denominator = number of all adults in the past 12 month x 100. The state's benchmark goal is to have fewer than 9% of adults reporting excessive drinking during the past 12 months.

Goal #3: Increase Patient Empowerment and Self-Management:

- **Patient Use of Personal Electronic Health Records (EHRs) or practice EMR patient portal:** Missouri will use CyberAccess or its successor or information from the practices' EMR patient portals to determine the extent to which patients use their personal electronic health records. The state will calculate the measures using the following formula: Numerator = number of times Direct Inform was used (patients online EHR

record was opened) in a 90-day period. Denominator = number of patients actively enrolled in the Health Home at any point during the 90 days x 90. The state's benchmark goal is greater than 25% use.

- **Satisfaction with Services:** Missouri will rely on responses from Mental Health Statistic Improvement Program (MHSIP) survey and calculate patient satisfaction scores using the SAMHSA National Outcome Measures (NOMS) specifications. The state's benchmark goal is greater than 90% satisfaction.

Goal #4: Improve Coordination of Care:

- **Care Coordination:** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within three days of discharge and performance medication reconciliation with input from PCP. The numerator will be aggregated from the monthly Health Home report using the following formula: Numerator = number of patients contacted (phone or face-to-face) within 72 hours of discharge and Denominator = number of all patients discharged x 100**.** The state's benchmark goal is to have 80% of members receive care coordination within three days**.**
- **Use of CyberAccess per member:** Missouri will calculate number of times that CyberAccess was opened per member per month using the standard management report available within the Cyber Access tool. The state's benchmark goal is one cyber access utilization per member each month.

Goal #5: Improve Preventive Care:

- **Body Mass Index (BMI) Control:** Missouri will calculate the percentage of patients with documented BMI between 18.5 and 24.9. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's EMR to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. The state's benchmark goal is 80% of patients having a BMI within the healthy range.
- **Metabolic Screening:** Missouri will calculate the percentage of patients with documented metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG) in the last 12 months. Missouri will rely on the following formula: Numerator: number of current enrollees with a documented metabolic screening in the last 12 months and Denominator: total enrollees. The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. The state's benchmark goal is 80% completion.

Goal #6: Improve Diabetes Care:

- **Adult Diabetes:** Missouri will calculate the percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%. Missouri will use data analytics of the diagnostic and service utilization information in Health Home EMRs to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines using the following formula: Numerator = for a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and a documented HbA1c in the previous 12 months for whom the most recent documented HbA1c level is .8% Denominator = for a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and having a documented HbA1c in the previous 12 months. The state's benchmark goal is >70% of treatment is within guidelines of care.
- **Metabolic Screening:** Missouri will calculate the percentage of patients with documented metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG) in the last 12 months. Missouri will rely on the following formula: Numerator: number of current enrollees with a documented metabolic screening in the last 12 months and Denominator: total enrollees. The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. The state's benchmark goal is 80% completion.

Goal #7: Improve Asthma Care:

- **Adult Asthma** - Missouri will calculate the percentage of patients 18-50 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home Disease Registry to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. Missouri will use the following formula: Numerator = for a given 90-day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry and a prescription for a controller medication and Denominator = for a given 90-day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry. The state's benchmark goal is >70% of care be provided consistent with treatment guidelines.
- **Adherence to Prescription Medications for Persons with Asthma**: Missouri will calculate the percentage of adherence to prescription medications for asthma and/or COPD. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Missouri will use the following formula:

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

The state's benchmark goal is >90% of care be provided consistent with treatment guidelines.

Goal #8: Improve Cardiovascular Disease (CVD) Care:

- **Hypertension:** Missouri will calculate the percentage of patients aged 18 to 85 years and older with a diagnosis of hypertension who have been seen will for at least two office visits, with blood pressure adequately controlled (BP < 140/90) during the measurement period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home disease registry to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. The state will use the following formula: Numerator = for a given 90-day period number of patients between the age of 18 to 85 years old identified as having hypertension in health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90 and Denominator = for a given 90-day period number of patients between the age of 18 to 75 years old identified as having hypertension in the Health Home disease registry who had two documented episodes of care in the previous 12 months. The state's benchmark goal is >90%.

- **Coronary Artery Disease (CAD)**: Missouri will calculate the percentage of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100). Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home disease registry to assess and monitor. The state will use the following formula; Numerator = for a given 90-day period number of patients between the age of 18 years or older identified as having cardiovascular disease in health home registry months where the most recent documented LDL level in the previous 12 months is < 100 **and** Denominator = for a given 90-day period number of patients between the age of 18 years and older identified as having cardiovascular disease in health home registry The state's benchmark goal is >70% of patients will have their lipid level adequately controlled.

- **Adherence to Prescription Medications for Persons with CVD**: Missouri will calculate the percentage of adherence to CVD medications and anti-hypertensive medications. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. The state will use the following formula: Numerator = number of members on that class of medication in the

past 90 days with medication possession ratio (MPR) > 80% and Denominator = number of all members on that class of medication in the past 90 days. The state's benchmark goal is >90% of care provided is consistent with treatment guidelines.

- **Statin Use:** Missouri will assess the use of statin medications by persons with a history of CAD (coronary artery disease) utilizing data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. The state will use the following formula: Numerator = for a given 90-day period number of patients identified as having coronary artery disease in health home registry and a prescription for a statin and Denominator = for a given 90-day period number of patients coronary artery disease in health home registry. The state's benchmark goal is >70%.

iii. Discussion of the expected impact of the proposed demonstration on Medicare and Medicaid costs, including specific mention of any effect on cost-shifting occurring today between the two programs and detailed financial projections over the next three years for Medicare, Medicaid, and total combined expenditures, including estimates of how much savings are anticipated.

Through Missouri's recently implemented Health Home programs, Missouri plans to accomplish the goal of improved service delivery and quality of care by improving the alignment between payment incentives and clinical outcomes. Missouri expects its Health Home programs to result in an entirely different beneficiary experience for Health Home program participants, inclusive of those dually eligible for Medicare and Medicaid, as well as to significantly impact service utilization patterns.

Drawing upon Missouri Medicaid's experience with its Chronic Care Improvement Program (CCIP), a disease management program implemented in 2007, Missouri expects to realize savings through this Medicare and Medicaid demonstration, especially considering the added coordination of all Medicare and Medicaid services. Missouri anticipates that there could be short-term increases in costs associated with addressing unmet beneficiary needs. However, savings associated with reductions in potentially avoidable hospitalizations, readmissions and non-urgent use of emergency department services would be expected to accrue thereafter. Missouri's CCIP program generated savings during its second year. Specifically, savings were driven by reductions in inpatient admission rates and more significant reductions in emergency room visit rates.

The outcomes observed in CCIP have shown that coordinated care management and investments in primary and preventive care services can produce savings. Thus, under this proposed demonstration Missouri expects to see increased use of primary care practitioners, increased use

of behavioral health services, increased use of home visits, increased monitoring of medication adherence, increased focus on post-hospital follow-up care and increased family/caregiver support. Missouri also expects to see decreased nursing home admissions, reduced lengths of stay for nursing home episodes, reduced hospital readmission rates, reduced emergency room visits, a reduction in duplicative unnecessary tests and more appropriate use of specialty services.

Missouri will work with its actuaries to request, analyze and refine the integrated Medicare and Medicaid data sets necessary to develop detailed three-year financial projections and savings estimates. Missouri looks forward to working in collaboration with CMS in establishing a methodology for shared Medicare savings produced through the Health Home programs and enhancing the quality and efficiency of services provided to these beneficiaries.

As discussed above, dually eligible patients have high costs in both the Medicare program ($639 PMPM) and the Medicaid program ($485 PMPM). Missouri's Health Home programs are designed to provide optimal care management across the array of services a dually eligible individual may need to allow for better coordinated care and support to the patient, resulting in higher quality and reduction of unnecessary or avoidable health care costs.

Specifically, the Health Home programs are likely to reduce unnecessary or avoidable ED visits as well as avoidable hospitalizations and readmissions. As Medicare is the primary payer for these services for dually eligible members, the majority of program savings are likely to accrue to the Medicare program.

Financial Impact Analysis of the Primary Care Health Homes Program on Medicaid Spending:

Missouri has conducted financial impact analysis to the Medicaid program of the Health Home program as shown in Table Two below. Because the individuals described in this demonstration are dually eligible and these services are provided by Medicare, the savings are likely to be higher as Medicare typically reimburses providers at a higher rate than Medicaid.

Table Two: Estimated net Medicaid savings from the Primary Care Health Home due to reduced utilization of Inpatient and ED care

	Assumed Reduction in Utilization	Average Admission	Medicaid Cost Per Day or ED Visit	Estimated Savings based on assumption of utilization without Health Home	Estimated Replacement Cost Factor	Net Estimated Savings
Inpatient Hospital	15.4%	3 days	$1672.62	$19.6 million	6%	$18.4 million
ED	23.5%	n/a	$343.37	$2.0 million	-	$2.05 million

Based on the experience of the MO HealthNet Division with the Chronic Care Improvement Program, the state estimates that the Section 2703 Health Home program for primary care sites will yield Medicaid cost savings over the year prior to the Health Home program (Year 0). These savings rates are net of the costs of the Health Home program, including the per-member, per-month payment to primary care providers enrolled as Health Home sites.

In calendar year 2010, total Medicaid health care costs for participants with at least two chronic conditions as listed in Section 2703 of the Affordable Care Act averaged $10,777.81 per-member, per-year (PMPY). The state estimates that the Section 2703 Health Home program for Primary Care Health Homes will yield the following rates of Medicaid cost savings over the year prior to the Health Home program (Year 0):

- Year 1 = 1.89% savings over Year 0;
- Year 2 = 3.78% savings over Year 0, and
- Year 3 = 5.67% savings over Year 0.

Based on prior year claim data, the state projects the Primary Care Health Home population to be 25,372 participants, inclusive of those dually eligible for Medicare and Medicaid.

Year 1 - Federal Fiscal Year 2012:

Average PMPY cost =	$ 10,777.81
Savings rate =	1.89%

PMPY savings =	$ 203.70		
Health Home Population =	25,372		
Estimated Medicaid cost savings for Health Home patients =	$ 5,168,292		
For the portion of FFY 2012 in which the SPA is effective (January - Sept. 2012) =	75%		
Estimated Medicaid cost savings for Primary Care Health Home patients =	$ 3,876,219	x 90% FMAP =	**$ 3,488,597**

Year 2, Federal Fiscal Year 2013:

Average PMPY cost =	$ 10,777.81		
Savings rate =	3.78%		
PMPM savings =	$ 407.40		
Health Home Population =	25,372		
Estimated Medicaid cost savings for Primary Care Health Home patients =	$ 10,336,584	x 90% FMAP =	**$ 9,302,925**

Financial Impact Analysis for the CMHC Health Home Program on Medicaid Spending:

The Missouri DMH and its statewide CMHC providers have been engaged in care coordination and disease management for general medical conditions in persons with severe mental illness (SMI) since 2004. As a result, Missouri is able to model anticipated Medicaid savings in the §2703 Health Homes for Chronic Conditions when provided by CMHCs based on actual historic savings in previous projects. Please see Table Three for the estimated program savings off trend.

Table Three: CMHC Health Home Intervention Savings Off Trend

CCIP Clients in CMHC Health Homes Base Period PMPM (FY06)	$1,556
Expected Trend	16.67%
Expected Trend PMPM with No Intervention	$1,815.81
Actual Trend PMPM in Performance Period (FY2007)	$1,504.34
Gross PMPM Cost Savings	$311.47
Number of Lives	6,757
Gross Program Savings	$25,254,928
Vendor Fees	$1,301,563
Net Program Savings	$23,953,365
NET PMPM Program Savings	$295.41
Net Program Savings/(Cost) as % of Expected PMPM	16.3%

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

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

It is important to note that the cohorts used in both of the preceding analyses included dual eligibles in the intervention groups, however the analyses did not include the Medicare costs. If the analyses had included Medicare costs, it is believed that there would have been additional proportional savings in these costs as well. Missouri did not explicitly flag which patients were dual eligibles or attempt to model how their inclusion impacted the overall savings. However, approximately 34% of the clients and service will be dual eligible at any given time in Missouri's CMHC programs. Taken together for the § 2703 CMHC Health Home, the state conservatively estimated including the cost of the CMHC Health Home intervention:

- Year 1 will yield 5% savings over year 0 total costs trended forward
- Year 2 will yield 10% savings over year 0 total costs trended forward
- Year 3 will yield 15% savings over year 0 total costs trended forward

SFY2010 Total Medicaid Healthcare Costs for CMHC SMI patients were:

Adults:	$1,616 PMPM
Children:	$1,070 PMPM
Age Weighted Average:	$1,471 PMPM

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

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

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

G. Infrastructure and Implementation

i. Description of State infrastructure/capacity to implement and oversee the proposed demonstration. States should address the following: staffing, expected use of contractors, and capacity to receive and analyze Medicare data as part of a linked database.

Because of the implementation of the Health Home program during the first quarter of CY 2012, Missouri has already developed the necessary infrastructure to implement and oversee the program's operations. In brief, the state's Medicaid agency, MO HealthNet, under the

leadership of Ian McCaslin, MD is the entity responsible for overseeing the success of both the Primary Care Health Home program and the CMHC Health Home program. Samar Muzaffar, MD and Joe Parks, MD are the co-directors of the Health Home program with Dr. Muzaffar being primarily responsible for overseeing the Primary Care Health Home program, and Dr. Parks being primarily responsible for overseeing the CMHC Health Home program. Mark Stringer, the Director of the Division of Comprehensive Services for the Department of Mental Health is also intimately involved in the leadership of the CMHC Health Home program. Dr. Muzaffar has eight staffers and Dr. Parks has seven staffers dedicated to their respective programs and share three additional staff between them. Attachment I provides an organizational chart that details the state's staffing infrastructure for ongoing Health Home program management. In addition, the state is utilizing contractors for technical support, including Mercer Government Human Services Consulting (actuarial services) and Bailit Health Purchasing (technical content support).

As cited above, the state seeks financial support from CMS to fund three positions: two analysts to work with Medicare data as part of a linked database and a Joint Team Project Coordinator to facilitate better integration of the Health Home programs.

Currently due to resource constraints, two out of the three shared positions are vacant (the Joint Team Project Coordinator and the Data Analyst.) Since the state hopes to receive additional Medicare data from CMS to help the state further identify dual eligible individuals who are potentially eligible for the Health Home program, and to provide the Health Home providers with additional information regarding their patients utilization patterns and costs, the state anticipates the need to fill these positions and expand its capacity to conduct data analysis. Under this new structure each Health Home Program would have its own dedicated data analyst available to support the Health Home providers and the success of the program as a whole.

ii. ***Initial description of the overall implementation strategy and anticipated timeline, including the activities associated with building the infrastructure necessary (e.g., systems changes) to implement the proposed demonstration. States should identify key tasks, milestones, and responsible parties, etc. (See attached Word template)***

The Health Home programs have already been implemented. The state implemented the CMHC Health Home program on January 1, 2012 and the Primary Care Health Home program was implemented in a phased process between January 1, 2012 and April 1, 2012. Please see Attachment A for a detailed timeline for additional administrative tasks that will be necessary under this demonstration project.

H. Feasibility and Sustainability

i. ***Identification of potential barriers/challenges and/or future State actions that could impact the state's ability to successfully implement the proposal and strategies for addressing them.***

The Health Home programs have already been implemented. The state implemented the CMHC Health Home program on January 1, 2012 and the Primary Care Health Home program was implemented in a phased process between January 1, 2012 and April 1, 2012. Therefore there are not any barriers to the implementation of the programs. However, it still remains to be seen whether the programs will succeed and the Health Homes will be able realize the savings that are anticipated under the model. In order to support the transformation process and maximize the potential for success, the state has offered the Health Homes numerous opportunities for support, including through participation in the learning collaborative described elsewhere.

The state anticipates that it will need to negotiate the terms of share savings arrangement with CMS prior to sharing with Health Homes any Medicare savings that the Health Homes generate.

iii. Description of any remaining statutory and/or regulatory changes needed within the State in order to move forward with implementation.

Since the Health Home programs have already been implemented, the state does not anticipate making any changes to the state statute or regulation as a result of this demonstration project.

iv. Description of any new State funding commitments or contracting processes necessary before full implementation can begin.

The state anticipates that it will need to negotiate the terms of share savings arrangement with CMS prior to sharing with Health Homes any Medicare savings that the Health Homes generate.

v. Discussion of the scalability of the proposed model and its replicability in other settings/States.

While Missouri benefits from strong support for the program and experience in practice transformation, Missouri has relied upon the Chronic Care Model, which is a nationally

recognized model of care. There are currently 24 Primary Care Health Homes and 29 CMHC Health Homes operating in the state of Missouri. If the Health Homes demonstrate strong clinical performance and generate cost savings, it is expected that other sites and potentially other states would be interested in adopting this model.

The Missouri Health Home model will be of particular interest to states with large fee-for-service programs, and also to states that are interested in care transformation involving CMHCs. Finally, the Missouri Health Home program is one of the few Medicaid-organized shared savings programs in the country. New payment arrangements are of particular interest nationally. All of what Missouri is doing is potentially replicable.

Already some replication work is under way. For example, the Center for Medical Home Improvement's Education, Translation and Stakeholder (ETS) Core, working with AHRQ, CMS, the National Association of State Mental Health Program Directors (NASMHPD) and others will lead the effort to translate effective practices in the Missouri CMHC- Health Home program to other settings. Missouri will develop and disseminate a Resource Guide on implementing health homes in CMHCs. Missouri will also pursue publishing the results in the academic medical peer reviewed literature. This research will advance the emerging literature related to the integration of medical and behavioral health care.

v. ***Letters of support from Governor's Office and any other relevant governmental and non-governmental stakeholders as appropriate, such as Congressional delegation; other relevant State agencies (e.g., departments of aging, mental health, disabilities, etc.); community-based organizations; provider associations; and advocacy organizations. (Will not count against page limit.)***

Letters of support will be subsequently provided in the final draft of the proposal.

I. Additional Documentation (as applicable)

Depending on the model proposed, States may be asked to provide additional documentation such as draft waiver applications, State plan amendments, etc. as part of the demonstration proposal. Such documents will not be counted against required page limit.

The state will provide the following attachments to this proposal:

A. The Implementation Timeline for the Health Home Programs

B. The CMHC State Plan Amendment (effective January 1, 2012)

C. The Primary Care State Plan Amendment (effective January 1, 2012)

D. Attendees from the initial November 2010 meeting of the Missouri Medical Home Collaborative (MMHC) Council

E. Missouri Medical Home Collaborative Steering Committee membership

F. Summary of Other Health Home Stakeholder Engagement Activities

G. Community Mental Health Centers participating in the CMHC Health Home program

H. Organizations participating in the Primary Care Health Home program

I. Organizational chart that describes the state's staffing infrastructure for ongoing Health Home program management

J. Interaction with Other HHS/CMS Initiatives

The Missouri Health Homes Program has incorporated concepts and best practices from the Partnership for Patients and the Million Hearts Campaign to support the Health Home providers. Specifically, through the Missouri Foundation for Health, the state is utilizing CSI Solutions (CSI) to run the learning collaboratives for both of the Health Home programs. CSI is working with Primaris which is involved in the Partnership for Patients and together they bring tools from the Partnership for Patients initiative to the learning collaboratives to support the Health Home providers in the areas of care transitions and reducing hospital readmissions. CSI and Primaris are working to sponsor speakers for the Health Home providers and plan to broker several regional meetings among area hospitals and the Health Homes to further facilitate the integration of the Health Home activities and the Partnership for Patients' care transitions activities.

Missouri does not currently have any plans to incorporate and/or build upon the HHS Action plan to reduce Racial and Ethnic Health Disparities as part of the Health Homes demonstration project.

Attachment A:

Workplan/Timeline for the Health Home Programs

Timeframe	Key Activities/Milestones	Responsible Parties
Summer 2011-December 2011	Ramp-up period (CMHC and primary care practices began hiring care managers and began the process of	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
Fall 2011	Pre-work for the Learning Collaboratives	The Department of Mental Health (CMHC) and MO HealthNet Division
January 1, 2012	Effective date of CMHC and Primary Care SPA	The Department of Mental Health (CMHC) and MO HealthNet Division
April 2012	State development of information for state-specific financial modeling of Medicare shared savings tool	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
April-May 2012	Public Stakeholder Meetings	The Department of Mental Health (CMHC) and MO HealthNet Division
April 16, 2012	**State Public Notice and Posting of Proposal**	The Department of Mental Health (CMHC) and MO HealthNet Division
April 16-May 15, 2012	State Public Comment Period	The Department of Mental Health (CMHC) and MO HealthNet Division
May 16-21, 2012	State Incorporates Public Comments, Revises Proposal	The Department of Mental Health (CMHC) and MO HealthNet Division
Spring/Early Summer 2012	Modeling for Missouri Complete	The Department of Mental Health (CMHC) and MO HealthNet Division
May 21, 2012	**State Submits Demonstration Proposal**	The Department of Mental Health (CMHC) and MO HealthNet Division
May 23, 2012	CMS Public Notice and Posting of Proposal	The Department of Mental Health (CMHC) and MO HealthNet Division
May 23-June 22, 2012	CMS Public Comment Period	The Department of Mental Health (CMHC) and MO HealthNet Division
May 23-June 27, 2012	CMS/State review of public comments	The Department of Mental Health (CMHC) and MO HealthNet Division
June 23-July 22, 2012	MOU Development and Finalization	The Department of Mental Health (CMHC) and MO HealthNet Division
June 23-July 22, 2012	Development of Comparison Group Methodology	The Department of Mental Health (CMHC) and MO HealthNet Division

July 23-27, 2012	**Signing of MOU**	The Department of Mental Health (CMHC) and MO HealthNet Division
July 28-August 25, 2012	Development of Final Agreement	The Department of Mental Health (CMHC) and MO HealthNet Division
July 28-August 25, 2012	Readiness Review (Concurrent with Development of Final Agreement)	The Department of Mental Health (CMHC) and MO HealthNet Division
August 25-31, 2012	**Signing of Final Agreement**	The Department of Mental Health (CMHC) and MO HealthNet Division
September 1, 2012	Beneficiary Notification and additional outreach by State to Medicare-Medicaid	The Department of Mental Health (CMHC) and MO HealthNet Division
October 1, 2012	**Demonstration Start / Implementation – Year 1**	The Department of Mental Health (CMHC) and MO HealthNet Division

Attachment B:

The CMHC State Plan Amendment

(effective January 1, 2012)

MEDICAID MODEL DATA LAB

Id: MISSOURI
State: Missouri
Health Home Services Forms (ACA 2703)
TN#: MO-11-0011 | Supersedes TN#: MO-00-0000 | Effective Date: 01/01/2012 | Approved Date: 10/20/2011

Transmittal Numbers (TN) and Effective Date

Supersedes Transmittal Number (TN) 00-0000 Transmittal Number (TN) 11-0011
Effective Date 01/01/2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☑ **Health Home Services**

How are Health Home Services Provided to the Medically Needy? Not provided to Medically Needy

i. Geographic Limitations

Health Homes will be provided as follows: Statewide Basis.
If Targeted Geographic Basis: N/A

ii. Population Criteria

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

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

from the list of conditions below:

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

Description of Other Chronic Conditions Covered.

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

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

Individuals eligible for Health Home services and identified by the state as being existing service users of a Health Home will be auto-assigned to eligible providers based on qualifying conditions. Upon enrollment, individuals assigned to a Health Home will be informed by the state via U.S. mail and other methods as necessary of all available Health Homes throughout the state. The notice will describe individuals' choice in selecting a Health Home as well as provide a brief description of Health Home services, and describe the process for individuals to opt-out of receiving treatment services from the assigned Health Home provider. Individuals who have been

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

iii. Provider Infrastructure

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

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

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

CMHCs will be supported in transforming service delivery by participating in statewide learning activities. Given CMHCs' varying levels of experience with practice transformation approaches, the State will assess providers to determine learning needs. CMHCs will therefore participate in a variety of learning supports, up to and including learning collaboratives,

specifically designed to instruct CMHCs to operate as Health Homes and provide care using a whole person approach that integrates behavioral health, primary care and other needed services and supports. Learning activities will be supplemented with monthly practice team calls to reinforce the learning sessions, practice coaching, and monthly practice reporting (data and narrative) and feedback. Learning activities will support providers of health home services in addressing the following components:

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

☐ **Team of Health Care Professionals as described in § 1945(h)(6)**
☐ **Health Team as described in § 1945(h)(7), via reference to § 3502**

iv. Service Definitions

A. Comprehensive Care Management

A. **Service Definition:** Comprehensive care management services are conducted by the Nurse Care Manager, Primary Care Physician Consultant, the Health Home

Administrative Support staff and Health Home Director with the participation of other team members and involve:

a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;
b. assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes;
c. assignment of health team roles and responsibilities;
d. development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
e. monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
f. development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

B. **Ways Health IT Will Link:** MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices and schools. The tool is a HIPAA-client portal that enables providers to:

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

B. Care Coordination

1. **Service Definition:** Care Coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and

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

2. **Ways Health IT Will Link:** MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:
   a. Download paid claims data submitted for an enrollee by any provider over the past 3 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;
   f. pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
   g. 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;
   h. Review laboratory data and clinical trait data;
   i. Determine medication adherence information and calculate medication possession ratios (MPR); and
   j. Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

C. Health Promotion

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

in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Health Home Director, Primary Care Physician Consultant, and Nurse Care Manager will each participate in providing Health Promotion activities.

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

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

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

2. **Ways Health IT Will Link:** MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the state's data analytics contractor which will match it to a list of all persons assigned and/or enrolled

in a Health Home. The contractor would then immediately notify the Health Home provider of the admission, which would enable the Health Home provider to:

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

E. Individual and Family Support Services (including authorized representatives)

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

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

F. Referral to Community and Social Support Services

1. **Service Definition:** Referral to community and social support services, including long term services and supports, involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples. For individuals with DD, the health team will refer to and

coordinate with the approved DD case management entity for this service. The Nurse Care Manager and Administrative support staff will provide this service.

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

v. Provider Standards

A. Initial Provider Qualifications

1. **State Qualifications:** In addition to being a state-designated CMHC, each Health Home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each Health Home:
   a. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals, defined as receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), furnished uncompensated care by the provider, or furnished services at either no cost or reduced based on a sliding scale. Patient percentage requirements will be determined by the state;
   b. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated through the application process and agreement to participate in learning activities including in-person sessions and regularly scheduled phone calls; and that agency leadership have presented the state approved "Paving the Way for Health Care Homes" PowerPoint introduction to Missouri's Health Home Initiative to all agency staff and board of directors;
   c. Meet state requirements for patient empanelment (i.e., each patient receiving CMHC health home services must be assigned to a physician);
   d. Meet the state's minimum access requirements as follows: Prior to implementation of health home service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week;
   e. Actively use MO HealthNet's comprehensive electronic health record (EHR) to conduct care coordination and prescription monitoring for Medicaid participants;
   f. Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;
   g. Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns;
   h. Conduct wellness interventions as indicated based on clients' level of risk;

i. Complete status reports to document clients' housing, legal, employment status education, custody etc.;
j. Agree to convene regular, ongoing and documented internal Health Home team meetings to plan and implement goals and objectives of practice transformation;
k. Agree to participate in CMS and state-required evaluation activities;
l. Agree to develop required reports describing CMHC Health Home activities, efforts and progress in implementing Health Home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of Primary Care Nurse Manager's time and activities);
m. Maintain compliance with all of the terms and conditions as a CMHC Health Home provider or face termination as a provider of CMHC Health Home services; and
n. Present a proposed Health Home delivery model that the state determines to have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the Health Home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

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

vi. Assurances

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

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

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

vii. Monitoring

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

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

C. **Describe the State's proposal for using health information technology in providing Health Home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider):** To facilitate the exchange of health information in support of care for patients receiving or in need of health home services, the state will utilize several methods of health information technology (HIT).

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

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

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

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

2. ***HIT for Health Promotion and Individual and Family Support Services*** – A module of the MO HealthNet comprehensive, web based EHR allows enrollees to access their own healthcare utilization information and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an

enrollee to attain the highest levels of health and functioning. Health Home providers will provide instruction to individuals on the use of the module. Utilization data available through the module includes:

(a) Administrative claims data for the past 3 years;
(b) Cardiac and diabetic risk calculators;
(c) Chronic health condition information awareness
(d) A drug information library; and
(e) The functionality to create a personal health plan and discussion lists to use with healthcare providers.

3. ***HIT for Comprehensive Transitional Care*** – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the states data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a Health Home. The contractor would then immediately notify the Health Home provider of the admission, which would enable the Health Home provider to:

(a) Use the hospitalization episode to locate and engage persons need of health home services;
(b) Perform the required continuity of care coordination between inpatient and outpatient; and
(c) Coordinate with the hospital to discharge and avoidable admission as soon as possible. The daily data transfer will be in place within six months of implementation of the SPA. In the interim, Health Homes will continue to implement or develop memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.

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

5. ***Specific HIT Strategies for CMHCs Customer Information Management, Outcomes and Reporting (CIMOR)*** - CMHCs will continue to utilize CIMOR for routine functions (e.g., contract management, billing, benefit eligibility, etc.); however CIMOR's capacity will continue to be expanded in support of CMHC comprehensive care management and care coordination functions. CIMOR will enable assignment of enrollees to a CMHC Health Home based on enrollee choice and admission for services. CMHC

Health Home providers utilize CIMOR to report Department of Mental Health required outcome measures. In addition, the CMHC Health Home enrollment data in CIMOR will be cross referenced with MO Health Net inpatient pre-authorization data to enable the automated real-time reporting of inpatient authorizations to the appropriate CMHC.

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

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

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

A. Goal 1: Improve Health Outcomes for Persons with Mental Illness

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1)Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive condition- age-standardized acute care hospitalization rate for	Claims	Numerator = Total # of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years / Denominator = Total mid-year population under age 75	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Health Homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care.

conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 75 yrs				
(2)Emergency Department Visits: preventative / ambulatory care-sensitive ER visits (algorithm, not formally a measure)	Claims	Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measures, which is too lengthy to place in the SPA. The algorithm is a nationally recognized method of calculating preventable ED visits.	Hospital ER visits will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Health Homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care
(3)Hospital Readmission: Hospital readmissions within 30 days	Claims	Percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology.	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Health Homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care

2. Experience of Care

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

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) All Members: Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers	Pharmacy Claims	Numerator = Number of members on that class of medication in the past 90 days with medication possession ratios (MPR) > 80% / Denominator = Number of all members on that class of medication in the past 90 days	The medication adherence HEDIS indicators & meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in administrative claims combined with clinical information & disease Registry to assess & monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>90%
(2) Care Coordination: % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed	Claims & Monthly Health Home Report	Number of patients contacted (by phone or face-to-face) within 72 hours of discharge / Number of all patients discharged	The numerator will be aggregated from the monthly health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80%

medication reconciliation with input from PCP.				

B. Goal 2: Reduce Substance Abuse

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months.	Annual status report	Numerator = Number of adults who report using illicit drugs in the previous 12 months / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual Health Home	5%
(2) Reduce the proportion of adults (18 and older) who drank excessively in the previous 12 months.	Annual status report	Numerator = Number of adults who report drinking excessively in the previous 12 months / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual Health Home.	9%

2. Experience of Care

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

3. Quality of Care

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

C. Goal 3: Increase patient empowerment and self-management

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Patient Use of personal HER (Direct Inform, or its successor)	Cyber Access or its success-sor	Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period / Denominator = Number of patients actively enrolled in the health home at any point during the 90 days x 90	This is a standard management report available within the CyberAccess tool. Results will be reported by individual Health Home on the spreadsheet and benchmark style and disseminated all Health Homes.	Greater than 0.25

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Satisfaction with services	Mental Health Statistic Improvem ent Program (MHSIP) survey	SAMHSA National outcome Measures (NOMS) specifications Numerator = number of MHSIP survey responses with an average score < 2.5 (1= strongly agree, 5 = strongly	Results of the MHSIP survey will be aggregated by Health Home and across the entire statewide initiative. Final report will benchmark individual Health Home performance compared to other Health Homes and the statewide average and identify individual items for performance improvement.	Greater than 90%

		disagree) across all **general satisfaction** questions / Denominator = number of MHSIP survey responses		

3. Quality of Care

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

D. Goal 4: Improve coordination of care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Care Coordination - % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performance medication reconciliation with input from PCP.	Claims and Monthly Health Home Report	Numerator = Number of patients contacted (phone or face-to-face) within 72 hours of discharge / Denominator = Number of all patients discharged x 100	The numerator will be aggregated from the monthly Health Home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80%

2. Experience of Care

Measure	N/A	Measure Specification	N/A

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

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Use of CyberAccess per member per month (or its successor) for non-MCO enrollees	Cyber-Access or successor	CyberAccess web hits PMPM Numerator = the number of times cyber access was open a healthcare home number for the 90 day reporting period. Denominator = Number of patients actively enrolled in the health home at any point during the 90 days x 90	This is a standard management report available within the Cyber Access tool. Results will be reported by individual Health Home on the spreadsheet and benchmark style and disseminated all health Homes.	One cyber access utilization PMPM

E. Goal 5: Improve preventive care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5 – 24.9	Disease Registry	Numerator = Number of patients with BMI of 18.5 - 24.9 / Denominator = Number of all patients with a documented BMI x 100	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific	80%

			individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	

2. Experience of Care

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

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Metabolic Screening - % of members screened in previous 12 months. Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG)	Disease Registry	Number of current enrollees with a documented metabolic screening in the last 12 months / Total enrollees.	The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80% completion

F. Goal 6: Improve Diabetes Care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal

Adult Diabetes - % of patients 18 – 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	Claims and Disease Registry	Numerator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and having a documented Hba1c in the previous 12 months	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in administrative claims combined with clinical information & Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Health Home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>70%

2. Experience of Care

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

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Preventive - % of members screened in previous 12 months – Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG)	Disease Registry	Numerator = Number of current enrollees with a documented metabolic screening in the last 12 months / Denominator = Total enrollees x 100	The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80% completion

G. Goal 7: Improve asthma care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Pediatric Asthma - % of patients 5–17 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller	Claims	Numerator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in health home registry and a prescription for a controller medication / Denominator =	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment	>70%

medication) during the measurement period.		for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in health home registry	guidelines are identified as high risk individuals. Monitoring reports will be provided to the Health Home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	
(2) Adult Asthma - % of patients 18-50 years old who were identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.	Claims	Numerator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry	(same)	>70%

1. Experience of Care

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

2. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Asthma: Adherence to prescription medications for asthma and/or COPD.	Claims	Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for asthma/COPD in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>90%

H. Goal 8: Improve Cardiovascular (CV) Care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Hypertension - % of patients aged 18-85 years	Claims and Disease Registry	Numerator = for a given 90 day period number of	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize	>90%

and older with a diagnosis of hypertension who have been seen will for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period		patients between the age of 18 t0 85 years old identified as having hypertension in health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90 / Denominator = for a given 90 day period number of patients between the age of 18 to 75 years old identified as having hypertension in health home registry who had two documented episodes of care in the previous 12 months	data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines.	
(2) CAD - % of patients	Claims and	Numerator = for a given 90	Persons whose care deviates from that recommended by the treatment	>70%

aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).	Disease Registry	day period number of patients between the age of 18 years or older identified as having cardiovascular disease in health home registry months where the most recent documented LDL level in the previous 12 months is < 100 / Denominator = for a given 90 day period number of patients between the age of 18 years and older identified as having cardiovascular disease in health home registry	guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	

2. Experience of Care

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

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Memb	Claims and	Numerator =	The medication adherence	>90%

ers with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds	Disease Registry	number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on that class of medication in the past 90 days	HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	
(2) Members with CVD: Use of statin medications by persons with a history of CAD (coronary artery disease).	Claims and Disease Registry	Numerator = for a given 90 day period number of patients identified as having coronary artery disease in health home registry and a prescription for a Statin / Denominator = for a given 90 day period	Same	>70%

		number of patients coronary artery disease in health home registry		

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation
Quality Measures: Service Based Measures **N/A**

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

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

i. Hospital admissions

1. Description: Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures).
2. Data Source: Claims
3. Frequency of Data Collection: Annual

ii. Emergency room visits

1. Description: Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure).
2. Data Source: Claims
3. Frequency of Data Collection: Annual

iii. Skilled Nursing Facility admissions

1. Description: Use of HEDIS 2011 codes for discharges for skilled nursing facility services (part of inpatient utilization – non-acute care (NON) measure).
2. Data Source: Claims
3. Frequency of Data Collection: Annual

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

i. Hospital admission rates: The State will consolidate data from its fee-for-service MMIS-based claims system and from MCO-generated encounter data for the participating Health Home sites to assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency), for the participating Health Home sites and for a control group of non-participating sites. The analysis will consider:

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 SMI or 2 or more chronic conditions drawn from a list of chronic conditions defined by the State.

ii. Chronic disease management: The State will audit each practice's implementation of chronic disease management, with a special focus on comprehensive care management. Audits will assess:

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 2 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.

iii. Coordination of care for individuals with chronic conditions: The State will assess provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment 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 2 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.

iv. Assessment of program implementation: The State will monitor implementation in 2 ways.

1. First, a 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.

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

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

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

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

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

INTERVENTION SAVINGS OFF TREND

CCIP Clients in CMHC Health Homes Base Period PMPM (FY2006)	$1,556
Expected Trend	16.67%
Expected Trend PMPM with No Intervention	$1,815.81
Actual Trend PMPM in Performance Period (FY2007)	$1,504.34
Gross PMPM Cost Savings	$311.47
Number of Lives	6,757
Gross Program Savings	$25,254,928
Vendor Fees	$1,301,563
Net Program Savings	$23,953,365
NET PMPM Program Savings	$295.41
Net Program Savings/(Cost) as % of Expected PMPM	16.3%

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

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

- Year 1 will yield 5% Savings over year 0 total costs trended forward
- Year 2 will yield 10% Savings over year 0 total costs trended forward
- Year 3 will yield 15% Savings over year 0 total costs trended forward

SFY2010 Total Medicaid Healthcare Costs for CMHC SMI Patients are:

Adults:	$1,616 PMPM
Children:	$1,070 PMPM
Age Weighted Average:	$1,471 PMPM

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

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

4.19 – B: Payment Methodology View

Attachment 4.19-B

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month **Provider Type:** CMHC Health Home Provider

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

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

	not otherwise reimbursable by MO HealthNet.

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

- The managed care plan will be informed of its members that are in Health Home services and a managed care plan contact person will be provided for each Health Home provider to allow for coordination of care.

- The managed care plan will be required to inform either the individual's Health Home or MO Health Net of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.

- The CMHC Health Home team will provide Health Home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the CMHC Health Home.

Clinical Care Management per member per month (PMPM) payment

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

A. The person is identified as meeting CMHC health home eligibility criteria on the State-run health home patient registry;
B. The person is enrolled as a health home member at the billing health home provider;

C. The minimum health home service required to merit PMPM payment is that the person has received Care Management monitoring for treatment gaps; or another health home service was provided that was documented by a health home director and/or nurse care manager; and
D. The health home will report that the minimal service required for the PMPM payment occurred on a monthly health home activity report.

Nurse Care Manager	1 FTE/250 enrollees $105,000 / year	PMPM $35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Health Home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases, treatments & medications h. Track required assessments and screenings i. Assist in implementing DMH Net health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes
Primary Care Physician Consultant	1 hr/enrollee/yr $150/hr	PMPM $12.50	a. Participates in treatment planning b. Consults with team psychiatrist c. Consults regarding specific consumer health issues d. Assists coordination with external

			medical providers
Health Home Director	1 FTE/500 enrollees $115,000 / year	PMPM $19.17	a. Provides leadership to the implementation and coordination of Healthcare Home activities b. Champions practice transformation based on Healthcare Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Healthcare Home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives
Administrative Support	1 FTE support staff/500 enrollees Non-PMPM paid staff training time Contracted services	PMPM $12.07	a. Referral tracking b. Training and technical assistance c. Data management and reporting d. Scheduling for Health Home Team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending Medical Records for care coordination
TOTAL PMPM		**$78.74**	

- Staff cost is based on a provider survey of all CMHC's statewide in the spring of 2011 regarding the current costs of similar staff and includes fringe, operating & indirect costs.
- All CMHC providers will receive the same single PMPM rate.
- The PMPM will be adjusted annually according to the CPI
- The PMPM method will be reviewed 18 months after the first PMPM payments to determine if the PMPM is economically efficient & consistent with quality of care. Whether to change the PMPM rate to tiered rates will be addressed at the 18 month review.
- Full-time PMPM funded staff will not be allowed to bill any other CMS funding opportunities. Staff for whom PMPM funding only covers a part of their total work time will log their time

funded by & dedicated to Section 2703 Health Home Services to assure that no other billing to CMS occurs during that time.

- The PMPM proposed does not cover the full training and technical assistance costs of implementing Health Homes in Missouri. Missouri Foundations, Providers and State agencies are spending over $1,500,000 to fund expert consultation, technical assistance, learning collaboratives, and other training required for Section 2703 Health Home planning, development and implementation.

Attachment C:

The Primary Care State Plan Amendment

(effective January 1, 2012)

MEDICAID MODEL DATA LAB

Id: MISSOURI - 2
State: Missouri
Health Home Services Forms (ACA 2703)
Page: 2

TN#: MO 2-11-0015 | Supersedes TN#: MO -2-00-0000 |
Effective Date: January 1, 2012 | Approved Date:

Transmittal Numbers (TN) and Effective Date

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

Supersedes Transmittal Number (TN)
00-0000

Transmittal Number (TN)
11-0015

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

Effective Date January 1, 2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

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

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

☑ **Health Home Services**

How are Health Home Services Provided to the Medically Needy? Not provided to Medically Needy

viii. Geographic Limitations

Health Homes will be provided as follows: Statewide
If Targeted Geographic Basis: N/A

ix. Population Criteria

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

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

from the list of conditions below:

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

Description of Other Chronic Conditions Covered.
Developmental Disabilities.

Individuals eligible for primary care health home services and identified by the state as being existing service users of a primary care health home will be auto-assigned to eligible providers based on qualifying conditions. Upon enrollment, individuals assigned to a primary care health home will be informed by the state via U.S. mail and other methods as necessary of all available primary care health homes throughout the state. The notice will describe individuals' choice in selecting a primary care health home as well as provide a brief description of primary care health home services, and describe the process for individuals to opt-out of receiving primary care health home services from the assigned primary care health home provider. Individuals who have been auto-assigned to a primary care health home provider will have the choice to opt out of receiving primary care health home services from the assigned primary care health home provider and select another service provider from the available primary care health homes throughout the state at any time. Individuals who have been auto-assigned to a primary care health home provider may also opt out of the primary care health home program altogether without jeopardizing their existing services. Other individuals with qualifying chronic conditions who are not currently receiving services at the primary care health home may request to be part of the primary care health home. Potentially eligible individuals receiving services in the hospital ED or as an inpatient will be notified about eligible primary care health homes and referred based on their choice of provider. Eligibility for primary care health home services will be identifiable through the state's comprehensive Medicaid electronic health record.

Primary care health home providers to which patients have been auto-assigned will receive communication from the state regarding a patient's enrollment in primary care health home services. The primary care health home will notify other treatment providers (e.g., behavioral health and specialists such as OB/GYN) about the goals and types of primary care health home services as well as encourage participation in care coordination efforts.

x. Provider Infrastructure

☑ Designated Providers as described in § 1945(h)(5)
Designated providers of primary care health home services will be federally qualified health centers (FQHCs), rural health clinics (RHCs) 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, up to and including learning collaboratives, 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 monthly practice reporting (data and narrative) and feedback.

Learning activities will support providers of primary care health home services in addressing the following components:

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

11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

☐ **Team of Health Care Professionals as described in § 1945(h)(6)**
☐ **Health Team as described in § 1945(h)(7), via reference to § 3502**

xi. Service Definitions

C. Comprehensive Care Management

1. **Service Definition:**

Comprehensive care management services are conducted by the Nurse Care Manager and involve:

a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;
b. assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes;
c. assignment 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.

2. Ways Health IT Will Link

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices and schools. The tool is a HIPAA-client portal that enables providers to:

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.

D. Care Coordination

3. Service Definition:

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

4. Ways Health IT Will Link:

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:

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.

E. Health Promotion

3. **Service Definition:**

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

Health promotion services also assist 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. The Primary Care Health Home Director, Nurse Care Manager, Behavioral Health Consultant and appropriate primary care health home Administrative Support staff will provide health promotion services.

2. **Ways Health IT Will Link:**

A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Utilization data available through the module includes:

a. Administrative claims data for the past 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.

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

3. **Service Definition:**

In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family

members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management. The Primary care health home Director and Nurse Care Manager, as necessary and appropriate, will provide comprehensive transitional care activities, including, whenever possible, participating in discharge planning.

2. **Ways Health IT Will Link:**

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

MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the state's data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a 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.

G. Individual and Family Support Services (including authorized representatives)

3. **Service Definition:**

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

2. **Ways Health IT Will Link:**

A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Utilization data available through the module includes:

a. Administrative claims data for the past 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.

H. Referral to Community and Social Support Services

3. **Service Definition:**

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

2. **Ways Health IT Will Link:**

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).

xii. Provider Standards

A. Initial Provider Qualifications

1. In addition to being a Federally Qualified Health Center, Rural Health Clinic 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 e-prescribe, 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.

B. Ongoing Provider Certification Requirements

1. Each practice must:
   a. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
   b. Demonstrate development of fundamental medical home functionality at 6 months and 12 months through an assessment process to be applied by the state;
   c. Demonstrate significant improvement on clinical outcome and process indicators specified by and reported to the state, and
   d. Submit an application for NCQA recognition by month 18 from the date at which supplemental payments commence and either:
      i. Attain NCQA 2008 PPC-PCMH "Level 1 Plus" recognition, with meeting Level 1 Plus defined as meeting NCQA 2008 PPC-PCMH Level 1 standards, plus the following NCQA 2008 PPC-PCMH standards at the specified levels of performance (e.g., 3C at 75%, 3D at 100%, and 4B at 50%)

      or

      ii. Attain NCQA 2011 PCMH "Level 1 Plus" recognition, with meeting Level 1 Plus defined as meeting NCQA 2011 PCMH Level 1 standards, plus the following NCQA 2011 PCMH standards at the specified levels of performance (e.g., 3B at 100% and 3C at 75%). Minor deficiencies in meeting standards may be addressed through submission and approval by the state of provider plans of correction.

   or

   e. Meet equivalent recognition standards approved by the state as such standards are developed.

xiii. Assurances

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

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

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

xiv. Monitoring

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

E. **Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications:** The State will annually perform an assessment of cost savings using a pre-/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. It will also be broken out for each 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.

F. **Describe the State's proposal for using health information technology in providing Health Home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider):**
To facilitate the exchange of health information in support of care for patients receiving or in need of 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 through 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 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.

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.

3. HIT for Comprehensive Transitional Care – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the states data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a 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 avoidable admission as soon as possible. The daily data transfer will be in place upon implementation of the SPA. In the interim, primary care health homes will continue to implement or develop memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.

4. Referral to Community and Social Support Services – Primary care 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 primary care health home providers of impending eligibility lapses (e.g., 60 days in advance).

5. Data Warehouse and Reporting System – The Missouri Primary Care Association launched the Missouri Quality Improvement Network (MOQuIN) in early 2011, and is in the final stages completing a data warehouse for the purpose of functioning as a patient registry for the FQHCs and generating quality measures to support clinical quality improvement. Patient demographics and clinically authenticated patient care data from the FQHC EMRs are included in the data set to support the required measures. The data will be refreshed daily. MPCA will host a web-based reporting platform for users. Each health center's data will be available to the health center for individual report generation at all levels, health center, site, provider, and patient, to assist with care management. MPCA will generate aggregate reports to support quality improvement, best practice identification, and benchmarking. The data warehouse is expected to be functional for reporting purposes by October 2011.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

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

I. Goal 1: Improve Health Outcomes for Persons with Chronic Conditions

4. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1)Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive condition-age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for	Claims	Numerator = Total # of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years / Denominator = Total mid-year population under age 75	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care.

admission to hospital, per 100,000 population under age 75 yrs				
(2)Emergency Department Visits: preventative / ambulatory care-sensitive ER visits (algorithm, not formally a measure)	Claims	Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measures, which is too lengthy to place in the SPA. The algorithm is a nationally recognized method of calculating preventable ED visits.	Hospital ER visits will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care
(3)Hospital Readmission: Hospital readmissions within 30 days	Claims	Percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology.	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care

5. Experience of Care

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

6. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(3) Care Coordination: % of	Claims & EMR	Numerator: Number of patients contacted	The numerator will be aggregated from the monthly primary care health home report.	80%

hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.		(by phone or face-to-face) within 72 hours of discharge / Denominator: Number of all patients discharged	The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home.	

J. Goal 2: Improve Behavioral Healthcare

4. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(3) Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days.	EMR	Numerator = Over the prior 12 months the Number of adults who report using illicit drugs in the previous 30 days / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual Primary care health home	<7.1% (HP2020 goal)

(4) Reduce the proportion of adults (18 and older) who drank excessively in the previous 30 days	EMR	Numerator = Over the prior 12 months the Number of adults who report drinking excessively in the previous 30 days / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	>25.3% (HP2020 goal)

5. Experience of Care

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

6. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
% of patients 18 years of age and older receiving depression screening through the use of a standardized screening instruments within the measurement period	EMR	Numerator = Number of adults screened for Depression in the previous 12 months / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	90%
Percentage of children screened	EMR or MHN on-line tool	Numerator = Number of children 0 – 18 y.o. with	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	>85%

through EPSDT for mental health issues.		EPSTD MH items completed in prior 12 months Denominator= total number of unique children enrolled in Health Home in prior 12 months		
% of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary	EMR	Numerator = Number of adults screened for drinking excessively in the previous 12 months / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	90%

K. Goal 3: Increase patient empowerment and self-management

4. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Patient Use of personal EHR (Direct Inform, or its successor) or practice EMR patient portal	Cyber Access or its success-sor or practice EMR patient portal	Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period / Denominator = Number of	This is a standard management report available within the CyberAccess tool or via EMR reporting. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all Primary care health homes.	Greater than 0.25

		patients actively enrolled in the primary care health home at any point during the 90 days x 90		

5. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Satisfaction with services	CAPHS CG 1.0 Adult and Child Primary Care Surveys Adult Questions #6, 17, 19, and 20. Child Questions #6, 17, 19, and 22.	Numerator = number questions with response of 3-usually or 4-always Denominator = total number of questions with any answer	Results of the CAPHS survey will be aggregated by Primary care health home and across the entire statewide initiative. Final report will benchmark individual Primary care health home performance compared to other Primary care health homes and the statewide average and identify individual items for performance improvement.	>80%

6. Quality of Care

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

L. Goal 4: Improve coordination of care

4. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Care Coordination - % of hospital-discharged	Claims and EMR	Numerator = Number of patients contacted (phone or face-	The numerator will be aggregated from the monthly Primary care health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and	80%

members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performance medication reconciliation with input from PCP.		to-face) within 72 hours of discharge / Denominator = Number of all patients discharged x 100	benchmark style by individual Primary care health home.	

5. Experience of Care

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

6. Quality of Care

Measure	**Data Source**	**Measure Specification**	**How Health IT Will be Utilized**	**Benchmark Goal**
Use of CyberAccess per member per month (or its successor) enrollees	Cyber-Access or successor	PMPM Numerator = the number of times cyber access was open a healthcare home number for the 90 day reporting period. Denominator = Number of patients actively enrolled in the primary care health home	This is a standard management report available within the Cyber Access tool. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all primary care health homes.	One cyber access utilization PMPM

		at any point during the 90 days x 90		

M. Goal 5: Improve preventive care

4. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5 – 24.9	EMR	Numerator = Number of patients with BMI of 18.5 - 24.9 / Denominator = Number of all patients with a documented BMI x 100	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	80%
Adult Weight Screening and Follow-Up- Percentage of patients aged 18 years or older with a calculated BMI in the	EMR	Numerator= Patients in the denominator with a calculated BMI in the past 3 months or during the current visit documented in	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals'	37 %

past three months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.		the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented./ Denominator= All active patients aged 18 years or older.	healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	
Weight Assessment and Counseling for Children and Adolescents- The percentage of patients 2-17 years of age who had an outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the 90	EMR	Numerator= Patients in the denominator with BMI % documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period/ Denominator= All active patients 2-17 years of age.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	15% (HP 2020- NWS-6.3) The percentage was derived from the HP 2020 goal of: Increase the proportion of physician visits made by all child or adult patients that include counseling about nutrition or diet.

day reporting period.				

5. Experience of Care

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

6. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
% of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday.	EMR	Numerator = number of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. Denominator total= number of children 2 years of age	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>80% completion (HP 2020)

N. Goal 6: Improve Diabetes Care

4. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Adult Diabetes - % of patients 18 – 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	EMR	Numerator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in primary care health home registry and having a	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>60% (NCQA 2009 DRP)

		documented Hba1c in the previous 12 months		
% of patients 18–75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.	EMR	Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent BP in the previous 12 months was <140/90 mmHg. Denominator = total number of patients in the previous 12 months 18–75 years of age with diabetes (type 1 or type 2)	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>65% (NCQA 2009 DRP)
% of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.	EMR	Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent LDL-C in the previous 12 months was <100mg/dL. Denominator = total	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the	>36% (NCQA 2009 DRP)

		number of patients in the previous 12 months 18–75 years of age with diabetes (type 1 or type 2)	Primary care health home both in the form of action required “to-do” lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	
Child Diabetes - % of patients under 18 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	EMR	Numerator = For a given 90-day period, number of patients under the age of 18 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients under the age of 18 years old identified as	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals’ healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required “to-do” lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>60%

		having diabetes in primary care health home registry and having a documented Hba1c in the previous 12 months		

5. Experience of Care

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

6. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Diabetes: Adherence to prescription medications for Diabetes.	Claims	Numerator = number of members on medication for Diabetes in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for Diabetes in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based	>90%

			treatments and aggregate reports of the overall Primary care health home performance.	

O. Goal 7: Improve asthma care

2. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(3) Pediatric Asthma - % of patients 5–17 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.	Claims	Numerator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>70%
(4) Adult Asthma - % of patients 18-50 years old who were identified as	Claims	Numerator = for a given 90 day period number of patients between the age of 18 to 50	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in	>70%

having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.		years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in primary care health home registry	administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	

3. Experience of Care

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

4. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Asthma: Adherence to prescription medications for asthma and/or COPD.	Claims	Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% /	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific	>90%

		Denominator = number of all members on medication for asthma/COPD in the past 90 days	individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	

P. Goal 8: Improve Cardiovascular (CV) Care

4. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(3) Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period	EMR	Numerator = for a given 90 day period number of patients between the age of 18 t0 85 years old identified as having hypertension in primary care health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines.	>50% (HP 2020)

		blood pressure in the previous 12 months is < 140/90 / Denominator = for a given 90 day period number of patients between the age of 18 to 75 years old identified as having hypertension in primary care health home registry who had two documented episodes of care in the previous 12 months		
(4) CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).	Claims and Disease Registry	Numerator = for a given 90 day period number of patients between the age of 18 years or older identified as having cardiovascular disease in primary care health home registry months where the most recent documented	Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>70%

		LDL level in the previous 12 months is < 100 / Denominator = for a given 90 day period number of patients between the age of 18 years and older identified as having cardiovascular disease in primary care health home registry		

5. Experience of Care

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

6. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds	Claims and Disease Registry	Numerator = number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on that class of	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment	>90%

		medication in the past 90 days	guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Quality Measures: Service Based Measures: N/A

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

x. Evaluations

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

iv. Hospital admissions

4. Description: Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures)
5. Data Source: Claims
6. Frequency of Data Collection: Annual

v. Emergency room visits

7. Description: Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure)
4. Data Source: Claims
5. Frequency of Data Collection: Annual

vi. Skilled Nursing Facility admissions

4. Description: Use of HEDIS 2011 codes for discharges for SNF services (part of inpatient utilization – non-acute care (NON) measure)
5. Data Source: Claims
6. Frequency of Data Collection: Annual

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

viii. 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:

3. 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
4. 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.

ix. 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:

5. Documented self-management support goal setting with all beneficiaries identified by the practice site as high risk;
6. Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge;
7. Documentation that there is a care manager in place; and

8. That the care manager is operating consistently with the requirements set forth for the practices by the State.

x. 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:

2. The State will measure:
   e. Care manager contact during hospitalization,
   f. Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge,
   g. Active care management of High Risk patients, and
   h. Behavioral activation of High Risk patients.

2. Measurement methodologies for these 4 measures are described in the preceding section.

xi. Assessment of program implementation: The State will monitor implementation in 2 ways.

3. 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.
4. 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.

xii. 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.

xiii. 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.

xv. **Estimates of cost savings:**

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.**

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.

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.

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%**

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.

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

i. **Geographic Limitations: N/A**
ii. **Population Criteria: N/A**
iii. **Provider Infrastructure: N/A**
iv. **Service Definitions: N/A**
v. **Provider Standards: N/A**
vi. **Assurances: N/A**
vii. **Monitoring: N/A**

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. **Quality Measures: Goal Based Quality Measures: N/A**

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Quality Measures: Service Based Measures: N/A

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

x. Evaluations: N/A

4.19 – B: Payment Methodology View

Attachment 4.19-B

Page: 49

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type: FQHC, RHC, Primary Care Clinics Operated by Hospital Primary care health home Providers

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

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

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

- The managed care plan will be informed of its members that are in primary care health home services and a managed care plan contact person will be provided for each primary care health home provider to allow for coordination of care.

- The managed care plan will be required to inform either the individual's primary care health home or MO Health Net of any inpatient admission or discharge of a primary care health home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.

- The Primary Care Primary care health home team will provide primary care 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 Primary Care Primary care health home.

Clinical Care Management per member per month (PMPM) payment

This reimbursement model is designed to only fund primary care health home functionalities that are not covered by any of the currently available Medicaid funding mechanisms. . Nurse Care

Manager, Behavioral Health Consultant, and Care Coordinator duties do not always involve face-to-face interaction with primary care health home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Missouri's primary care health home model includes significant support for the leadership and administrative functions that are required to transform a traditional primary service delivery system to the new data-driven, population focused, person centered Primary care health home requirements.

The criteria required for receiving a monthly PMPM payment is:

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

Team Member	FTE/Cost	PMPM	Team Member Role
Nurse Care Manager	1 FTE/250 enrollees $105,000 / year	PMPM $35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Primary care health home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases,

Team Member	FTE/Cost	PMPM	Team Member Role
			treatments & medications h. Track required assessments and screenings i. Assist in implementing MHD health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes
Behavioral Health Consultant	1 FTE/750 enrollees $70,000/year	PMPM $7.78	a. screening/evaluation of individuals for mental health and substance abuse disorders b. brief interventions for individuals with behavioral health problems c. behavioral supports to assist individuals in improving health status and managing chronic illnesses d. The behavioral health consultant both meets regularly with the primary care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal "curbside " manner as part of the daily routine of the clinic e. Integration with Primary Care i. Support to Primary Care physician/teams in identifying and behaviorally intervening with patients who could benefit from behavioral intervention. ii. Part of front line interventions with first looking to manage behavioral health needs within

Team Member	FTE/Cost	PMPM	Team Member Role
			the primary care practice. iii. Focus on managing a population of patients versus specialty care f. Intervention i. Identification of the problem behavior, discuss impact, decide what to change ii. Specific and goal directed interventions - Use monitoring forms - Use behavioral health "prescription" - Multiple interventions simultaneously g. Education i. Handouts ii. "Teach back" strategy iii. Tailored to specific issue h. Feedback to PCP i. Clear, concise, BRIEF ii. Focused on referral question iii. Description of action plan iv. Plan for follow-up
Primary care health home Director Administrative support	1 FTE/2500 enrollees $90,000 / year Non-PMPM paid staff training time Contracted services	PMPM $8.87	a. Provides leadership to the implementation and coordination of Healthcare Home activities b. Champions practice transformation based on Healthcare Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Healthcare Home performance and leads improvement efforts e. Designs and develops prevention and

Team Member	FTE/Cost	PMPM	Team Member Role
			wellness initiatives Referral tracking f. Training and technical assistance g. Data management and reporting h. Non-PMPM paid staff training time
Care Coordination	1 FTE/750 enrollees $65,000/year	PMPM $7.22	a. Referral tracking b. Training and technical assistance c. Data management and reporting (can be separated into second part time function) d. Scheduling for Primary care health home Team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending Medical Records for care coordination
TOTAL PMPM		**$58.87**	

Payment Type: Alternate Payment Methodology: ***N/A***

Provider Type: N/A

Description: N/A

Attachment D:

Missouri Medical Home Collaborative (MMHC)
Meeting Attendees - November 8, 2010

Organization	Representative Attending
American College of Physicians MO Chapter MU Center for Health Ethics	David A Fleming, MD
American Academy of Pediatrics- Missouri Chapter	Robert Steele, MD Johanna Derda Johanna Echols Blaine Sayre, MD
Anthem Blue Cross & Blue Shield MO	Wayne Meyer, MD Veryl Alexander
AOA - Missouri Association of Osteopathic Physicians and Surgeons, Inc.	Brian Bowles
Barnes Jewish Hospital	Ann Abad Melanie Lapidus
Children's Mercy Family Health Partners	Elizabeth S. Peterson, MD
CIGNA HealthCare of Mid-America	Evan Peters
CIGNA HealthCare of St. Louis	Jordan Ginsburg, MD Diane Schilling
Citizen's Memorial Hospital	Tim Wolters
Community Health Center of Central Missouri	Alan Stevens
Cox Health	Tim Fursa, MD
Edward Jones	Kim Grbac Mary Ellen Bartells
Esse Health	Thomas Hastings, MD
Freeman Health System	Lisa Nelson
Group Health Plan & Coventry - St. Louis Coventry Health Care/GHP	Scott Spradlin, MD Ryan Voisey
Hannibal Regional Hospital	Julie Leverenz Tim Polley Sarah Boleach

Organization	Representative Attending
HealthCare USA	Dan Paquin
Hermann Area District Hospital	Ellen Schaumberg (also for MARHC)
Mercy Medical Group	Tom Hale, MD
Missouri Academy of Family Physicians	Jennifer Bauer
Missouri Association of Rural Health Clinics (MARHC)	Ellen Schaumberg (also for Hermann) Tom Warner Doug Easler David Winton
Missouri Care (MO Care)	Stacy Meyer
Missouri Care Health Plan/ Harmony Health Plan	Vijay Kotte
Missouri Health Advocacy Alliance	Brian Colby
Missouri Highlands	Sherilyn Clark
Missouri Primary Care Association	Angela Herman Kathy Davenport Janice Pirner
MO HealthNet Division	Ian McCaslin, MD Julie Creach George Oestreich Joe Parks
Molina Healthcare of Missouri	Joanne Volovar
Monsanto	Carolyn George Plummer Mark D'Amico
Schnucks	Ed Keady
SSM Health Care-St. Louis	Mark Renken
St. Louis Area Business Health Coalition	Louise Probst
St. Louis University School of Medicine	Gillian Stephens, MD
UnitedHealthcare of the Midwest, Inc.	Robert W. Smith, MD Karen E Miller

Organization	Representative Attending
	Shannon Nelson Deborah Waedekin
University of Missouri Center for Health Policy Office of Continuing Education	Karen Edison, MD
University of Missouri School of Medicine at Columbia Division of General Internal Medicine	Robert Lancey, MD
University of Missouri	Suzanne Hart Laura Schopp

Attachment E:

Missouri Medical Home Collaborative Steering Committee

Organization / Practice Affiliation	Representative
Anthem Blue Cross & Blue Shield of MO	Walter Bielefeld Ruth Meyer Hollenback
Community Health Center of Central MO (FQHC)	Katherine Friedebach, MD
Coventry Health Care/GHP	Scott Spradlin, MD DO FACOI Ryan Voisey
Cox Health RHC (Private Hospital Provider RHCs)	Nancy Bolduc Janice Jones, APRN
Crider Health Center (CMHC, Wentzville)	Karl Wilson, Ph.D.
Esse Health (St. Louis)	Rob Richman
Family Care Health Center (FQHC)	Heidi Miller, MD
Freeman Health System (Joplin)	Daxton Holcomb
Hermann Area Health System	Ellen Schaumberg
HealthCare USA	Pam Victor
Kneibert Clinic (Independent RHC)	Tom Warner
Missouri Care (Aetna)	John Esslinger, MD
Missouri Dept. of Mental Health	Joe Parks, MD
Missouri Health Advocacy Alliance	Susan Hinck
MO HealthNet Division	Ian McCaslin, MD
Pathways Midwest Behavioral Healthcare (CMHC Central MO)	Mel Fetter President, CEO
Patients First Health Care	Kelly Bain, MD
Sam Rodgers Health Center	Dan Purdom, MD
SSM Health Care	Tom Hanley, MD Mark Renken
St. Louis Area Business Health Coalition	Louise Probst

Organization / Practice Affiliation	Representative
UnitedHealthcare	Karen Miller Shannon Nelson Robert Smith, MD
University of Missouri School of Medicine at Columbia, Division of Internal Medicine	David A Fleming, MD, FACP Robert Lancey, MD, FACP, FAAP
Missouri Foundation for Health	Web Brown Cynthia Hayes Terry Plain
Bailit Health Purchasing, LLC (consultant)	Michael Bailit Marge Houy Christine Hughes

Appendix F:
Summary of Additional Stakeholder Engagement Activities

Missouri solicited input on the two Health Home programs from internal and external stakeholders, including consumers and beneficiaries through the following organizations. These organizations will continue to get updates and be consulted on the implementation of the Health Home programs on an ongoing basis.

Name of Organization	Purpose/ Mission	Membership of Organization	Consumer/ Beneficiary Involvement?
Psychiatric Services State Advisory Council	A council that advises the state and make recommendations to improve the system of care in mental health	25 members appointed by the Director of the Division of Comprehensive Psychiatric Services including: • mental health consumers, including parents of children receiving services and family members. • representation is required from the following state agencies: Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing and Mental Health.	Yes
Mental Health Commission	Statutorily mandated public commission overseeing DMH activities	Comprised of seven members, including: • a physician recognized as an expert in the treatment of mental illness; • a physician recognized as an expert in the evaluation or habilitation of the mentally retarded and developmentally disabled; • a representative of groups who are consumers or families of consumers interested in the services provided by the department in the treatment of mental illness; • a representative of groups who are consumers or families of consumers interested in services provided by the department in the habilitation of the mentally retarded; • a person recognized for his or her expertise in general business matters and procedures; • a person recognized for his interest and	Yes

		expertise in dealing with alcohol and drug abuse, and • a person recognized for his interest or expertise in community mental health services.	
Missouri Commission on Autism Spectrum Disorders	State-wide commission for oversight of autism spectrum related services	24 members including: • four members of the general assembly, with two members from the senate and two members from the house of representatives. • the director of the Department of Mental Health, or his or her designee; • the commissioner of the Department of Elementary and Secondary Education, or his or her designee; • the director of the Department of Health and Senior Services, or his or her designee; the director of the Department of Public Safety, or his or her designee; • the commissioner of the Department of Higher Education, or his or her designee; the director of the Department of Social Services, or his or her designee; • the director of the Department of Insurance, Financial Institutions and Professional Registration, or his or her designee; • two representatives from different institutions of higher learning located in Missouri; • an individual employed as a director of special education at a school district located in Missouri; • a speech and language pathologist; • a diagnostician; • a mental health provider; • a primary care physician; • two parents of individuals with autism spectrum disorder, including one parent of an individual under the age of eighteen and one parent of an individual over the age of eighteen; • two individuals with autism spectrum disorder, and • a representative from an independent private provider or non-profit provider or organization.	Yes

Assessment & Improvement (QA&I) Advisory Group	Advises MO HealthNet (Missouri Medicaid) on quality improvement efforts associated with managed care	• state agency staff (MO HealthNet, , DMH, Family Support Division) • provider organizations (DentaQuest, Children's Mercy Family Health Partners, MHA, BA+) • health plans (Missouri Care, Harmony, HealthCare USA, Molina Health Care) • legal services organizations (LAWMO, Legal Services Southern MO, Mid-MO Legal services, Legal Services Western MO)	No
Behavioral Health Task Force	A task force of the QA&I Advisory Group, Advises MO HealthNet (Missouri Medicaid) on Behavioral Health Issues	• Same as for the Assessment & Improvement (QA&I) Advisory Group	No
Missouri Association of Public Administrators	an association representing Missouri Public Administrators	• an organization comprised of County Public Administrators from each county in Missouri	No
National Council for Community Behavioral Healthcare	an association representing Missouri behavioral health organizations	• Behavioral health organizations operating in the state of Missouri	No
Missouri Foundation for Health	To support health related project in the state of Missouri	• a non-profit foundation that helps develop and fund programs through grants to eligible organizations in the region	No
Missouri	An association	• Primary care providers operating in the state of Missouri	No

Primary Care Association	representing Missouri primary care providers		
Missouri Association of Assisted Living Facilities	An association representing Missouri assisted living facilities	• Assisted Living Facilities operating in the state of Missouri	No

The Health Home programs were discussed and stakeholder advice and feedback was requested on the following dates:

Behavioral Health Task Force (QA&I Advisory Group)	8/20/2010
Psychiatric Services State Advisory Council	9/23/2010
Meeting with Assessment & Improvement Advisory Group	10/21/2010
Psychiatric Services State Advisory Council	10/28/2010
Meeting with Assessment & Improvement Advisory Group	1/27/2011
Psychiatric Services State Advisory Council	1/27/2011
Behavioral Health Task Force (QA&I Advisory Group)	2/18/2011
Psychiatric Services State Advisory Council	3/24/2011
Meeting with Assessment & Improvement Advisory Group	4/28/2011
Psychiatric Services State Advisory Council	4/28/2011
National Council for Community Behavioral Healthcare	5/1/2011
Medical Home Summit	5/25/2011
Meeting with Assessment & Improvement Advisory Group	7/28/2011
Psychiatric Services State Advisory Council	7/28/2011
Missouri Association of Assisted Living Facilities	8/7/2011
Behavioral Health Task Force (QA&I Advisory Group)	8/19/2011
Psychiatric Services State Advisory Council	8/25/2011
Missouri Foundation for Health	8/26/2011
Mental Health Commission	9/8/2011
Missouri Primary Care Association	9/22/2011
Psychiatric Services State Advisory Council	9/29/2011
Primary Care Health Home Conference Call with the public and interested stakeholders	10/13/2011
Psychiatric Services State Advisory Council	10/27/2011
Missouri Association of Public Administrators	11/8/2011
Primary Care Health Home Conference Call with the public and interested stakeholders	11/8/2011
Missouri Autism Commission	11/16/2011
Missouri Association of Public Administrators	1/24/2012

Additionally, public notice of the Health Home state plan amendment was published as follows below:

- December 20, 2011 – Columbia Tribune, Independence Examiner, Kansas City Star, Springfield News Leader, St. Joseph News Press
- December 21, 2011 – St. Louis Post Dispatch

Attachment G:

List of Community Mental Health Centers participating in the CMHC Health Home program:

Adapt of Missouri, Inc.
BJC Behavioral Health St. Louis
BJC Behavioral Health Farmington
Bootheel Counseling Services
Burrell Behavioral Health SA10
Burrell Behavioral Health - SA 12
Clark Community Mental Health Center
Community Counseling Center
Comprehensive Health Systems
Comprehensive Mental Health Services
Community Treatment, Inc.
Crider Health Center, Inc.
East Central Missouri Behavioral Health
Family Counseling Center, Inc.
Family Guidance Center
Hopewell Center
Independence Center
Mark Twain
New Horizons
North Central Missouri MHC
Ozark Center
Ozark Medical Center
Pathways Community Behavioral Healthcare
Places For People
Preferred Family Healthcare, Inc.
ReDiscover
Swope Health Services
Tri-County Mental Health Services
Truman Medical Center Behavioral Health

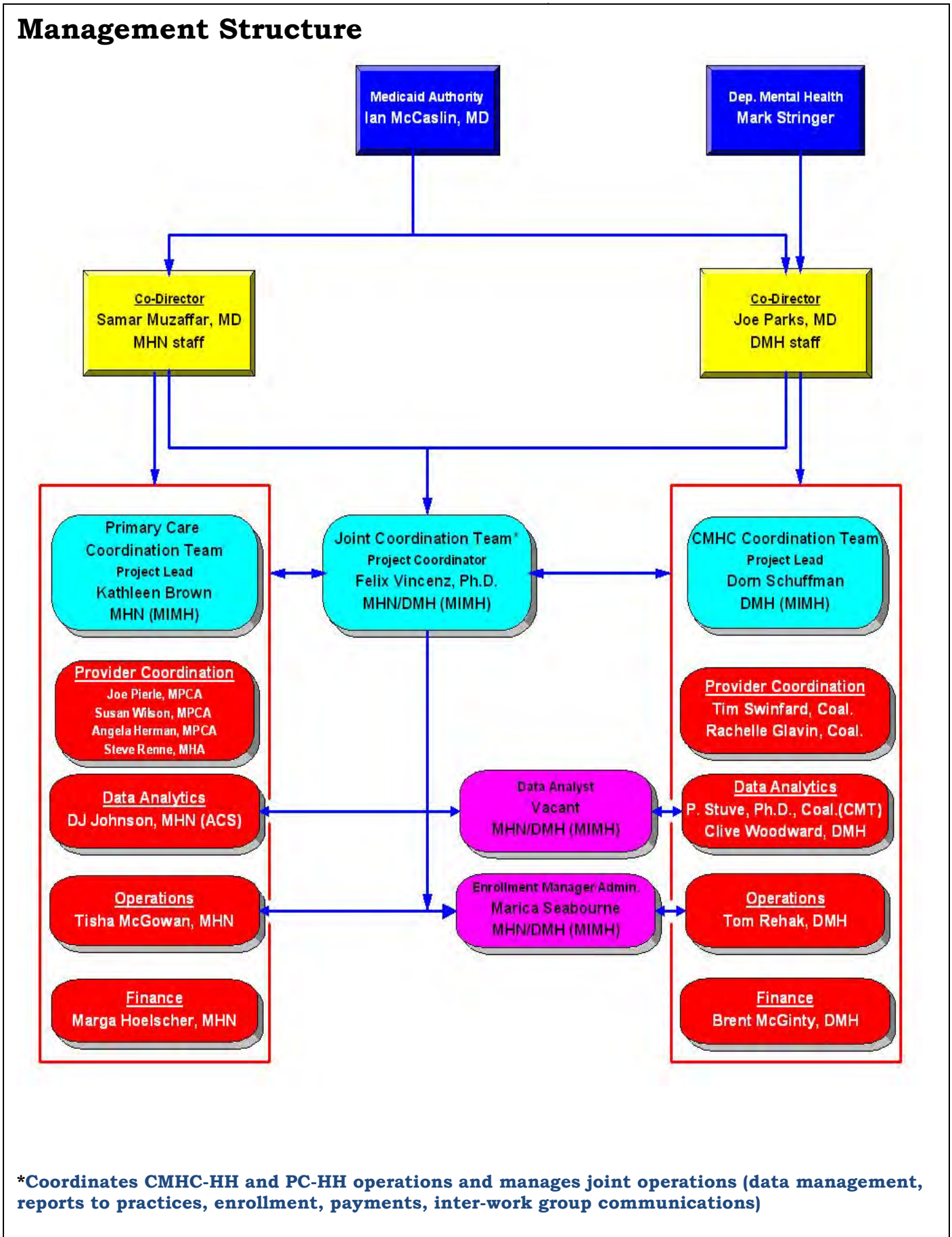
Attachment H:

List of all of the organizations participating in the Primary Care Health Home program

Name of Organization	Provider Type
Betty Jean Kerr People's Health Centers	FQHC
Citizens Memorial Healthcare	Hosp Based RHCs
Community Health Center of Central Missouri	FQHC
Fitzgibbon Hospital	Hosp Based RHC
Access Family Care	FQHC
Crider Health Center	FQHC
Family Care Health Centers	FQHC
Family Health Center of Boone County	FQHC
Fordland Clinic	FQHC
Grace Hill Health Centers	FQHC
Jordan Valley Community Health Center	FQHC
Katy Trail Community Health	FQHC
Missouri Highlands Health Care	FQHC
Myrtle Hilliard Davis Comprehensive Health Centers	FQHC
Northwest Health Services	FQHC
Southeast Missouri Health Network	FQHC
Swope Health Services	FQHC
Truman Medical Centers	Hosp Based Clinics
University of Missouri Health System	Hosp Based Clinics
CoxHealth	Hosp Based Clinic
Northeast Missouri Health Council	FQHC
Samuel U. Rodgers Health Center	FQHC
Skaggs Regional Medical Center	Hosp Based RHCs
Southern Missouri Community Health Center	FQHC

Attachment I:

Organizational chart detailing the state's staffing infrastructure for the Health Home programs.



***Coordinates CMHC-HH and PC-HH operations and manages joint operations (data management, reports to practices, enrollment, payments, inter-work group communications)**