DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12ᵗʰ Street, Suite 235
Kansas City, Missouri 64106

CMS

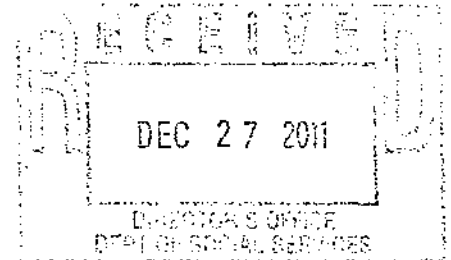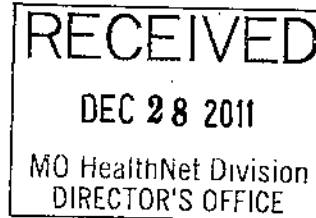CENTERS for MEDICARE & MEDICAID SERVICES

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Division of Medicaid and Children's Health Operations

December 23, 2011

Brian Kinkade, Interim Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, Missouri 65102-1527

Dear Mr. Kinkade:

On November 4, 2011, the Centers for Medicare & Medicaid Services (CMS) received Missouri's State Plan Amendment (SPA), transmittal #11-15 through which the State is implementing Primary Care Clinic-Health Homes through section 2703 of the Affordable Care Act.

This SPA is approved December 22, 2011, with an effective date of January 1, 2012. In accordance with the statutory provisions at section 1945(c)(1) of the Social Security Act, for payments made to health home providers under State Plan Amendment MO-SPA# 11-15 during the first 8 fiscal year quarters that the State Plan Amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

In addition, this approval is based on the State's agreement to implement and comply with CMS' core set of quality measures.

Enclosed is a copy of the CMS 179 form, as well as, the approved pages for incorporation into the Missouri State plan.

If you have any questions regarding this State Plan Amendment, please call Sandra Levels at (816) 426-5925.

Sincerely,

Timothy A. Weidler

Timothy A. Weidler
Acting Associate Regional Administrator
for Medicaid and Children's Health Operations

Enclosure

cc: Ian McCaslin, M.D., MPH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 1 1 – 1 5	2. STATE Missouri
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2012	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 2703 of the Affordable Care Act and Section 1945 of the Social Security Act	7. FEDERAL BUDGET IMPACT (in thousands): a. FFY _2012_ $ (3,489) b. FFY _2013_ $ (9,303)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-H, page 2 Attachment 4.19-B, page 49	9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable): New material

10. SUBJECT OF AMENDMENT:

Designation of certain qualified primary care clinics as health homes for individuals with chronic conditions

11. GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: _[signature]_	16: RETURN TO: MO HealthNet Division P.O. Box 6500 Jefferson City, MO 65102
13. TYPE NAME: Brian Kinkade	
14. TITLE: Interim Director	
15. DATE SUBMITTED: 11 - 4 - 11	

FOR REGIONAL OFFICE USE ONLY

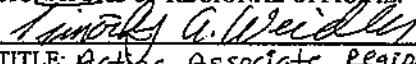| 17. DATE RECEIVED: November 4, 2011	18: DATE APPROVED: December 22, 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2012	20. SIGNATURE OF REGIONAL OFFICIAL: _Timothy A. Weidler_
21. TYPED NAME: Timothy A. Weidler	22. TITLE: Acting Associate Regional Administrator for Medicaid and Childrens Health Operations
23. REMARKS:	

FORM HCFA-179 (07-92)

MEDICAID MODEL DATA LAB

Id: MISSOURI-2
State: Missouri
Health Home Services Forms (ACA 2703)
Page: 1-10

TN#: MO-11-0015 | Superseeds TN#: MO-00-0000 | Effective Date: 01/01/2012 | Approved Date: DEC 2 2011

Transmital Numbers (TN) and Effective Date

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

Supersedes Transmital Number (TN)

> 00-0000

Transmital Number (TN)

> 11-0015

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

Effective Date

> 01/01/2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

Page 2

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

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

☑ Health Home Services

How are Health Home Services Provided to the Medically Needy?

> Not provided to Medically Needy

i. Geographic Limitations

> Statewide Basis

If Targeted Geographic Basis,

>

ii. Population Criteria

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

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

from the list of conditions below:

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

Description of Other Chronic Conditions Covered.

Description of "At Risk" Criteria:

1. Tobacco use (tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD).
2. Diabetes (Diabetes is considered an at-risk behavior for chronic conditions such as CVD and BMI over 25).

Other Chronic Conditions Covered: Developmental Disabilities.

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

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

iii. Provider Infrastructure

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

Designated providers of primary care health home services will be federally qualified health centers (FQHCs), rural health clinics (RHCs) and primary care clinics operated by hospitals. All designated providers will be required to meet state qualifications.

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

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

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

☐ Team of Health Care Professionals as described in Section 1945(h)(6)

☐ Health Team as described in Section 1945(h)(7), via reference to Section 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

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

f. development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

Ways Health IT Will Link

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

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

Care Coordination

Service Definition

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

Ways Health IT Will Link

MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:
a. Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
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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.

Health Promotion

Service Definition

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

Health promotion services also assist patients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Primary Care Health Home Director, Nurse Care Manager, Behavioral Health Consultant and appropriate primary care health home Administrative Support staff will provide health promotion services.

Ways Health IT Will Link

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

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

Service Definition

In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management. The Primary care health home Director and Nurse Care Manager, as necessary and appropriate, will provide comprehensive transitional care activities, including, whenever possible, participating in discharge planning.

Ways Health IT Will Link

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

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

Individual and Family Support Services (including authorized representatives)

Service Definition

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

with the approved DD case management entity for services more directly related to Habilitation and coordinate with the approved DD case management entity for services more directly related a particular healthcare condition. Nurse Care Managers, Behavioral Health Consultant and Care Coordinator will provide individual and family support services.

Health IT Will Link

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

Referral to Community and Social Support Services

Service 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 team will refer to and coordinate with the approved DD case management entity for this service. The Nurse Care Manager and Care Coordinator will provide referrals to community and social support services.

Ways Health IT Will Link

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

v. Provider Standards

1. In addition to being a Federally Qualified Health Center, Rural Health Clinic or primary care clinic operated by a hospital, each primary care health home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each primary care health home:
a. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals, defined as receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), furnished uncompensated care by the provider, or furnished services at either no cost or reduced based on a sliding scale. Patient percentage requirements will be determined by the state;
b. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated by through the application process and agreement to participate in learning activities, including in-person sessions and regularly scheduled phone calls;
c. Meet state requirements for patient empanelment (i.e., each patient receiving primary care health home services must be assigned to a physician);
d. Meet the state's minimum access requirements. Prior to implementation of primary care health home service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week;
e. Have a formal and regular process for patient input into services provided, quality assurance, access and other practice aspects;
f. Have completed EMR implementation and been using the EMR as its primary medical record solution, to e-prescribe, and to generate, or support the generation of through a third party such as a data repository, clinical quality measures relevant to improving chronic illness care and prevention for at least six months prior to the beginning of primary care health home services;
g. Actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for Medicaid participants;
h. Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;
i. Within three months of primary care health home service implementation, have developed a contract or MOU with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of primary care health home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a primary care health home site, and in addition motivate hospital staff to notify the primary care health home's designated staff of such opportunities; the state will assist in obtaining hospital/primary care health home MOU if needed;
j. Agree to convene regular, ongoing and documented internal primary care health home team meetings to plan and implement goals and objectives of practice transformation;
k. Agree to participate in CMS and state-required evaluation activities;
l. Agree to develop required reports describing primary care health home activities, efforts and progress in implementing primary care health home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of primary care health home service staff time and activities);
m. Maintain compliance with all of the terms and conditions as a primary care health home provider or face termination as a provider of primary care health home services; and
n. Present a proposed healthcare delivery model that the state determines to have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the primary care health home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

B. Ongoing Provider Certification Requirements

1. Each practice must:
a. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
b. Demonstrate development of fundamental medical home functionality at 6 months and 12 months through an assessment process to be applied by the state;
c. Demonstrate significant improvement on clinical outcome and process indicators specified by and reported to the state, and
d. Submit an application for NCQA recognition by month 18 from the date at which supplemental payments commence and either:
i. Attain NCQA 2008 PPC-PCMH "Level 1 Plus" recognition, with meeting Level 1 Plus defined as meeting NCQA 2008 PPC-PCMH Level 1 standards, plus the following NCQA 2008 PPC-PCMH standards at the specified levels of performance (e.g., 3C at 75%, 3D at 100%, and 4B at 50%)
or
ii. Attain NCQA 2011 PCMH "Level 1 Plus" recognition, with meeting Level 1 Plus defined as meeting NCQA 2011 PCMH Level 1 standards, plus the following NCQA 2011 PCMH standards at the specified levels of performance (e.g., 3B at 100% and 3C at 75%). Minor deficiencies in meeting standards may be addressed through submission and approval by the state of provider plans of correction.
or
e. Meet equivalent recognition standards approved by the state as such standards are developed.

vi. Assurances

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

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

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

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

> Using claims data, the state will track avoidable hospital readmissions by calculating ACSC readmissions/1000: (# of readmissions with a primary diagnosis consisting of an AHRQ ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

> The State will annually perform an assessment of cost savings using a pre-/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. It will also be broken out for each 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.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

> To facilitate the exchange of health information in support of care for patients receiving or in need of primary care health home services, the state will utilize several methods of health information technology (HIT). Following is a summary of HIT currently available for primary care health home providers to conduct comprehensive care management, care coordination, health promotion and individual and family support services. Also included is a description of the state's process to improve health information exchange (HIE) for comprehensive transitional care services. As Missouri implements its primary care health home models, the state will also be working toward the development of a single data portal through to facilitate information exchange, measures documentation and calculation and state reporting to CMS. The state will also continue to refine a process for HIE between CMHCs and primary care practices.
>
> 1. HIT for Comprehensive Care Management and Care Coordination – MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:
> a. Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
> b. View dates and providers of hospital emergency department services;
> c. Identify clinical issues that affect an enrollee's care and receive best practice information;
> d. Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
> e. Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
> f. Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice; and
> g. Review laboratory data and clinical trait data;
> h. Determine medication adherence information and calculate medication possession ratios (MPR); and
> i. Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.
>
> 2. HIT for Health Promotion and Individual and Family Support Services – A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to access their own healthcare utilization information and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Primary care health home providers will provide instruction to individuals on the use of the module. Utilization data available through the module includes:
> a. Administrative claims data for the past three years;
> b. Cardiac and diabetic risk calculators;
> c. Chronic health condition information awareness
> d. A drug information library; and
> e. The functionality to create a personal health plan and discussion lists to use with healthcare providers.
>
> 3. HIT for Comprehensive Transitional Care – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the states data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a healthcare home. The contractor would then immediately notify the healthcare home provider of the admission, which would enable the primary care health home provider to:
> a. Use the hospitalization episode to locate and engage persons in need of primary care health home services;
> b. Perform the required continuity of care coordination between inpatient and outpatient; and
> c. Coordinate with the hospital to discharge and avoidable admission as soon as possible. The daily data transfer will be in place upon implementation of the SPA. In the interim, primary care health homes will continue to implement or develop memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.
>
> 4. Referral to Community and Social Support Services – Primary care health home providers will be encouraged to monitor continuing Medicaid eligibility using the FSD eligibility website and data base. MO HealthNet and the Department of Mental Health will also refine process to notify primary care health home providers of impending eligibility lapses (e.g., 60 days in advance).
>
> 5. Data Warehouse and Reporting System – The Missouri Primary Care Association launched the Missouri Quality Improvement Network (MOQuIN) in early 2011, and is in the final stages completing a data warehouse for the purpose of functioning as a patient registry for the FQHCs and generating quality measures to support clinical quality improvement. Patient demographics and clinically authenticated patient care data from the FQHC EMRs are included in the data set to support the required measures. The data will be refreshed daily. MPCA will host a web-based reporting platform for users. Each health center's data will be available to the health center for individual report generation at all levels, health center, site, provider, and patient, to assist with care management. MPCA will generate aggregate reports to support quality improvement, best practice identification, and benchmarking. The data warehouse is expected to be functional for reporting purposes by October 2011.

3.1 - A: Categorically Needy View

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

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

viii. Quality Measures: Goal Based Quality Measures

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

Goal 1:

Improve Health Outcomes for Persons with Chronic Conditions

Measure

1. Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive condition- age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 75 yrs
2. Emergency Department Visits: preventative / ambulatory care-sensitive ER visits (algorithm, not formally a measure)
3. Hospital Readmission: Hospital readmissions within 30 days

Data Source

1. Claims
2. Claims
3. Claims

Measure Specification

1. Numerator = Total # of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years / Denominator = Total mid-year population under age 75 [BENCHMARK GOAL: NCQA's most recently published 50th percentile regional rate for Medicaid managed care.]

2. Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measures, which is too lengthy to place in the SPA. The algorithm is a nationally recognized method of calculating preventable ED visits. [BENCHMARK GOAL: NCQA's most recently published 50th percentile regional rate for Medicaid managed care.]

3. Percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology. [BENCHMARK GOAL: NCQA's most recently published 50th percentile regional rate for Medicaid managed care.]

How Health IT will be Utilized

1. Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.

2. Hospital ER visits will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.

3. Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

Care Coordination: % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.

Data Source

Claims & EMR

Measure Specification

Numerator: Number of patients contacted (by phone or face-to-face) within 72 hours of discharge / Denominator: Number of all patients discharged

How Health IT will be Utilized

The numerator will be aggregated from the monthly primary care health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home. [BENCHMARK GOAL: 80%]

Goal 2:

Improve Behavioral Healthcare

Clinical Outcomes

Measure

1. Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days.
2. Reduce the proportion of adults (18 and older) who drank excessively in the previous 30 days

Data Source

1. EMR
2. EMR

Measure Specification

1. Numerator = Over the prior 12 months the Number of adults who report using illicit drugs in the previous 30 days / Denominator = Total number of adults in the past 12 months x 100 [BENCHMARK GOAL: <7.1%, HP 2020 Goal]

2. Numerator = Over the prior 12 months the Number of adults who report drinking excessively in the previous 30 days / Denominator = Number of all adult in the past 12 mo. x 100 [BENCHMARK GOAL: >25.3%, HP 2020 Goal]

How Health IT will be Utilized

1. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home
2. Results will be reported in a spreadsheet and benchmark style by individual primary care health home.

Experience of Care

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Quality of Care

Measure

> 1. % of patients 18 years of age and older receiving depression screening through the use of a standardized screening instruments within the measurement period
> 2. Percentage of children screened through EPSDT for mental health issues.
> 3. % of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary

Data Source

> 1. EMR
> 2. EMR or MHN on-line tool
> 3. EMR

Measure Specification

> 1. Numerator = Number of adults screened for Depression in the previous 12 months / Denominator = Total number of adults in the past 12 months x 100 [BENCHMARK GOAL: 90%]
>
> 2. Numerator = Number of children 0 – 18 y.o. with EPSTD MH items completed in prior 12 months
> Denominator= total number of unique children enrolled in Health Home in prior 12 months [BENCHMARK GOAL: XXX>85%]
>
> 3. Numerator = Number of adults screened for drinking excessively in the previous 12 months / Denominator = Number of all adult in the past 12 mo. x 100 [BENCHMARK GOAL: 90%]

How Health IT will be Utilized

> 1. Results will be reported in a spreadsheet and benchmark style by individual primary care health home.
> 2. Results will be reported in a spreadsheet and benchmark style by individual primary care health home.
> 3. Results will be reported in a spreadsheet and benchmark style by individual primary care health home.

Goal 3:

> Increase patient empowerment and self-management

Clinical Outcomes

Measure

> Patient Use of personal EHR (Direct Inform, or its successor) or practice EMR patient portal

Data Source

> CyberAccess or its success-sor or practice EMR patient portal

Measure Specification

> Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period / Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90 [BENCHMARK GOAL: Greater than 0.25]

How Health IT will be Utilized

> This is a standard management report available within the CyberAccess tool or via EMR reporting. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all Primary care health homes.

Experience of Care

Measure

> Satisfaction with services

Data Source

> CAPHS CG 1.0 Adult and Child Primary Care Surveys Adult Questions #6, 17, 19, and 20. Child Questions #6, 17, 19, and 22.

Measure Specification

> Numerator = number questions with response of 3-usually or 4-always / Denominator = total number of questions with any answer [BENCHMARK GOAL: >80%]

How Health IT will be Utilized

> Results of the CAPHS survey will be aggregated by Primary care health home and across the entire statewide initiative. Final report will benchmark individual Primary care health home performance compared to other Primary care health homes and the statewide average and identify individual items for performance improvement.

Quality of Care

Measure

> NA

Data Source

> NA

Measure Specification

NA

How Health IT will be Utilized

NA

Goal 4:

Improve coordination of care

Clinical Outcomes

Measure

Care Coordination - % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performance medication reconciliation with input from PCP.

Data Source

Claims and EMR

Measure Specification

Numerator = Number of patients contacted (phone or face-to-face) within 72 hours of discharge / Denominator = Number of all patients discharged x 100 [BENCHMARK GOAL: 80%]

How Health IT will be Utilized

The numerator will be aggregated from the monthly Primary care health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home.

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

Use of CyberAccess per member per month (or its successor) enrollees

Data Source

Cyber-Access or successor

Measure Specification

Numerator = the number of times cyber access was open a healthcare home number for the 90 day reporting period. Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90 [BENCHMARK GOAL: One cyber access utilization PMPM]

How Health IT will be Utilized

This is a standard management report available within the Cyber Access tool. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all primary care health homes.

Goal 5:

Improve preventive care

Clinical Outcomes

Measure

1. Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5 – 24.9
Adult Weight Screening and Follow-Up- Percentage of patients aged 18 years or older with a calculated BMI in the past three months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

2. Weight Assessment and Counseling for Children and Adolescents- The percentage of patients 2-17 years of age who had an outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period.

Data Source

1. EMR
2. EMR

Measure Specification

1. Numerator = Number of patients with BMI of 18.5 - 24.9 / Denominator = Number of all patients with a documented BMI x 100 [BENCHMARK GOAL: 37%]

1. Numerator= Patients in the denominator with a calculated BMI in the past 3 months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented./ Denominator= All active patients aged 18 years or older. [BENCHMARK GOAL: 37%]

How Health IT will be Utilized

1. The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring

reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance

2. The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Quality of Care

Measure

> % of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday.

Data Source

> EMR

Measure Specification

> Numerator = number of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday / Denominator total= number of children 2 years of age [BENCHMARK GOAL: >80% completion]

How Health IT will be Utilized

> The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.

Goal 6:

> Improve Diabetes Care

Clinical Outcomes

Measure

> 1. Adult Diabetes - % of patients 18 – 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%
>
> 2. % of patients 18–75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.
>
> 3. % of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.
>
> 4. Child Diabetes - % of patients under 18 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%

Data Source

> 1. EMR
> 2. EMR
> 3. EMR
> 4. EMR

Measure Specification

> 1. Numerator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients of 18 to 75 years old identified as having diabetes in primary care health home registry and having a documented Hba1c in the previous 12 months. [BENCHMARK GOAL: >60%]
>
> 2. Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent BP in the previous 12 months was <140/90 mmHg.
> Denominator = total number of patients in the previous 12 months 18-75 years of age with diabetes (type 1 or type 2) [BENCHMARK GOAL: >65%]
>
> 3. Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent LDL-C in the previous 12 months was <100mg/dL. / Denominator = total number of patients in the previous 12 months 18–75 years of age with diabetes (type 1 or type 2) [BENCHMARK GOAL: >36%]
>
> 4. Numerator = For a given 90-day period, number of patients under the age of 18 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients under the age of 18 years old identified as having diabetes in primary care health home registry and having a documented Hba1c in the previous 12 months. [BENCHMARK GOAL: >60%]

How Health IT will be Utilized

> The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.

Experience of Care

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Quality of Care

Measure

> Members with Diabetes: Adherence to prescription medications for Diabetes.

Data Source

> Claims

Measure Specification

> Numerator = number of members on medication for Diabetes in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for Diabetes in the past 90 days [BENCHMARK GOAL: >90%]

How Health IT will be Utilized

> The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.

Goal 7:

> Improve asthma care

Clinical Outcomes

Measure

> 1. pediatric Asthma - % of patients 5-17 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.
> 2. adult Asthma - % of patients 18-50 years old who were identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.

Data Source

> 1. Claims
> 2. Claims

Measure Specification

> 1. Numerator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry [BENCHMARK GOAL: >70%]
>
> 2. Numerator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in primary care health home registry [BENCHMARK GOAL: >70%]

How Health IT will be Utilized

> The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines.
> Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance

Experience of Care

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Quality of Care

Measure

> Members with Asthma: Adherence to prescription medications for asthma and/or COPD.

Data Source

> Claims

Measure Specification

> Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% /
> Denominator = number of all members on medication for asthma/COPD in the past 90 days [BENCHMARK GOAL: >90%]

How Health IT will be Utilized

> The medication adherence HEDIS Indicators and meaningful use measures were developed from treatment guidelines. We will utilize data
> analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry
> to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care
> deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the
> healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and
> aggregate reports of the overall Primary care health home performance.

Goal 8:

> Improve Cardiovascular (CV) Care

Clinical Outcomes

Measure

> 1. Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least 2 office
> visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period
>
> 2. CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).

Data Source

> 1. EMR
> 2. Claims and Disease Registry

Measure Specification

> 1. Numerator = for a given 90 day period number of patients between the age of 18 t0 85 years old identified as having hypertension in
> primary care health home registry and who had two documented episodes of care in the previous 12 months where the most recent
> documented blood pressure in the previous 12 months is < 140/90 / Denominator = for a given 90 day period number of patients between
> the age of 18 to 75 years old identified as having hypertension in primary care health home registry who had two documented episodes of
> care in the previous 12 months [BENCHMARK GOAL: >50%]
>
> 2. Numerator = for a given 90 day period number of patients between the age of 18 years or older identified as having cardiovascular disease
> in primary care health home registry months where the most recent documented LDL level in the previous 12 months is < 100 / Denominator
> = for a given 90 day period number of patients between the age of 18 years and older identified as having cardiovascular disease in primary
> care health home registry [BENCHMARK GOAL: >70%]

How Health IT will be Utilized

> 1. The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data
> analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry
> to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines.
>
> 2. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports
> will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based
> treatments and aggregate reports of the overall Primary care health home performance

Experience of Care

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Quality of Care

Measure

> Members with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds

Data Source

> Claims and Disease Registry

Measure Specification

> Numerator = number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% /
> Denominator = number of all members on that class of medication in the past 90 days [BENCHMARK GOAL: >90%]

How Health IT will be Utilized

> The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data
> analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry
> to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care
> deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the
> healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and
> aggregate reports of the overall Primary care health home performance.

Goal 9:

> NA

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Goal 10:

NA

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

3.1 - A: Categorically Needy View

▣ Comprehensive Care Management

Clinical Outcomes

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Experience of Care

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Quality of Care

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Service

▣ Care Coordination

Clinical Outcomes

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Experience of Care

Measure

> NA

Data Source

> NA

Measure Specification

> NA

How Health IT will be Utilized

> NA

Quality of Care

Measure

> NA

Data Source

| NA |

Measure Specification

| NA |

How Health IT will be Utilized

| NA |

Service

☐ Health Promotion

Clinical Outcomes

Measure

| NA |

Data Source

| NA |

Measure Specification

| NA |

How Health IT will be Utilized

| NA |

Experience of Care

Measure

| NA |

Data Source

| NA |

Measure Specification

| NA |

How Health IT will be Utilized

| NA |

Quality of Care

Measure

| NA |

Data Source

| NA |

Measure Specification

| NA |

How Health IT will be Utilized

| NA |

Service

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

Clinical Outcomes

Measure

| NA |

Data Source

| NA |

Measure Specification

| NA |

How Health IT will be Utilized

| NA |

Experience of Care

Measure

| NA |

Data Source

| NA |

Measure Specification

| NA |

How Health IT will be Utilized

| NA |

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Experience of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

Quality of Care

Measure

NA

Data Source

NA

Measure Specification

NA

How Health IT will be Utilized

NA

3.1 - A: Categorically Needy View

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

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

ix. Evaluations

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

i. Hospital admissions

Description

Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures)

Data Source

Claims

Frequency of Data Collection

Annual

ii. Emergency room visits

Description

Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure)

Data Source

Claims

Frequency of Data Collection

Annual

iii. Skilled Nursing Facility admissions

Description

Use of HEDIS 2011 codes for discharges for SNF services (part of inpatient utilization – non-acute care (NON) measure)

Data Source

Claims

Frequency of Data Collection

Annual

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

i. Hospital admission rates

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

ii. Chronic disease management

The State will audit each practice's implementation of chronic disease management, with a special focus on comprehensive care management. Audits will assess:
1. Documented self-management support goal setting with all beneficiaries identified by the practice site as high risk;

2. Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge;
3. Documentation that there is a care manager in place; and
4. That the care manager is operating consistently with the requirements set forth for the practices by the State.

iii.

Coordination of care for individuals with chronic conditions

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

iv. Assessment of program implementation

The State will monitor implementation in 2 ways.
1. First, a Primary care health homes Work Group comprised of Dept. of Social Services and Dept. of Mental Health personnel and provider representatives will meet regularly to track implementation against a) a work plan and b) against performance indicators to assess implementation status. The meetings will initially occur on a biweekly basis, and then transition to monthly meetings 6 months into implementation.
2. Second, the 2 Departments will join private payers and provider representatives on the Steering Committee of the Missouri Medical Home Collaborative to review monthly practice data submissions and analysis by the Missouri Foundation for Health, as well as the status of practice transformation activities in conjunction with a Missouri Foundation for Health-funded learning collaborative and possible practice coaching to be provided to at least some of the participating practices.

v.

Processes and lessons learned

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

vi. Assessment of quality improvements and clinical outcomes

The State will use the quality process and outcome measures described in the prior section to assess quality improvements and clinical outcomes. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, and at the aggregate level for all participating primary care health homes. For registry and claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. For registry-based measures for which national Medicaid benchmark data is available for Medicaid managed care plans, comparisons will be made to regional and national benchmarks, even though such benchmarks are not specific to persons with chronic conditions.

vii. Estimates of cost savings

I. INPATIENT UTILIZATION IMPACT:

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

II. EMERGENCY ROOM UTILIZATION IMPACT:

A. Assumed reduction in hospital emergency room utilization is 23.4857% for Medicaid patients in primary care health homes (PCHHs).
B. Assume that an MHD ER visit is at least as costly as the average hospital outpatient visit.
C. Assume that an MHD participant would have at least 1 ER visit annually if not assigned to a Health Home.
D. For the months of June thru August 2011, the following MHD O/P hospital amounts were shown on the monthly FSD / MHD managerial reports:
June 2011: $ 45,239,283 hospital outpatient payments for 104,082 recipients, = $ 434.65 average O/P visit cost.
July 2011: $ 52,051,110 hospital outpatient payments for 114,477 recipients, = $ 454.69 average O/P visit cost.
August 2011: $ 57,679,060 hospital outpatient payments for 122,824 recipients, = $ 469.61 average O/P visit cost.
Average MHD hospital O/P cost per visit = $ 452.98 for June - August 2011.
E. Effective October 1, 2011, radiology services will be paid on a fee schedule instead of the hospital outpatient percentage methodology. Estimated impact on total outpatient costs = $50,000,000 reduction on an annual SFY basis. Based on hospital O/P payments above, estimated O/P payments for an entire SFY without the radiology fee schedule conversion = $206,625,937. Percentage reduction in future total O/P costs would = 24.20%. Average MHD hospital O/P cost per visit reflecting future reduction in hospital outpatient radiology costs = $343.37.
F. Assumed number of MHD Health Home assigned patients =25,372
G. I. $ 343.37 average cost per MHD hospital ER / OP visit, multiplied by 25,372 estimated MHD HH patients,= $ 8,711,919 estimated MHD cost of ER visits for Health Home patients prior to PCHH services.
II. $ 8,711,919 estimated cost of ER for MHD HH patients, times 23.4857% average I/P cost reduction, = $ 2,046,055 estimated Medicaid ER cost savings.

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

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

3.1 - B: Medically Needy View

Page

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

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

☐ Health Home Services

i. Geographic Limitations

If Targeted Geographic Basis,

ii. Population Criteria

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

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

from the list of conditions below:

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

iii. Provider Infrastructure

☐ Designated Providers as described in Section 1945(h)(5)

☐ Team of Health Care Professionals as described in Section 1945(h)(6)

☐ Health Team as described in Section 1945(h)(7), via reference to Section 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

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

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition

Ways Health IT Will Link

v.Provider Standards

vi. Assurances

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

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

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

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

3.1 - B: Medically Needy View

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

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

viii. Quality Measures: Goal Based Quality Measures

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

Goal 1:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 3:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 4:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

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Goal 7:

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Clinical Outcomes

Measure

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Data Source

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Measure Specification

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How Health IT will be Utilized

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Experience of Care

Measure

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Data Source

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Measure Specification

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How Health IT will be Utilized

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Quality of Care

Measure

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Data Source

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Measure Specification

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How Health IT will be Utilized

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Goal 8:

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Clinical Outcomes

Measure

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Measure Specification

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How Health IT will be Utilized

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Experience of Care

Measure

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Measure Specification

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How Health IT will be Utilized

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Quality of Care

Measure

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Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

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

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

viii. Quality Measures: Service Based Measures

Service

☐ Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

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

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How
Health

IT will be Utilized

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

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

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

ix. Evaluations

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

I. Hospital admissions

Description

Data Source

Frequency of Data Collection

II. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

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

i. Hospital admission rates

ii. Chronic

disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v.

Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

Attachment 4.19-B

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

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

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

> Overview of Payment Structure: Missouri has developed the following payment structure for designated primary care health homes. All payments are contingent on the primary care health home meeting the requirements set forth in their primary care health home applications, as determined by the State of Missouri. Failure to meet such requirements is grounds for revocation of primary care health home status and termination of payments. The payment methodology for primary care health homes is in addition to the existing fee-for-service or Managed Care plan payments for direct services, and is structured as follows:
>
> Clinical Care Management per-member-per-month (PMPM) payment - Missouri will pay for reimbursement of the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Nurse Care Managers, Behavioral Health Consultant, Care Coordination and Administrative Support staff) whose duties are not otherwise reimbursable by MO HealthNet.

Description

> Managed Care: All primary care health home payments including those for MO HealthNet ("MHN") participants enrolled in managed care plans will be made directly from MHN to the primary care health home provider. As a result of the additional value that managed care plans will receive from MHN direct paid Primary care health home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the CMS reimbursed HH services. This primary care health home delivery design and payment methodology will not result in any duplication of payment or services between Primary Care Health Homes and managed care or any of the other delivery systems including waivers and state plan options. Additionally:
> • The managed care plan will be informed of its members that are in primary care health home services and a managed care plan contact person will be provided for each primary care health home provider to allow for coordination of care.
>
> • The managed care plan will be required to inform either the individual's primary care health home or MO Health Net of any inpatient admission or discharge of a primary care health home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes within 24 hours.
>
> • The Primary Care Primary Care Health home team will provide primary care health home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the Primary Care Primary care health home.

Clinical Care Management per member per month (PMPM) payment
This reimbursement model is designed to only fund primary care health home functionalities that are not covered by any of the currently available Medicaid funding mechanisms. . Nurse Care Manager, Behavioral Health Consultant, and Care Coordinator duties do not always involve face-to-face interaction with primary care health home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Missouri's primary care health home model includes significant support for the leadership and administrative functions that are required to transform a traditional primary service delivery system to the new data-driven, population focused, person centered Primary care health home requirements.
The criteria required for receiving a monthly PMPM payment is:
A. The person is identified as meeting primary care health home eligibility criteria on the State-run primary care health home patient registry;
B. The person is enrolled as a primary care health home member at the billing primary care health home provider;
C. The minimum primary care health home service required to merit PMPM payment is that the person has received Care Management monitoring for treatment gaps; or another primary care health home service was provided that was documented by a primary care health home director and/or nurse care manager; and
D. The primary care health home will report that the minimal service required for the PMPM payment occurred on a monthly primary care health home activity report.
1. Nurse Care Manager 1 FTE/250 enrollees, $105,000 / year, PMPM $35.00
a. Develop wellness & prevention initiatives
b. Facilitate health education groups
c. Participate in the initial treatment plan development for all of their Primary care health home enrollees
d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases
e. Consult with Community Support Staff about identified health conditions
f. Assist in contacting medical providers & hospitals for admission/discharge
g. Provide training on medical diseases, treatments & medications
h. Track required assessments and screenings
i. Assist in implementing MHD health technology programs & initiatives (i.e., CyberAccess, metabolic screening)
j. Monitor HIT tools & reports for treatment
k. Medication alerts & hospital admissions/discharges
l. Monitor & report performance measures & outcomes

2. Behavioral Health Consultant 1 FTE/750 enrollees, $70,000/year, PMPM $7.78
a. screening/evaluation of individuals for mental health and substance abuse disorders
b. brief interventions for individuals with behavioral health problems
c. behavioral supports to assist individuals in improving health status and managing chronic illnesses
d. The behavioral health consultant both meets regularly with the primary care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal "curbside " manner as part of the daily routine of the clinic
e. Integration with Primary Care
i. Support to Primary Care physician/teams in identifying and behaviorally intervening with patients who could benefit from behavioral intervention.
ii. Part of front line interventions with first looking to manage behavioral health needs within the primary care practice.
iii. Focus on managing a population of patients versus specialty care
f. Intervention
i. Identification of the problem behavior, discuss impact, decide what to change
ii. Specific and goal directed interventions
- Use monitoring forms
- Use behavioral health "prescription"
- Multiple interventions simultaneously
g. Education
f. Handouts
ii. "Teach back" strategy
iii. Tailored to specific issue
h. Feedback to PCP
i. Clear, concise, BRIEF
ii. Focused on referral question
iii. Description of action plan
iv. Plan for follow-up

3. Primary care health home Director Administrative support, FTE/2500 enrollees $90,000 / year, Non-PMPM paid staff training time, Contracted services, PMPM $8.87
a. Provides leadership to the implementation and coordination of Healthcare Home activities
b. Champions practice transformation based on Healthcare Home principles
c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities
d. Monitors Healthcare Home performance and leads improvement efforts
e. Designs and develops prevention and wellness initiatives Referral tracking
f. Training and technical assistance
g. Data management and reporting
h. Non-PMPM paid staff training time

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

• Staff cost is based on a provider survey of prospective Primary Care Health Home providers statewide in the Fall of 2011 regarding the current costs of similar staff and includes fringe, operating & indirect costs.
• All Primary Care Health Home providers will receive the same single PMPM rate.
• The PMPM will be adjusted annually according to the CPI
• The PMPM method will be reviewed 18 months after the first PMPM payments to determine if the PMPM is economically efficient & consistent with quality of care. Whether to change the PMPM rate to tiered rates will be addressed at the 18 month review.
• Full-time PMPM funded staff will not be allowed to bill any other CMS funding opportunities. Staff for whom PMPM funding only covers a part of their total work time will log their time funded by & dedicated to Section 2703 Health Home Services to assure that no other billing to CMS occurs during that time.
• The PMPM proposed does not cover the full training and technical assistance costs of implementing Health Homes in Missouri. Missouri Foundations, Providers and State agencies are spending over $1,500,000 to fund expert consultation, technical assistance, learning collaboratives, and other training required for Section 2703 Health Home planning, development and implementation.

☐ Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

NA

Description

NA

☐ Tiered?