

Jason Kander
Secretary of State
Administrative Rules Division

RULE TRANSMITTAL

Administrative Rules Stamp

RECEIVED

SEP 29 2016

SECRETARY OF STATE
ADMINISTRATIVE RULES

Rule Number 13 CSR 70-3.240

COPY

Use a "SEPARATE" rule transmittal sheet for EACH individual rulemaking.

Name of person to call with questions about this rule:

Content Billie Waite Phone 573-751-6922 FAX 573-751-6564

Email address Danielle.M.Rubino@dss.mo.gov

Data Entry Debbie Meller Phone 573-751-6922 FAX 573-751-6564

Email address Debbie Meller

Interagency mailing address 615 Howerton Court, Jefferson City, MO 65109

TYPE OF RULEMAKING ACTION TO BE TAKEN

- Emergency rulemaking, include effective date
 Proposed Rulemaking
 Withdrawal Rule Action Notice In Addition Rule Under Consideration
 Request for Non-Substantive Change
 Statement of Actual Cost
 Order of Rulemaking

Effective Date for the Order _____

Statutory 30 days OR Specific date _____

Does the Order of Rulemaking contain changes to the rule text? NO

YES—LIST THE SECTIONS WITH CHANGES, including any deleted rule text:

Small Business Regulatory
Fairness Board (DED) Stamp

SMALL BUSINESS
REGULATORY FAIRNESS BOARD

SEP 29 2016

RECEIVED

JCAR Stamp

JOINT COMMITTEE ON

SEP 29 2016

ADMINISTRATIVE RULES

Missouri Department of
SOCIAL SERVICES

Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, DIRECTOR

MO HEALTHNET DIVISION

September 29, 2016

Jason Kander
Secretary of State
Administrative Rules Division
600 West Main Street
Jefferson City, Missouri 65101

Re: 13 CSR 70-3.240 MO HealthNet Primary Care Health Homes

Dear Secretary Kander,

CERTIFICATION OF ADMINISTRATIVE RULE

I do hereby certify that the attached is an accurate and complete copy of the proposed amendment lawfully submitted by the Department of Social Services, MO HealthNet Division.

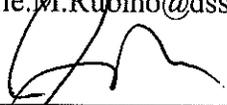
The Department of Social Services, MO HealthNet Division has determined and hereby certifies that this proposed rulemaking will have an economic impact on small businesses. A small business impact statement is attached. The Department of Social Services, MO HealthNet Division further certifies that it has conducted an analysis of whether or not there has been a taking of real property pursuant to section 536.017, RSMo 2000, that the proposed rulemaking does not constitute a taking of real property under relevant state and federal law, and that the proposed rulemaking conforms to the requirements of 1.310, RSMo, regarding user fees.

The Department of Social Services, MO HealthNet Division has determined and hereby also certifies that this proposed rulemaking complies with the small business requirements of 1.310, RSMo, in that it does not have an adverse impact on small businesses consisting of fewer than fifty full or part-time employees or it is necessary to protect the life, health, or safety of the public, or that this rulemaking complies with 1.310, RSMo, by exempting any small business consisting of fewer than fifty full or part-time employees from its coverage, by implementing a federal mandate, or by implementing a federal program administered by the state or an act of the general assembly.

Statutory Authority: 208.201, RSMo Supp. 2013.

If there are any questions regarding the content of this proposed amendment, please contact:

Billie A. Waite
MO HealthNet Division
615 Howerton Court
Jefferson City, MO 65109
(573) 751-6922
Danielle.M.Rubino@dss.mo.gov


Joseph Parks, M.D., Director
Department of Social Services
MO HealthNet Division

A Interpretive services are available by calling the Participant Services Unit at 1-800-392-2161.
Prevodilačke usluge su dostupne pozivom odjela koji učestvuje u ovom servisu na broj 1-800-392-2161.
Servicios Intreprative están disponibles llamando a la unidad de servicios de los participantes al 1-800-392-2161.

RELAY MISSOURI

FOR HEARING AND SPEECH IMPAIRED 1-800-735-2466 VOICE • 1-800-735-2966 TEXT PHONE

An Equal Opportunity Employer, services provided on a nondiscriminatory basis

Missouri Department of
SOCIAL SERVICES

Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, DIRECTOR

MO HEALTHNET DIVISION

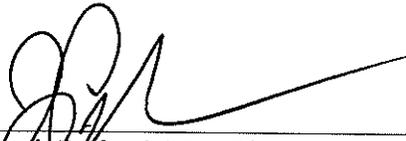
September 29, 2016

Cindy Kadlec, Director
Joint Committee on Administrative Rules
Capitol Building, Room 8-B
Jefferson City, MO 65101

Dear Ms. Kadlec:

Enclosed is an accurate and complete copy of the proposed amendment regarding 13 CSR 70-3.240, which is to be submitted to the Secretary of State on September 29, 2016.

Statutory Authority: 208.201, RSMo Supp. 2013.



Joseph Parks, M.D., Director
MO HealthNet Division

JP:dm

Enclosure:
Proposed Amendment 13 CSR 70-3.240

Interpretive services are available by calling the Participant Services Unit at 1-800-392-2161.
Prevodilačke usluge su dostupne pozivom odjela koji učestvuje u ovom servisu na broj 1-800-392-2161.
Servicios Intreprative están disponibles llamando a la unidad de servicios de los participantes al 1-800-392-2161.

RELAY MISSOURI

FOR HEARING AND SPEECH IMPAIRED 1-800-735-2466 VOICE • 1-800-735-2966 TEXT PHONE

An Equal Opportunity Employer, services provided on a nondiscriminatory basis.

AFFIDAVIT

PUBLIC COST

STATE OF MISSOURI)
) ss.
COUNTY OF COLE)

I, Brian Kinkade, Director of the Department of Social Services, first being duly sworn, on my oath, state that it is my opinion that the attached fiscal note for the proposed amendment to 13 CSR 70-3.240 is a reasonably accurate estimate.

Brian Kinkade
Brian Kinkade
Director
Department of Social Services

Subscribed and sworn to before me this 28 day of Sept. 2016. I am
commissioned as a notary public within the County of Cole
State of Missouri, and my commission expires
on March 5, 2019.

DONNA A. SYBOUTS
Notary Public - Notary Seal
State of Missouri
Commissioned for Cole County
My Commission Expires: March 05, 2019
Commission Number: 15633724

Donna A. Sybouts
Notary public

RECEIVED

SEP 29 2016

SECRETARY OF STATE
ADMINISTRATIVE RULES

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of
General Applicability

PROPOSED AMENDMENT

COPY

13 CSR 70-3.240 MO HealthNet Primary Care Health Homes. The Division is revising sections (1), (3), and (4).

PURPOSE: This amendment adds uncontrolled asthma in children and obesity as stand-alone chronic conditions that qualify MO HealthNet participants as Primary Care Health Home patients. The amendment also adds depression, anxiety, and substance use disorder as chronic conditions that, in combination with another qualifying chronic condition, qualify MO HealthNet participants as Primary Care Health Home patients. The amendment adds a performing provider requirement to Primary Care Health Homes with patients receiving services for a substance use disorder chronic condition. The amendment removes the no-longer applicable requirement for Health Home provider participation in learning collaboratives, and updates the Health Home certification requirements. The amendment revises Health Home team requirements to include a Physician Champion. Finally, the amendment updates the process for alerting Health Homes to potential enrollees, and simplifies how Primary Care Health Homes may share information with area hospitals on Health Home enrollees.

(1) Definitions.

(A) EMR—Electronic Medical Records, also referred to as Electronic Health Records (EHR).

(B) Health Home—A primary care practice or site that provides comprehensive primary physical and behavioral health care to MHD patients with chronic physical and/or behavioral health conditions, using a partnership or team approach between the Health Home practice's/site's health care staff and patients in order to achieve improved primary care and to avoid preventable hospitalization or emergency department use for conditions treatable by the Health Home.

[(C) Learning Collaborative—Group training sessions that primary care providers must attend if they are chosen to participate in the MO HealthNet Health Home program. The training will include meetings with mandatory attendance by certain officers and medical staff of the Health Home site and monthly conference calls.]

SMALL BUSINESS
REGULATORY FAIRNESS BOARD

SEP 29 2016

RECEIVED

JOINT COMMITTEE ON

SEP 29 2016

ADMINISTRATIVE RULES

[(D)] (C) Meaningful Use Stage One—The American Recovery and Reinvestment Act (ARRA) of 2009 created the Electronic Health Records (EHR) incentive payments program to provide Medicare or Medicaid incentive payments to eligible professionals in primary care practices. Meaningful use means that the eligible professionals or providers document that they are using certified EHR technology in ways that can be measured significantly in quality and in quantity. Stage one of meaningful use means the eligible professionals meet twenty (20) out of twenty-five (25) meaningful use objectives as specified by the Centers for Medicare and Medicaid Services (CMS).

[(E)] (D) MHD—MO HealthNet Division, Department of Social Services.

[(F)] (E) NCQA—National Committee of Quality Assurance, *[the]* an entity chosen by MHD to certify that a primary care practice has obtained a level of Health Home recognition after the practice achieves specified Health Home standards.

[(G)] (F) Needy Individuals—Patients whose primary care services are either reimbursed by MHD or the Children’s Health Insurance Program (CHIP), or are provided as uncompensated care by the primary care practice, or are furnished at no cost or at reduced cost to patients without insurance.

[(H)] (G) Patient Panel—The list of patients for whom each provider at the practice site serves as the primary care provider.

[(I)] (H) CMS—Centers for Medicare and Medicaid Services.

(I) The Joint Commission--an entity chosen by MHD to certify that a primary care practice has obtained a level of Health Home recognition after the practice achieves specified Health Home standards.

(3) Health Home Responsibilities After Selection.

(A) Health Home practice sites will *[be physician- or nurse practitioner-led]* **have a physician champion to provide physician leadership and encourage practice transformation to the Health Home model. Health Home practice sites** *[and]* shall form a health team comprised of, at a minimum, a primary care physician (i.e., family practice, internal medicine, or pediatrics) or nurse practitioner, *[a licensed nurse or medical assistant,]* a behavioral health consultant, and a nurse clinical care manager*[, and the practice administrator or office manager]*. The team will be supported as needed by the care coordinator, *[and]* Health Home Director, **and the practice administrator or office manager**. Other team members may include, for example, dietitians, nutritionists, pharmacists, or social workers.

(B) Practice sites selected to be MHD Health Homes shall participate in Health Home *[learning collaboratives. MHD will announce the dates and locations for learning collaborative meetings]* **webinars, care team forums, and other training opportunities.**

[1. At a minimum, each Health Home practice site shall send to the learning collaborative meetings a team consisting of a senior clinician, another clinician, and a non-clinician member of the practice (site) such as the practice manager or practice administrator.

2. A Health Home will participate in monthly learning collaborative conference calls or webinars.

3.] A Health Home will participate in topical work groups as requested by MHD.

[4. A practice organization that has more than one (1) of its practice sites recognized by MHD as Health Homes, but not all of its sites selected for learning collaborative participation, shall designate a trainer to participate in a “train the trainer” program. The trainer shall attend the learning collaborative as a member of a practice’s core practice team and then train all of the organization’s other Health Home practice sites that were not selected for learning

collaborative participation. MHD or its designee shall identify content that the practice organization trainer will teach to the Health Home practice sites that do not participate in the learning collaborative.]

(C) Health Homes shall convene practice team meetings at regular intervals to assist with the practice's transformation into a Health Home and to support continual Health Home evolution.

(D) A Health Home shall create and maintain a patient registry using EHR software, a stand-alone registry, or a third-party data repository and measures reporting system. The patient registry is the system used to obtain information critical to the management of the health of a primary care practice's patient population, including dates of services, types of services, and laboratory values needed to track chronic conditions. The Health Home's patient registry will be used for—

1. Patient tracking;
2. Patient risk stratification;
3. Analysis of patient population health status and individual patient needs; and
4. Reporting as specified by MHD.

(E) Primary care practice sites must transform how they operate in order to become Health Homes. Transformation involves mastery of thirteen (13) Health Home core competencies to be taught through the learning collaborative. The thirteen (13) core competencies are—

1. Patient/family/peer/advocate/caregiver-centeredness or a whole-patient orientation to care;
2. Multi-disciplinary team-based approach to care;
3. Personal patient/primary care clinician relationships;
4. Planned visits and follow-up care;
5. Population-based tracking and analysis with patient-specific reminders;
6. Care coordination across settings, including referral and transition management;
7. Integrated clinical care management services focused on high-risk patients including medication management, such as medication histories, medication care plans, and medication reconciliation;
8. Patient and family education;
9. Self-management support by members of the practice team;
10. Involvement of the patient in goal setting, action planning, problem solving, and follow-up;
11. Evidence-based care delivery, including stepped care protocols;
12. Integration of quality improvement strategies and techniques; and
13. Enhanced access.

(F) By the eighteenth month following the receipt of the first MHD Health Home payment, a practice site participating in the Health Home program shall demonstrate to MHD that the practice site has either—

1. Submitted to the National Committee of Quality Assurance (NCQA) an application for Health Home status and has obtained NCQA recognition of Health Home status of at least **[“]Level 1 [Plus.”]** **under the most recent NCQA standard [“Level 1 Plus” recognition is defined for these purposes as meeting 2011 NCQA Level 1 standards, plus recognition for achieving the following 2011 NCQA patient-centered medical home standard at the specified level of performance: Standard 3C at one hundred percent (100%), or at seventy-five percent (75%) with an acceptable plan of correction];** or

2. *[Submitted]* **Applied** to *[NCQA an application for Health Home status and has obtained NCQA recognition of Health Home status at "Level 1 Plus," defined as meeting NCQA 2008 PPC-PCMH Level 1 standards, plus recognition for achieving the following NCQA 2008 PPC-PCMH standards at the specified levels of performance: Standard 3C at seventy-five percent (75%), Standard 3D at one hundred percent (100%), and Standard 4B at fifty percent (50%)]*

The Joint Commission for certification as a Primary Care Medical Home.

(G) A Health Home shall submit to MHD or its designee the following information, as further specified by MHD or its designee, within the specified time frames:

1. Monthly narrative practice reports that describe the Health Home's efforts and progress toward implementing Health Home practices;

2. Monthly clinical quality indicator reports utilizing clinical data obtained from the Health Home's patient registry or third-party data repository;

[3. Periodic submission of Medicaid Home Implementation Quotient (MHIQ) survey scores, as specified by MHD;] and

[4] **3.** Other reports as specified by MHD.

(H) Practices selected to participate in the Health Home program must provide evidence of Health Home practice transformation on an ongoing basis using measures and standards established by MHD. Evidence of Health Home transformation includes:

1. Development of fundamental Health Home functionality at six (6) months and at twelve (12) months of entering the Health Home program, based on an assessment process to be applied by MHD or its designee;

2. Significant improvement on clinical indicators specified by and reported to MHD or its designee; and

3. Development of quality improvement plans to address gaps and opportunities for improvement identified during and after the Health Home application process.

(I) A Health Home must notify MHD within five (5) working days of the following changes:

1. *[If the employment or contract of a clinical care manager is terminated after the initiation of clinical care management payments]* **Changes in the employment or contracting of Health Home team members, or changes in the percentage of full time equivalent work time devoted to the Health Home by any Health Home team member; or**

2. If the Health Home experiences substantive changes in practice ownership or composition, including:

A. Acquisition by another practice;

B. Acquisition of another practice; or

C. Merger with another practice.

(J) Health Homes shall participate in evaluations determined necessary by CMS and/or MHD. Participation in evaluations may require responding to surveys and requests for interviews of Health Home practice staff and patients. Health Homes shall provide all requested information to an evaluator in a timely fashion.

(K) Within three (3) months of selection to be a Health Home, a practice site will develop *[agreements or memorandums of understanding to formalize traditional care planning with area hospitals, in which the hospitals agree to—*

1. *Notify the Health Home when Health Home patients are admitted to inpatient hospital departments;*

2. *Identify for the Health Home individuals seeking emergency department services who might benefit from connection with the Health Home;*

3. Notify the Health Home when Health Home patients seek treatment in the hospitals' emergency departments; and

4. Refer patients to the Health Home for follow-up care] processes with area hospitals to share information on Health Home participants admitted to inpatient departments or seen in the emergency department.

(L) In order to provide Health Home services to a participant with substance use disorder and who is eligible for Health Home services in accordance with subparagraph (4)(A)2.A., a Primary Care Health Home practice must have at least one performing provider who qualifies and applies for a waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000) to provide medication-assisted treatment.

(4) Health Home Patient Requirements.

(A) To become a MO HealthNet Health Home patient, an individual—

1. Must be an MHD participant or a participant enrolled in an MHD managed care health plan; and

2. Must have at least—

A. Two (2) of the following chronic [health] conditions:

(I) Asthma;

(II) Diabetes;

(III) Cardiovascular disease;

(IV) A developmental disability; [or]

(V) Be overweight, as evidenced by having a [n adult] body mass index (BMI) [over] of at least twenty-five (25) for adults, or being at or above the eighty-fifth (85th) percentile on the standard pediatric growth chart for children; [or]

(VI) Depression;

(VII) Anxiety; or

(VIII) Substance use disorder; or

B. One (1) chronic health condition and be at risk for a second chronic health condition as defined by MHD. In addition to being a chronic health condition, diabetes shall be a condition that places a patient at risk for a second chronic condition. Smoking or regular tobacco use shall be considered at-risk behavior leading to a second chronic health condition[.]; or

C. One (1) of the following stand-alone chronic conditions:

(I) Uncontrolled pediatric asthma as defined by MO HealthNet; or

(II) Obesity, as evidenced by having a BMI over thirty (30) for adults, or being above the ninety-fifth (95th) percentile on the standard pediatric growth chart for children.

(B) A list of participants eligible for Health Home services and identified by MHD as [an] existing users of services at Health Home [services] practices will be [auto-assigned to a] provided monthly to each Health Home based on qualifying chronic health conditions. [A participant not enrolled in an MHD managed care health plan will be attributed to a Health Home using a standard patient algorithm adopted by MHD. A participant enrolled in an MHD managed care health plan will be attributed to a Health Home practice site that the participant has selected or to which the participant has been assigned by the health plan] Health Home organizations will determine enrollees from the lists provided by MHD as well as practice patients identified through the Health Homes' EMR systems.

(C) After being [assigned to] enrolled in Health Homes, participants will be granted the option at any time to change their Health Homes if desired. [A participant assigned to a Health Home

will be notified by MHD of all available Health Home sites throughout the state. The notice will—

1. Describe the participant's choice in selecting a Health Home;
2. Provide a brief description of Health Home services, including the role of care managers and coordinators; and
3. Describe the process for the participant] **Participants will be given the opportunity to opt out of receiving services from their [assigned] Health Home providers.**

[(D) Participants eligible for Health Home services who receive inpatient hospital or hospital emergency department services will be notified of eligible Health Homes and will be referred to Health Homes based on their choice of providers. Participants who are admitted to a hospital or who receive hospital emergency department services will be identified as eligible for Health Home services through the MHD comprehensive Medicaid electronic health record.

(E) Health Home providers to which patients have been auto-assigned will be notified by MHD of patients' enrollment for Health Home services. The Health Homes will notify their patients' other treatment providers in order to explain Health Home goals and services, and to encourage their patients' other treatment providers to participate in care coordination efforts.]

AUTHORITY: section 208.201, RSMo Supp. [2011] 2013. Original rule filed Dec. 15, 2011, effective July 30, 2012. Amended: Filed _____, 2016.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

PUBLIC ENTITY COST: This proposed amendment will cost state agencies or political subdivisions approximately \$1,844,321 in SFY 2017 and annually thereafter.

PRIVATE ENTITY COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication in the Missouri Register. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.

**FISCAL NOTE
PUBLIC COST**

- I. Department Title:** Title 13 - Department of Social Services
Division Title: Division 70 - MO HealthNet Division
Chapter Title: Chapter 3 – Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

Rule Number and Name:	13 CSR 70-3.240 MO HealthNet Primary Care Health Homes
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services, MO HealthNet Division	SFY 2017 = \$1.844 million and annually thereafter

III. WORKSHEET

Estimated Cost for SFY 2017:

2,500 additional Primary Care Health Home payments from patients with the additional qualifying chronic conditions, divided by 16,500 current average monthly Primary Care Health Home PMPM payments per month, = 15.15% increase in monthly PMPM payments.

Projected Primary Care Health Home payments of \$12,172,520 in SFY 2016, multiplied by the 15.15% increase in monthly PMPM payments from patients with additional qualifying chronic conditions, = **\$1,844,321** increase in PMPM expenditures from Primary Care Health Home patients with additional chronic conditions.

Blended FMAP of 63.23%, multiplied by \$1,844,321 increase in PMPM expenditures from additional Primary Care Health Home patients, = \$1,166,164 federal share of increase. \$1,844,321 - \$1,166,164 = \$678,157 state share of increase from additional PMPM expenditures attributed to the proposed amendment.

IV. ASSUMPTIONS

The new Primary Care Health Home patients with additional qualifying chronic conditions in the proposed amendment would start receiving services in SFY 2017. The enrollment of the new patients would be staggered throughout SFY 2017. To avoid underestimating the fiscal impact of the new Primary Care Health Home patients, the calculations assume that the new patients are enrolled and receiving Health Home services at the start of SFY 2017.

The current average number of Primary Care Health Home payments per month = 16,500. This number of monthly payments is the base without additional patients from the expansion of qualifying chronic conditions.

The estimated increase in Primary Care Health Home patients with qualifying chronic conditions = 2,500. The calculations assume that all 2,500 of these new patients generate a PMPM payment every month.

Projected Primary Care Health Home PMPM payments in SFY 2016 = \$12,172,520, which reflects a 2% increase in the PMPM rate effective with January 2016 Health Home services.

Small Business Regulatory Fairness Board

Small Business Impact Statement

Date: September 29, 2016

Rule Number: 13 CSR 70-3.240

Name of Agency Preparing Statement: Department of Social Services

Name of Person Preparing Statement: Billie Waite

Phone Number: (573)751-6922 Email: Debbie.Meller@dss.mo.gov

Name of Person Approving Statement: Joseph Parks, M.D.

Please describe the methods your agency considered or used to reduce the impact on small businesses (*examples: consolidation, simplification, differing compliance, differing reporting requirements, less stringent deadlines, performance rather than design standards, exemption, or any other mitigating technique*).

Primary Care Health Homes, some of which are small businesses, enroll and manage the health care of MO HealthNet participants with qualifying chronic conditions, such as asthma, diabetes, and tobacco use. The proposed amendment would expand the number of qualifying chronic conditions for patients to be eligible for the Primary Care Health Home program.

Primary Care Health Homes receive a per-member per-month (PMPM) payment when a Health Home service is provided to a Health Home patient. The current PMPM rate for Primary Care Health Home services is \$63.72. The PMPM reimburses the Health Homes for their necessary costs of Health Home staff and contracted services. MO HealthNet Division developed the PMPM rate based on the estimated costs of Health Home staff and contracted services, and the Division believes the PMPM payments fairly compensate the Primary Care Health Homes for their incurred costs.

Primary Care Health Homes have thus far yielded improved health indicators for their enrolled patients while reducing the amount of inpatient admissions and emergency department utilization by these patients. As the patients become accustomed to working with and trusting Health Home team members, their health care can be more easily and efficiently managed. The positive results translate into fewer resources required for these patients by both MO HealthNet and the Primary Care Health Home practices.

Please explain how your agency has involved small businesses in the development of the proposed rule.

MO HealthNet has discussed the proposed amendment for some time with the Primary Care Health Home organizations, and the provider associations to which the organizations belong. The provider associations and the Primary Care Health Homes, including Health Homes that are small businesses, support the proposed amendment.

The proposed amendment will be filed with the Secretary of State's office and published in the Missouri Register, where it will be open for comments for 30 days before a final rule will be published.

Please list the probable monetary costs and benefits to your agency and any other agencies affected. Please include the estimated total amount your agency expects to collect from additionally imposed fees and how the moneys will be used.

Projected PMPM payments to Primary Care Health Homes will come to \$12.17 million in SFY 2016. MO HealthNet estimates that, with the adoption of the additional chronic conditions in the proposed amendment, an additional 2,500 participants will be eligible for Health Home services. The estimated PMPM payments for the additional qualifying patients come to \$1.84 million in SFY 2017.

MO HealthNet has seen reduced inpatient admissions and emergency department utilization with the current Primary Care Health Home population. Primary Care Health Home patients have also shown improved health measures. MO HealthNet expects the same outcomes with the patients who qualify for Health Home services as a result of the proposed amendment.

MO HealthNet does not collect or assess fees or provider taxes for Primary Care Health Homes.

Please describe small businesses that will be required to comply with the proposed rule and how they may be adversely affected.

Some of the Primary Care Health Homes, such as rural federally qualified health centers and rural hospital-based clinics, are small businesses. All Primary Care Health Homes are required to meet guidelines and qualifications spelled out in 13 CSR 70-3.240. The only new Primary Care Health Home requirement in the proposed amendment concerns Health Homes who enroll new patients with a qualifying chronic condition of substance use disorder.

Please list direct and indirect costs (in dollars amounts) associated with compliance.

The proposed amendment will yield an estimated 2,500 newly qualifying Primary Care Health Home participants. All eligible Primary Care Health Home patients, including those who qualify as a result of the proposed amendment, generate PMPM payments to their Health Homes when they receive Health Home services. The PMPM payments reimburse Primary Care Health Homes for their required staffing and contracted costs. The estimated 2,500 newly qualifying Health Home patients would generate \$1.84 million in PMPM payments in SFY 2017. This amount also represents the additional costs to the Primary Care Health Homes for increased staffing and contracted services.

Please list types of business that will be directly affected by, bear the cost of, or directly benefit from the proposed rule.

All Primary Care Health Homes, including those that are small businesses, may enroll patients with the additional qualifying chronic conditions in the proposed amendment. The Health Homes may need additional staff and contracted services as a result of increased enrollment. The costs of additional staff and contracted services will be reimbursed by the PMPM payments generated from Health Home services to the new patients.

Does the proposed rule include provisions that are more stringent than those mandated by comparable or related federal, state, or county standards?

Yes ___ No X

If yes, please explain the reason for imposing a more stringent standard.

For further guidance in the completion of this statement, please see §536.300, RSMo.