CMS-10434 OMB 0938-1188

Package Information

Package ID	MO2018MS0009O	**Submission Type**	Official
Program Name	Missouri-2 Health Home Services	**State**	MO
SPA ID	MO-19-0003	**Region**	Kansas City, KS
Version Number	4	**Package Status**	Approved
Submitted By	Marissa Crump	**Submission Date**	6/6/2019
Package Disposition		**Approval Date**	8/15/2019 1:20 PM EDT

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

Package Header

Package ID MO2018MS0009O
SPA ID MO-19-0003
Submission Type Official
Initial Submission Date 6/6/2019
Approval Date 8/15/2019
Effective Date N/A
Superseded SPA ID N/A

State Information

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

Submission Component

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

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

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Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID MO-19-0003

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	9/1/2019	16-0002
Health Homes Geographic Limitations	9/1/2019	16-0002
Health Homes Population and Enrollment Criteria	9/1/2019	16-0002
Health Homes Providers	9/1/2019	16-0002
Health Homes Service Delivery Systems	9/1/2019	16-0002
Health Homes Payment Methodologies	9/1/2019	16-0002
Health Homes Services	9/1/2019	16-0002
Health Homes Monitoring, Quality Measurement and Evaluation	9/1/2019	16-0002

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

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Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives

Missouri is amending its approved Primary Care Health Home (PCHH) State Plan Amendment 16-002 dated July 5, 2016 to add new qualifying conditions and risk factors for enrollment. The PCHH was originally implemented 1/1/2012 and its integrated team care concept has shown and continues to show success in meeting the following goals:
- Reduction in avoidable hospitalizations
- Reduction in emergency department visits
- Improvement in clinical measures such as hypertension, hemoglobin A1C, and cholesterol levels
-Positive impact to quality of life for participants and providers
-Reduction in healthcare costs associated with avoidable use of healthcare services
Missouri's PCHH works with primary care providers throughout the state in the provision of team-based care to qualifying individuals enrolled in their health homes. Care teams include a health home director, nurse care manager, behavioral health consultant and care coordinator who are paid through the PCHH per-member-per-month payment, and other clinic staff who work in collaboration with the PCHH team such as physicians, nurse practitioners, clinic managers, pharmacists, nutritionists, information technology, etc.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2020	$-57475
Second	2021	$-62700

Federal Statute / Regulation Citation

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

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

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Superseded SPA ID	N/A		

Governor's Office Review

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

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

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The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [x] Benefits and Payments
  - [x] Health Homes Program
    - ( ) Create new Health Homes program
    - (•) Amend existing Health Homes program
    - ( ) Terminate existing Health Homes program

    *
    - [x] Amend an existing program that is neither approved in MACPro nor converted.

    * **Name of Health Homes Program to be amended:** Missouri-2 Health Home Services

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

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

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☑ Website Notice

Select the type of website

- ☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: Jul 26, 2018
Website URL: https://dss.mo.gov/mhd/alerts~public-notices.htm

- ☐ Website for State Regulations
- ☐ Other
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
public-notice-7-26-18	8/8/2018 5:10 PM EDT	
PublicNotice-ProspectiveAmendment	8/13/2019 3:29 PM EDT	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☑ Eligibility

- **Summarize comments:** We received a suggestion that in addition to children currently in foster care, we add children who have ever been in foster care as an eligible at risk criteria for enrollment in the Primary Care Health Home initiative.
- **Summarize response:** The internal review/approval process of this SPA amendment brought awareness about other MO HealthNet/state programs addressing care management of children in foster care. A decision was made to delay seeking CMS approval to add foster care as a qualifying condition/risk factor for the Primary Care Health Home pending a thorough review of these programs. All references to adding foster care have been deleted from this SPA.

- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Tribal Input

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Superseded SPA ID	N/A		

Name of Health Homes Program:

Missouri-2 Health Home Services

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ◉ No

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

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Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

Missouri-2 Health Home Services

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

Date of consultation
6/30/2016

Health Homes Intro

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Package ID	MO2018MS0009O	**SPA ID**	MO-19-0003
Submission Type	Official	**Initial Submission Date**	6/6/2019
Approval Date	8/15/2019	**Effective Date**	9/1/2019
Superseded SPA ID	16-0002		
	User-Entered		

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

Missouri-2 Health Home Services

Executive Summary

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

Missouri is amending its approved Primary Care Health Home (PCHH) State Plan Amendment 16-002 dated July 5, 2016 to add a new qualifying condition and risk factor for enrollment. The PCHH was originally implemented 1/1/2012 and its integrated team care concept has shown and continues to show success in meeting the following goals:
- Reduction in avoidable hospitalizations
- Reduction in emergency department visits
- Improvement in clinical measures such as hypertension, hemoglobin A1C, and cholesterol levels
-Positive impact to quality of life for participants and providers
-Reduction in healthcare costs associated with avoidable use of healthcare services
Missouri's PCHH works with primary care providers throughout the state in the provision of team-based care to qualifying individuals enrolled in their health homes. Care teams include a health home director, nurse care manager, behavioral health consultant and care coordinator who are paid through the PCHH per-member-per-month payment, and other clinic staff who work in collaboration with the PCHH team such as physicians, nurse practitioners, clinic managers, pharmacists, nutritionists, information technology, etc.

General Assurances

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

Health Homes Geographic Limitations

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Superseded SPA ID	16-0002		

User-Entered

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

Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Homes Services

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

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

Health Homes Population and Enrollment Criteria

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Population Criteria

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

☑ Two or more chronic conditions

Specify the conditions included:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease
☑ BMI over 25
☑ Other (specify):

Name	Description
Mental Health Condition	Anxiety and/or Depression
Developmental Disabilities	Developmental disabilities present additional challenges to people trying to manage chronic physical and behavioral health conditions
Substance Use Disorder	Restricted to primary care organizations that have at least one clinician certified to provide medication-assisted treatment
Chronic Pain	Chronic Pain is pain that lasts past the time of normal tissue healing. Risk stratification for severity of pain as well as for worsening condition and/or opioid dependency will be incorporated into eligibility. Qualified participant eligibility shall be limited to chronic non-cancer neck and back pain, chronic pain post trauma [for example, motor vehicle collision], and others as determined medically necessary through a prior approval process.

☑ One chronic condition and the risk of developing another

Specify the conditions included:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease
☑ BMI over 25
☑ Other (specify):

Name	Description

Name	Description
Tobacco Use	Tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD
Developmental Disabilities	Developmental disabilities can present challenges to people trying to manage chronic physical and behavioral conditions
Diabetes	Diabetes is considered an at-risk condition for chronic conditions such as CVD and BMI over 25
Mental Health Condition	Anxiety and/or Depression
Obesity	Obesity is considered an at-risk condition for chronic conditions such as CVD and DM
Pediatric Asthma	Pediatric asthma is considered an at-risk condition for higher rates of school absenteeism; inadequate sleep leading to short attention, impulsivity, emotional liability, hyperactivity, irritability, cognitive and speech-language problems, and poor academic outcomes; and anxiety, depression, and other emotional and behavioral problems
Chronic Pain	Chronic pain can lead to other problems in individuals such as substance use disorder, overweight/obesity, depression, anxiety or low self-esteem. Other physical or somatic problems such as gastrointestinal ulcers can also originate due to these secondary emotional problems.

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

See above

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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User-Entered

Enrollment of Participants

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

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

Describe the process used:

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

☑ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.

Name	Date Created	
PCHH Auto Enrollment Letter	7/6/2018 1:32 PM EDT	

Health Homes Providers

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Types of Health Homes Providers

☑ Designated Providers

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

☐ Physicians

☑ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

see "Other Provider Standards" below

☑ Rural Health Clinics

Describe the Provider Qualifications and Standards

see "Other Provider Standards" below

☐ Community Health Centers

☐ Community Mental Health Centers

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

☑ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

see "Other Provider Standards" below

☑ Other (Specify)

Provider Type	Description
Primary care clinics operated by hospitals	see "Other Provider Standards" below

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

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

Supports for Health Homes Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services

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

Description

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

Other Health Homes Provider Standards

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

1. In addition to being a Federally Qualified Health Center, Rural Health Clinic, clinical practice/clinical group practice, or primary care clinic operated by a hospital, each primary care health home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each primary care health home:
a. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals, defined as receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), furnished uncompensated care by the provider, or furnished services at either no cost or reduced based on a sliding scale. Patient percentage requirements will be determined by the state;
b. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated by through the application process and agreement to participate in learning activities, including in-person sessions and regularly scheduled phone calls;
c. Meet state requirements for patient empanelment (i.e., each patient receiving primary care health home services must be assigned to a physician);
d. Meet the state's minimum access requirements. Prior to implementation of primary care health home service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week;
e. Have a formal and regular process for patient input into services provided, quality assurance, access and other practice aspects;
f. Have completed EMR implementation and been using the EMR as its primary medical record solution, to eprescribe, and to generate, or support the generation of through a third party such as a data repository, clinical quality measures relevant to improving chronic illness care and prevention for at least six months prior to the beginning of primary care health home services;
g. Actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for Medicaid participants;
h. Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;
i. Within three months of primary care health home service implementation, have developed a relationship with regional hospital(s) or system(s) to ensure a process 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 facilitating this relationships as 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 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 primary care health home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

2. Ongoing Provider Certification Requirements
a. Each practice must:
1. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
2. Demonstrate development of fundamental medical home functionality at 6 months and 12 months through an assessment process to be applied by the state;
3. Demonstrate significant improvement on clinical outcome and process indicators specified by and reported to the state, and
4. Achieve NCQA Patient-Centered Medical Home recognition under most current standards by month 18 from the date at which supplemental payments commence; or
5. Meet equivalent/equitable recognition standards approved by the state as such standards are developed.

3. For health home organizations that want to enroll individuals with substance use disorder, at least one physician at each applicable practice site must qualify* and apply for a waiver** under the Drug Addiction
Treatment Act of 2000 (DATA 2000).
*Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified physicians may apply for waivers to treat opioid dependency with approved buprenorphine products in any settings in which they are qualified to practice, including an office, community hospital, health department, or correctional facility. A "qualifying physician" is specifically defined in DATA 2000 as one who is:
• Licensed under state law (excluding physician assistants or nurse practitioners)
• Registered with the Drug Enforcement Administration (DEA) to dispense controlled substances

• Required to treat no more than 30 patients at a time within the first year
• Qualified by training and/or certification
Also, in order to maintain a waiver, a physician must be capable of referring patients to counseling and other services.
**To qualify for a waiver, a licensed physician (M.D. or D.O.) must meet any one or more of the following criteria and provide supporting documentation for all that apply:
• Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties
• Hold an addiction certification from the American Society of Addiction Medicine (ASAM)
• Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association
• Have completed required training for the treatment and management of patients with opioid use disorders. This involves not less than eight hours of training through classroom situations, seminars at professional society meetings, electronic communications, or training otherwise provided by ASAM and other organizations.
• Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment. The physician's participation
should be confirmed in a statement by the sponsor of the approved medication to Department of Health and Human Services (HHS).
• Have other training or experience that the state medical licensing board (of the state in which the physician will provide maintenance or detoxification treatment) considers a demonstration of the physician's ability to treat and manage patients with opioid dependency.
• Have completed other training or experience that HHS considers a demonstration of the physician's ability to treat and manage patients with an opioid dependency. The criteria of HHS for this training or experience will be established by regulation.

4. Organizations that want to enroll people with chronic pain diagnoses must, at a minimum, regularly participate in interactive video conferences on chronic pain that include pain management specialists who will provide guidance on the management of people with a chronic pain diagnosis. When possible, organizations are encouraged to directly collaborate with a pain management specialist on the management of these individuals. A pain management specialist is defined as a licensed physician (MD or DO) who is board certified in anesthesiology or pain management.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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Superseded SPA ID	16-0002		
	User-Entered		

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

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

Health Homes Payment Methodologies

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Payment Methodology

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

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

        Describe below

        See description in Rate Development section below.
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

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

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's per-member-per-month rate was set as of January 1, 2016 and is effective for services provided on or after that date.

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

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

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

Effective Date

1/1/2016

Website where rates are displayed

http://dss.mo.gov/mhd/cs/health-homes/pdf/pchh-per-member-per-month-rates.pdf.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

Package Header

Package ID	MO2018MS0009O	**SPA ID**	MO-19-0003
Submission Type	Official	**Initial Submission Date**	6/6/2019
Approval Date	8/15/2019	**Effective Date**	9/1/2019
Superseded SPA ID	16-0002		
	User-Entered		

Rate Development

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

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

Comprehensive Description

Cost Assumptions/Factors Used to Determine Payment: Missouri will pay PCHH the cost of staff primarily responsible for delivery of services not covered by
other reimbursement (Nurse Care Managers, Behavioral Health Consultants, Care Coordinators and Health Home Directors) whose duties are not otherwise reimbursable by MO HealthNet. In addition, PCHH Health Homes receive payments related to Health Home specific training, technical assistance,
administration, and data analytics.

All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Missouri. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments.
Clinical Care Management per-member-per-month (PMPM) payment:

• Staff cost is based on a provider survey of all PCHH statewide and includes fringe, operating & indirect
costs.

• All PCHH providers will receive the same PMPM rate.

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

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

Health Homes Payment Methodologies

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Assurances

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

Describe below how non-duplication of payment will be achieved

Managed Care: All Health Home payments including those for MO HealthNet (MHN) participants enrolled in managed care plans will be made directly from MHN to the Health Home provider. As a result of the additional value that managed care plans will receive from MHN direct paid Health Home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the CMS reimbursed health home services (i.e. the conditions for which an individual was enrolled in the Health Home). This Health Home delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care. The managed care plan will be informed of its members that are in Health Home services and a managed care plan contact person will be provided for each Health Home provider to allow for coordination of care.

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

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

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

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

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

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

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Service Definitions

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

Comprehensive Care Management

Definition

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

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description

Provider Type	Description
Rural health clinics, FQHCs, clinical practices and clinical group practices, primary care practices operated by hospitals	These are the types of providers that participate in Missouri's PCHH program

Care Coordination

Definition

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

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
Rural health clinics, FQHCs, clinical practices and clinical group practices, primary care practices operated by hospitals	These are the types of providers that participate in Missouri's PCHH program

Health Promotion

Definition

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

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

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

b. Cardiac and diabetic risk calculators;
c. Chronic health condition information awareness;
d. A drug information library; and
e. The functionality to create a personal health plan and discussion lists to use with healthcare providers.

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
Rural health clinics, FQHCs, clinical practices and clinical group practices, and primary care clinics operated by hospitals	These are the types of providers that participate in Missouri's PCHH program

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

Definition

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

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

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

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Rural health clinics, FQHCs, clinical practices and clinical group practices, and primary care clinics operated by hospitals	These are the types of providers that participate in Missouri's PCHH program

Individual and Family Support (which includes authorized representatives)

Definition

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

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
Rural health clinics, FQHCs, clinical practices and clinical group practices, and primary care clinics operated by hospitals	These are the types of providers that participate in Missouri's PCHH program

Referral to Community and Social Support Services

Definition

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

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

Primary care health home providers will be encouraged to monitor continuing Medicaid eligibility using the DFS eligibility website and data base. MO HealthNet and the Department of Mental Health will also refine processes to notify primary care health home providers of impending eligibility lapses (e.g., 60 days in advance).

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
Rural health clinics, FQHCs, clinical practices and clinical group practices, and primary care practices operated by hospitals	These are the types of providers that participate in Missouri's PCHH program

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

Package Header

Package ID MO2018MS0009O

SPA ID MO-19-0003

Submission Type Official

Initial Submission Date 6/6/2019

Approval Date 8/15/2019

Effective Date 9/1/2019

Superseded SPA ID 16-0002

User-Entered

Health Homes Patient Flow

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

PCHH. PCHH providers also query their EHR systems for this purpose. PCHH staff contact them to explain PCHH, and that they will be assigned a Nurse Care Manager (NCM) to assist them in improving their health/wellness goals, that these services are free, participation is optional, and choosing not to enroll will have NO impact on their currents services. Enrollment forms are submitted for interested individuals. Once enrolled, the NCM meets with participants to review history and health status, and to discuss
wellness, health, and self-management goals. A care plan including these topics is developed with input from the participants. The NCM (or behavioral health consultant) attempts to see all PCHH participants when they come for visits or other services. When patients do not have appointments, PCHH staff contact them by phone or secure email and/or monitor them (CyberAccess review, check on referrals, share targeted educational information, and review reports provided by MO HealthNet that show recent ER visits or
hospitalizations, high utilization of ERs or excessive hospitalizations, and opportunities for care coordination with other program (e.g. home & community-based services or developmental disabilities). Staff members also provide needed coordination, referral, and follow-up for other services such as specialty care, ongoing behavioral health care, and community resources. PCHHs often offer health/wellness classes (e.g. smoking cessation or nutrition), and encourage PCHH enrollees to participate. NCMs provide transition of care coordination and attempt contact within 72 hours of hospital discharge or ER visit to do a medication reconciliation and ensure appropriate follow-up care.
If patients achieve their goals and their chronic conditions are well-controlled, they may be discharged from PCHH to the provider's general patient-centered medical home.

Name	Date Created	
PCHH Flow Chart 12242015	6/26/2018 4:53 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MO2018MS0009O | MO-19-0003 | Missouri-2 Health Home Services

Package Header

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Monitoring

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

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

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

To facilitate the exchange of health information in support of care for patients receiving or in need of primary care health home services, the state will utilize several methods of health information technology (HIT). Following is a summary of HIT currently available for primary care health home providers to conduct comprehensive care management, care coordination, health promotion and individual and family support services. Also included is a description of the state's process to improve health information exchange (HIE)
for comprehensive transitional care services. As Missouri implements its primary care health home models, the state will also be working toward the development of a single data portal to facilitate information exchange, measures documentation and calculation and state reporting to CMS. The state will also continue to refine a process for HIE between CMHCs and primary care practices.

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

2. HIT for Health Promotion and Individual and Family Support Services – A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to access their own healthcare utilization information and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Primary care health home providers will provide instruction to individuals on the use of the module. Utilization data available through the module includes:
a. Administrative claims data for the past three years;
b. Cardiac and diabetic risk calculators;
c. Chronic health condition information awareness
d. A drug information library; and
e. The functionality to create a personal health plan and discussion lists to use with healthcare providers.
Primary care health home providers are also required to have patient portals in their electronic medical records system which also make various types of information available to enrollees.

3. HIT for Comprehensive Transitional Care – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health have developed a daily process to notify each
healthcare home provider of all authorized admissions, which enables the primary care health home provider to:
a. Use the hospitalization episode to locate and engage persons in need of primary care health home services;
b. Perform the required continuity of care coordination between inpatient and outpatient; and
c. Coordinate with the hospital to discharge and avoidable admission as soon as possible.

4. Referral to Community and Social Support Services – Primary care health home providers will be encouraged to monitor continuing Medicaid eligibility using the FSD eligibility website and data base.
Primary care health home providers can also access information about impending eligibility lapses (e.g., 60 days in advance).

5. Data Warehouse and Reporting System – The Missouri Primary Care Association maintains a data warehouse for the purpose of functioning as a patient

registry for the primary care health home providers and generating quality measures to support clinical quality improvement. Patient demographics and clinically authenticated patient care data from the health home EMRs are included in the data set to support the required measures. MPCA also hosts a web-based reporting platform for users. Each health center's data is available to the health center for individual report generation at all levels, health center, site, provider, and patient, to assist with care management. MPCA generates aggregate reports to support quality improvement, best practice identification, and benchmarking.

Health Homes Monitoring, Quality Measurement and Evaluation

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	User-Entered		

Quality Measurement and Evaluation

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

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