<table>
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<th>Package ID</th>
<th>MO2021MS00060</th>
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<tr>
<td>Program Name</td>
<td>Migrated PHH: Community Mental Health Center - Health Homes</td>
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<tr>
<td>SPA ID</td>
<td>MO-21-0033</td>
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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2021-0033 | Migrated_JH:Conversly Mental Health Center - Health Homes

Package Header

Package ID: MO2021-MO0060
SPA ID: MO-21-0033
Submission Type: Official
Approval Date: N/A
Effective Date: N/A

State Information

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

Submission Component

☑️ State Plan Amendment
☑️ Medicaid
☐ CHIP
# Medicaid State Plan Print View

## Submission - Summary

| Medicaid | Medicaid State Plan | Health Homes | MO-2021MS00060 | MO-21-0033 | Migrated | Community Mental Health Center - Health Homes |

## Package Header

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## SPA ID and Effective Date

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<thead>
<tr>
<th>Reviewable Unit</th>
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<tbody>
<tr>
<td>Health Homes Intro</td>
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<td>MO-19-0017</td>
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<tr>
<td>Health Homes Geographic Limitations</td>
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Executive Summary

The purpose of this state plan amendment (SPA) is to add Complex Trauma as a qualifying condition and update one of the four core Health Home staff. Missouri would like to expand Health Home enrollment of children and adolescents. Adding Complex Trauma as a qualifying condition will allow an overall focus of how trauma affects both behavioral and physical health conditions. Missouri would like to update the Primary Care Physician Consultant to the Specialized Healthcare Consultant. Updating the Primary Care Physician Consultant to a Specialized Healthcare Consultant will allow Health Homes flexibility in offering additional consultation from a variety of healthcare professionals for special populations.

This SPA also updates the Per Member Per Month (PMPM) payment for Community Mental Health Centers (CMHC) Health Homes effective October 1, 2021.

Federal Budget Impact and Statute/Regulation Citation

<table>
<thead>
<tr>
<th>Federal Budget Impact</th>
<th>Federal Fiscal Year</th>
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<tr>
<td>First 2022</td>
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Supporting documentation of budget impact is uploaded (optional).
Submission - Summary

Package Header

Package ID M02021MS0060
Submission Type Official
Approval Date N/A
Superseded SPA ID N/A

SPA ID M0-21-0033
Initial Submission Date N/A
Effective Date N/A

Governor's Office Review

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

https://macpro.cms.gov/suite/tempo/records/item/lUBGxuxnAYNcw8VbrAI1LJGcRp00563FFKDCsDPUvFMYpuiOsfFgFQcOlpY00haWWLNNI2msC18t...
### Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | 100030181500000 | 1003-21-0031 | Migrated, HI Community Mental Health Center - Health Homes

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
- [x] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program" below.

- [ ] Create new Health Homes program
- [ ] Amend existing Health Homes program
- [ ] Terminate existing Health Homes program

#### Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

<table>
<thead>
<tr>
<th>Reviewable Unit Name</th>
<th>Source Type</th>
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<tbody>
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</table>

1 - 8 of 8
Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.
Submission - Tribal Input

Package Header

Submission Type: Official
Approval Date: N/A
Superseded SPA ID: N/A

Name of Health Homes Program:
Migrated HH Community Mental Health Center - Health Homes

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state:

☑ Yes
☐ No
Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | MO2021MSQ0060 | MO-21-0033 | Migrated HH Community Mental Health Center – Health Homes

Package Header

Package ID: MO2021MSQ0060
Submission Type: Official
Approval Date: N/A
Superseded SPA ID: N/A

SAMHSA Consultation

Name of Health Homes Program
Migrated_HH_Community Mental Health Center – Health Homes

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

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Health Homes Intro

Package Header

Program Authority

Executive Summary

General Assurances

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

Missouri Community Mental Health Center (CMHC) Health Homes have successfully implemented and maintained the Health Home program since January 2012. There is ongoing statewide management, training, and technical assistance provided to the agencies to promote optimal, long-term sustainability for the program. These efforts have supported Missouri in being a model of integrated care for other states. The Health Home program is designed to assist individuals in accessing needed health services and supports, managing their co-occurring behavioral health and physical health conditions, and improving their general health by providing integrated care for chronic physical health conditions. A review of Missouri’s Medicaid population in 2008 indicated individuals who accounted for the highest Medicaid expenditures often had a mental health condition as well as other chronic health conditions. The Health Home is designed to improve client experience of care, improve population health outcomes, and reduce cost of care. In order to be eligible for the Health Home, individuals must have (1) a diagnosis of serious mental illness or serious emotional disturbance; (2) have a diagnosis of a mental health disorder and substance use disorder; or (3) have a mental health or substance use disorder and at least one of the following chronic health conditions or risk factors: asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease, diabetes, obesity, developmental disability, or tobacco use. Forty-eight percent (48%) of the Health Home adult population has a mental health condition in addition to two or more of these chronic health conditions and, in general, have two to three times the rates of the listed conditions compared to the general population. The goals of the Health Home are to improve health outcomes, reduce the use of high cost medical services such as the number of emergency department and hospital visits, and reduce the cost of healthcare for the Health Home population. The following results demonstrate the continued success of the Health Home to achieve the goals of the program. The Health Home population has significantly higher prevalence of chronic health conditions compared to the general population. On average, individuals with serious mental illness (SMI) have a loss of 20 potential life-years compared to the general population. Programs like Health Home may help to reduce the disparity in life-years for individuals with SMI; however, it is expected a reduction will take time. An initial look at mortality rates of Health Home enrollees indicates individuals who stay in Health Home longer are likely to have more life-years. Additionally, the mortality rate for individuals who have remained in Health Home at least 60 months is only 2%, whereas the mortality rates for all other cohorts was 6-7%.

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

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

The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.

The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.
Health Homes Geographic Limitations

Medicaid State Plan: Health Homes | MO:21-0033 | Migrated from Community Mental Health Center – Health Homes

Package Header

Package ID: MO:21-0033
Submission Type: Official
Approval Date: N/A
Superseded SPA ID: MO:19-0017
User-Entered

☒ Health Homes services will be available statewide
☐ Health Homes services will be limited to the following geographic areas
☐ Health Homes services will be provided in a geographic phased approach
Health Homes Population and Enrollment Criteria

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

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

[ ] Medically Needy Eligibility Groups
# Health Homes Population and Enrollment Criteria

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

- [ ] Two or more chronic conditions
- [ ] One chronic condition and the risk of developing another

## Population Criteria

**Specify the conditions included:**

- Developmental disability
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI Over 25
- Other (specify):

**Name**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Developmental disability</td>
</tr>
<tr>
<td>Complex Trauma</td>
</tr>
</tbody>
</table>

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

- Developmental disability: this term is defined as defined in section 630.005(9) of the Revised Statutes of Missouri.
- Complex Trauma: an individual's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.

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

Description of "At Risk" Criteria:

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

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

- Developmental disability: this term is defined as defined in section 630.005(9) of the Revised Statutes of Missouri.
- Complex Trauma: an individual's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.

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One serious and persistent mental health condition

10. Anxiety Disorders
   A. Generalized Anxiety Disorder
   B. Panic Disorder with Agoraphobia
   C. Panic Disorder without Agoraphobia
   D. Agoraphobia without Panic Disorder
   E. Social Phobia

11. For children and youth only
   A. Major depressive disorder, single episode
   B. Bipolar
   C. Reactive attachment disorder of infancy or early childhood

12. For adults aged 65 or years and over
   A. Major depressive disorder, single episode

13. Adults with a functional assessment score range defined by the department, in combination with one of the following DSM-5 diagnoses, meet the disability and diagnostic requirements:
   A. Bipolar Disorder, Most Recent Episode Unspecified
   B. Shared Psychiatric Disorder
   C. Conversion Disorder
   D. Dissociative Identity Disorder
   E. Dissociative Disorder
   F. Depersonalization Disorder
   G. Body Dysmorphic Disorder
   H. Hypochondriasis
   I. Somatization Disorder
   J. Unspecified Somatoform Disorder
   K. Paraphilic Disorder
   L. Cyclothymic Disorder
   M. Schizoid Personality Disorder
   N. Schizotypal Personality Disorder
   O. Obsessive-Compulsive Personality Disorder
   P. Histrionic Personality Disorder
   Q. Dependent Personality Disorder
   R. Antisocial Personality Disorder
   S. Narcissistic Personality Disorder
   T. Avoidant Personality Disorder
   U. Personality Disorder NOS
   V. Pathological Gambling
   W. Pathological Gambling and Substance Use Disorders
   X. Impulse Control Disorder NOS
   Y. Disruptive Behavior Disorder NOS
   Z. Attention-Deficit/Hyperactivity Disorder (Predominantly Inattentive Type, Predominantly Hyperactive-Impulsive Type, Combined Type)

14. Individuals younger than 18 with a functional assessment score range defined by the department, in combination with the following DSM-5 psychiatric diagnoses, meet the disability and diagnostic requirements:
   A. Mood Disorder NOS
   B. Anxiety Disorder NOS
   C. Dissociative Disorder NOS
   D. Personality Disorder NOS
   E. Depressive Disorder NOS
   F. Impulse Control Disorder NOS
   G. Dissociative Behavior Disorder NOS
   H. ADHD NOS
   I. Bipolar Disorder NOS
   J. Schizophrenia
   K. Depression
   L. Anxiety
   M. Obsessive-Compulsive Disorder
   N. Schizoaffective Disorder
   O. Posttraumatic Stress Disorder
   P. Dissociative Identity Disorder
   Q. Dissociative Amnesia
   R. Depersonalization Disorder
   S. Hypochondriasis
   T. Somatic Symptom Disorder
   U. Chronic Fatigue Syndrome
   V. Chronic Fatigue Syndrome
   W. Myalgic Encephalomyelitis
   X. Functional Disturbances
   Y. Somatoform Disorder
   Z. Somatoform Disorder

15. Youth or adults, with a functional assessment score range defined by the department, and who have one of the following Not Otherwise Specified (NOS) Disorders, meet the disability and diagnostic requirements. When an NOS disorder is used as the diagnosis, documentation must specifically include a detailed history/examination for each of the NOS criteria and a clear rationale for how these criteria are met, thus supporting the appropriateness of an NOS diagnosis.
   A. Mood Disorder NOS
   B. Anxiety Disorder NOS
   C. Dissociative Disorder NOS
   D. Personality Disorder NOS
   E. Depressive Disorder NOS
   F. Impulse Control Disorder NOS
   G. Dissociative Behavior Disorder NOS
   H. ADHD NOS
   I. Bipolar Disorder NOS
   J. Schizophrenia
   K. Depression
   L. Anxiety
   M. Obsessive-Compulsive Disorder
   N. Schizoaffective Disorder
   O. Posttraumatic Stress Disorder
   P. Dissociative Identity Disorder
   Q. Dissociative Amnesia
   R. Depersonalization Disorder
   S. Hypochondriasis
   T. Somatic Symptom Disorder
   U. Chronic Fatigue Syndrome
   V. Chronic Fatigue Syndrome
   W. Myalgic Encephalomyelitis
   X. Functional Disturbances
   Y. Somatoform Disorder
   Z. Somatoform Disorder

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

In Missouri, "Serious and Persistent Mental Health Condition" is defined as "Serious Mental Illness" (SMI), defined by disability, diagnosis, and duration which are outlined below:

- Disability: There shall be clear evidence of serious and/or substantial impairment in the ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning, as indicated by intake evaluation and assessment:
  - Social role functioning/social life—ability to sustain function in a role of worker, student, homemaker, family member, or a combination of these, and
  - Daily living skills/skills of care—ability to engage in personal care (such as grooming, personal hygiene) and community living (performing individual activities, performing household chores), learning ability to self-direct, and activities appropriate to the individual's age, developmental level, and social role functioning.

- Diagnosis: A physician or licensed psychologist shall certify a Primary Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis using the current edition of the manual. This diagnosis may coexist with other psychiatric diagnoses.
2. Delusional disorder
3. Bipolar I disorders
   A. Single manic episode
   B. Most recent episode mania
   C. Most recent episode depressed
   D. Most recent episode mixed
4. Bipolar II disorders
5. Psychotic disorders NOS
6. Major depressive disorder-recurrent
7. Obsessive-Compulsive Disorder
8. Post-Traumatic Stress Disorder
9. Borderline Personality Disorder

(This description is continued above in the box for "Additional description of other chronic conditions")
Health Homes Population and Enrollment Criteria

Package Header

PackagelD M02021MS0006
Submission Type Official
Approval Date N/A
Superseded SPA ID M0-19-0006

Enrollment of Participants

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

☑ Opt-in to Health Homes provider
☐ Referral and assignment to Health Homes provider with opt-out
☐ Other (describe)

Describe the process used:

Individuals with qualifying chronic conditions who are not currently receiving Health Home services may request to be enrolled in a Health Home of their choice. An approved CMHC Health Home provider completes a comprehensive assessment of the individual and confirms they meet the eligibility requirements for Health Home enrollment. An enrollment form is submitted for review and approval, and the Individual is enrolled in the Health Home and entered into the Health Home client registry. At the time of enrollment, the individual will receive from the Health Home confirmation of enrollment along with a brief description of Health Home services and the individual’s rights and responsibilities. Individuals who are enrolled with a Health Home provider may request to be discharged from the Health Home at any time without jeopardizing existing services.
Health Homes Providers

Types of Health Homes Providers

Provider Infrastructure

Describe the Provider Qualifications and Standards

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

- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

[ ] Terms of Health Care Professionals
[ ] Health Teams

Supports for Health Home Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care services, including support to individuals in 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
7. Coordinate and provide access to individual and family supports, including referral to community, faith, and support, and other 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 this person's clinical and social health care needs
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.

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

Description
CMHC Healthcare Homes will be supported as the state continually assesses the CMHCs to determine training needs. CMHCs will participate in a variety of centralized learning supports including: learning collaboratives, educational webinars, peer-led training and education, one-on-one training and technical assistance, and community resource trainings.

Other Health Homes Provider Standards

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

Initial Provider Qualifications

1. State Qualifications: In addition to being a state-designated CMHC, each Health Home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each Health Home:
   a. Have a substantial percentage of individuals enrolled in Medicaid;
   b. Have strong, engaged leadership committed to and capable of leading the practice as demonstrated through the application process and agreement to participate in learning activities including: in-person sessions and regularly scheduled phone calls as required by the department;
   c. Meet the department's minimum access requirements. Prior to implementation of Health Home service coverage, provide assurance to the department of enhanced patient access to the care team, including development of alternatives to face-to-face visits (such as telephone or email) and 24 hours per day 7 days per week for crises services;
   d. Use the department's identified health information technology tool to conduct care coordination, input metabolic syndrome screening results, track, and measure care of individuals, automate care reminders, produce exception reports for care planning, and monitor prescriptions;
   e. Use an electronic health management tool to determine problematic prescribing patterns;
   f. Conduct wellness interventions, as indicated based on the individual's level of risk;
   g. Complete status reports to document individual's housing, legal, employment, education, and custody status;
   h. Agree to convene regular, ongoing and documented internal Health Home team meetings to plan and implement goals and objectives of ongoing practice transformation;
   i. Agree to participate in CMS and department-approved evaluation activities;
   j. Agree to develop required reports describing Health Home activities, efforts, and progress in implementing Health Home services;
   k. Meet accreditation standards approved by the department.

2. Ongoing Provider Qualifications. Each CMHC must also:
   a. Coordinate care and build relationships with regional hospital(s) or hospital system(s) to develop a structure for transitional care planning, including communication of inpatient admissions of Health Home participants, and maintain a mutual awareness and collaboration to identify individuals seeking emergency department services who might benefit from connection with a Health Home, and encourage hospital staff to notify the area Health Home staff of such opportunities;
   b. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
   c. Demonstrate continuity of development of fundamental Health Home functionality through an assessment process to be applied by the state;
   d. Demonstrate significant improvement on clinical indicators specified by and reported to the department;
   e. Provide a Health Home that demonstrates overall cost effectiveness and;
   f. Meet accreditation standards approved by the department.

Health Homes Service Delivery Systems

Medicaid | Medicaid State Plan | Health Homes |
---|---|---|
MO2021MS00060 | MO-21-0033 | MO-2021M5U160 | MO-21-0033 | MO-2021M5U160

Package Header

Submission Type | Initial Submission Date | Superseded SPA ID
---|---|---
Official | N/A | MO-19-0007
Approval Date | Efffective Date
N/A | 10/1/2021

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

- [ ] Fee for Service
- [ ] IPCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System
Health Homes Payment Methodologies

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

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

Describe any variations in all CMHC Health Home providers who receive the same PMPM rate:

- Comprehensive Methodology included in the Plan
- Incentive Payment Reimbursement

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

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

Package Header

Package ID MD2021MS00060
Submission Type Offical
Approval Date N/A
SupersededSPA ID MD-19-0017
User-Entered

Agency Rates

Describe the rates used

☐ FFS Rates Included in plan
☐ Comprehensive methodology included in plan
☐ The agency rates are set as of the following date and are effective for services provided on or after that date
Health Homes Payment Methodologies

Package Header

Package ID: MO2021MS00060
Submission Type: Official
Approval Date: N/A
Superseded SPA ID: MO-19-0017
User-Entered

Rate Development

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

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

Comprehensive Description Rate Basis/Development

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

Clinical Care Management per-member-per-month (PMPM) payment:

Cost Assumptions/Factors Used to Determine Payment:

Clinical Care Management per-member-per-month (PMPM) payment:

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

Clinical Care Management Standards

Managed Care: All Health Home payments, including those for MO HealthNet participants enrolled in managed care plans, will be made directly from MO HealthNet to the Health Home provider. As a result of the additional value managed care plans will receive from MO HealthNet, this managed care plan is not required to provide care coordination or case management services which would duplicate Health Home services reimbursed by CMS. This Health Home delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care. The managed care plan will be informed of members that are enrolled in Health Home services and a managed care plan contact person will be provided for each Health Home provider. Health Home staff will provide the name of a contact person to the managed care plan to allow for coordination of care.

- The CMHC Health Home provider will report to MO HealthNet any inpatient hospital admission or discharge within 24 hours of the occurrence, as determined through its inpatient admission initial authorization and concurrent review processes.

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

Minimum Criteria for Payment:

- The criteria required for receiving the PMPM payment is:
  A. The person is identified as meeting CMHC Health Home eligibility criteria on the state-run Health Home patient registry.
  B. The person is enrolled as a Health Home member at the billing Health Home provider and is enrolled in only one Health Home at a time;
  C. The person has received Care Management monitoring for treatment gaps or another Health Home service was provided that was documented, and
  D. The Health Home will report that the minimum service required for the PMPM rate payment occurred on a monthly Health Home attestation report.

Except as otherwise noted in the plan, state-developed PMPM rates are the same for both governmental and private providers of Health Home services. The department's PMPM rate is published on the website at: https://dhso.mo.gov/mental-health-care-home and is effective for services provided on or after October 1, 2021.
Assurances

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

Describe below how non-duplication of payment will be achieved. Health Home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e., managed care, other delivery systems including waivers, any future Health Home state plan benefits, and other state plan services). In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

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

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

The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(12).

Optional Supporting Material Upload

Name

Date Created

No items available
Health Homes Services

The Department of Mental Health maintains an electronic web-based health management tool for care management, care coordination, and population health. This tool provides a comprehensive approach to:

- Managing care and support, including referrals and linkages to needed services,
- Developing treatment guidelines that establish clinical pathways for care teams to follow across risk levels or health conditions,
- Determining adherence to or variation from treatment guidelines by monitoring population and individual health status and service delivery practices; and
- Development and dissemination of reports which indicate progress toward meeting outcomes for individuals' satisfaction, health status, service delivery, and costs.

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

The Department of Mental Health maintains an electronic web-based health management tool for care management, care coordination, and population health. This tool provides a comprehensive view of the individuals' medical and behavioral health including integration of alerts, metabolic trends, patient histories based on Medicaid claims (diagnoses, procedures, pharmacy), hallmark events (ER visits, hospitalizations), and care team members.

The tool also provides for customized reporting on any data within the system and provides a dashboard of quality measures for providers to identify needed interventions.

In addition, MO HealthNet maintains a web-based EHR accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. This tool is a HIPAA-compliant portal that enables providers to:

- Download paid claims data submitted for an enrollee, by any provider, over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
- View dates and providers of hospital emergency department services;
- Identify clinical issues that affect an enrollee's care and receive best practice information;
- Prospectively examine how specific POL and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirements for Medicaid payment;
- Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee's pharmacy of choice;
- Review laboratory data and clinical lab data;
- Determine medication adherence information and calculate Medication Possession Ratio (MPR).

Scope of service

The service can be provided by the following provider types:

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

Provider Type    Description
CMHC              Community Mental Health Center

Care Coordination

Care Coordination is the implementation of the individualized treatment plan (with active individual 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 individual family members.

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

The Department of Mental Health maintains an electronic web-based health management tool for care management, care coordination, and population health. This tool provides a comprehensive view of the individuals' medical and behavioral health including integration of alerts, metabolic trends, patient histories based on Medicaid claims (diagnoses, procedures, pharmacy), hallmark events (ER visits, hospitalizations), and care team members.

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- Review laboratory data and clinical lab data;
- Determine medication adherence information and calculate Medication Possession Ratio (MPR).
The service can be provided by the following provider types

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

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<td>Community Mental Health Center</td>
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Health Promotion

Definition

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

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

Health Homes have integrated digital behavioral health solutions for individuals to access via an app or the web. Individuals must opt-in to access their solutions, which are designed to identify, engage, and support their specific individual's emergent and urgent needs. The solutions contain highly interactive, individually tailored applications to empower users to address conditions such as depression, anxiety, stress, substance use, chronic pain, and sleep challenges, while also supporting the physical and spiritual aspects of whole-person health. Health Homes work with the individual to address these identified challenges and guide recommended evidence-based resources through the solutions which are accessible to the individual 24 hours a day.

In addition, Health Homes have staff trained in a peer wellness coaching model which incorporates eight dimensions of wellness: spiritual, emotional, occupational, social, physical, environmental, financial, and intellectual. This model focuses on an individual's strengths and aids to consider areas an individual may want to strengthen, change, or improve. This training has been effective in delivering better patient-centered care, increasing patient engagement, and promoting health and well-being.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dietitians
- Nutritionists
- Other (specify)
Definition
In conducting comprehensive transitional care, a member of the care team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The care team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing individuals’ and family members’ ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
MO HealthNet maintains an initial and concurrent authorization of stay tool, which requires hospitals to notify MO HealthNet (via 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. These authorizations are sent daily to the Department of Mental Health HIT vendor which then sends an alert to the appropriate treatment team at the Health Home (via the HIT vendor’s web-based solution for care management and population health). This information and process allows the Health Home provider to:

- Use the hospitalization episode to locate and engage individuals in need of Health Home services;
- Perform the required continuity of care coordination between inpatient and outpatient providers; and
- Coordinate with the hospital to discharge an avoidable admission as soon as possible.

Scope of service
The service can be provided by the following provider types
- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician’s Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dietitians
- Nutritionists
- Other (specify)

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Individual and Family Support (which includes authorized representatives)

Definition
Individual and family support service activities include, but are not limited to, advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, care 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 a developmental disability (DD), the Health Home will refer to and coordinate with the approved DD case management entity for services related to habilitation and healthcare conditions.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum
A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in layperson’s terms. The information facilitates self-management and monitoring necessary for enrollees to attain the highest level of health and functioning. Utilization data available through the module includes:

- Administrative claims data for the past 3 years;
- Cardiovascular risk calculator;
- Chronic health condition information awareness;
- A drug information library; and
- The functionality to create a personal health plan and discussion lists to use with healthcare providers.

Scope of service
The service can be provided by the following provider types
- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician’s Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic
- Licensed Complementary and alternative Medicine Practitioners
- Dietitians
- Nutritionists
- Other (specify)
Referral to Community and Social Support Services

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

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

Health Home providers will monitor the continuing Medicaid eligibility of enrollees through an electronic health management tool which notifies Health Home providers of impending eligibility lapses in advance.

Scope of service

The service can be provided by the following provider types:

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

Provider Type: CMHC

Description: Community Mental Health Center
Health Homes Services

Health Homes Patient Flow

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

1. The CMHC outreach worker, or an individual’s case manager, offers the opportunity to enroll in the Health Home, and explains a Nurse Case Manager (NCM) will be assigned to assist in improving health and wellness goals. The availability of these services as a Medicaid benefit is optional, and choosing not to enroll will have no impact on current services.

2. Once an individual accepts, the CMHC completes a comprehensive health screen. The NCM meets with the individual to review the results of the screen and their treatment history, and to discuss wellness, health, and healthcare goals.

3. A multidisciplinary care team collaborates with the individual to develop a treatment plan, which is reviewed at least quarterly through a functional assessment, and includes wellness, health, healthcare, and self-management goals.

4. The individual’s Primary Care Physician (PCP) is notified of enrollment in the Health Home. If the individual does not have a PCP, the CMHC works to connect them with one. Case managers assist individuals to manage chronic health conditions through coordination and collaboration with the PCP.

5. The care team assigns treatment plan responsibilities related to wellness, health status, chronic disease management, housing, employment, and care coordination. Case managers assist individuals to address chronic health conditions through wellness coaching techniques and strategies.

6. The health information technology platform updates care management registries for each enrollee. The registries enable NCMs to identify if individuals receive psychotropic medications outside of best practice guidelines; if the individual fails to fill prescribed medications for chronic health conditions or psychotropic medications; if individuals with hypertension, diabetes, and cardiovascular disease have lab values which exceed desired levels; and track progress in controlling BMI levels, tobacco use, and metabolic screening values.

7. When goals are achieved, the individual may be discharged or transferred to a Primary Care Health Home for continued care management with the option of returning to the CMHC, if needed.

Flow Chart for Individuals Engaged thru Outreach 08/2021

Flow Chart for Existing CMHC Consumers 08/2021
Health Homes Monitoring, Quality Measurement and Evaluation

Package Header

Package ID  MO2021SM00060
Submission Type  Official
Approval Date  11/11/2021
Superseded SPA ID  MO-19-0017
User-entered

Monitoring

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

The state will annually conduct a methodology which establishes estimated cost savings for the health home population on the basis of reductions in utilization for key targets identified by the program.

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

To facilitate the exchange of health information in support of care for individuals receiving or in need of Health Home services, the state will utilize several methods of health information technology (HIT).

The State has developed mechanisms with MO HealthNet to document performance measures and aggregate state data reporting to CMS.

The following is a summary of HIT currently available for Health Home providers to conduct comprehensive care management, care coordination, health promotion, individual and family support, and referral to community and social support services.

1. HIT for Comprehensive Care Management and Care Coordination - The Department of Mental Health maintains an electronic web-based health management tool for care management, care coordination, and population health. This tool provides a comprehensive view of the individuals’ medical and behavioral health including integration of alerts, metabolic trends, patient histories based on Medicaid claims (diagnoses, procedures, pharmacy), halftime events (ER visits, hospitalizations), and care team members. The tool also provides for customizing reports on any data within the system and provides a dashboard of quality measures for providers to use to identify needed interventions.

In addition, MO HealthNet maintains a web-based EHR accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. This tool is a HIPAA-compliant portal that enables providers:

a. Download paid dates 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. Prescriptively examine how specific POI and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;

e. Identify approved or denied drug prior authorizations or clinical edit override or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee’s pharmacy of choice;

f. Review laboratory data and clinical trial status and

g. Determine medication adherence information and calculate Medication Possession Ratio (MPR).

2. HIT for Health Promotion and Individual and Family Support Services - Health Homes have integrated digital behavioral health solutions for individuals to access via an app or the web. Individuals must opt-in to access the solutions, which are Individual-specific in design to identify, engage, and support the individual’s emergent and urgent needs. The solutions contain highly interactive, individually tailored applications to empower users to address conditions such as depression, anxiety, stress, substance use, chronic pain and sleep challenges, while also supporting the physical and spiritual impacts of whole person health. Health Homes work with the individual to address these identified challenges and guides recommended evidence-based resources through the solutions where the individual has access to 24-hours a day.

In addition, Health Homes have staff trained in a peer wellness coaching model which incorporates eight dimensions of wellness: spiritual, emotional, occupational, social, physical, environmental, financial, and intellectual. This model focuses on an individual’s strengths and also to consider areas an individual may want to strengthen, change, or improve. This training has been effective in delivering better patient-centered care, increasing patient engagement, and promoting health and well-being.

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 a new admission of any Medicaid enrollee and provide information about diagnosis, condition, and treatment for authorization of an inpatient stay. These authorizations are sent daily to the Department of Mental Health HIT vendor which then sends an alert to the appropriate treatment team at the Health Home (via the HIT vendor’s web-based solution for care management and population health). This information and process allows the Health Home provider to:

a. Use the hospitalization episode to locate and engage individuals in need of Health Home services;

b. Perform the required continuity of care coordination between inpatient and outpatient; and

c. Coordinate with the hospital to discharge the enrollee at the earliest possible time.

4. HIT for Community and Social Support Services - Health Home providers will monitor the continuing Medicaid eligibility of enrollees through an electronic health management tool which notifies Health Home providers of impending eligibility lapses in advance.

5. Specific HIT Strategies for CMHCs Customer Information Management, Outcomes and Reporting (CIMOR) - CMHCs will continue to utilize CIMOR for routine functions (e.g., contract management, billing, and benefit eligibility). In addition, the CMHC Health Home enrollment data in CIMOR will be cross-referenced with MO HealthNet learners pre-authorization data to enable the automated real-time reporting of inpatient authorizations to the appropriate CMHC.

6. Specific HIT Strategies for Prescribing Practices - CMHCs will utilize an electronic health management tool to receive aggregate and individual identification and reporting of potentially problematic prescribing patients.
Quality Measurement and Evaluation

- The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- The state provides assurance that it will identify measurable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as reports to Congress as described in Section 2703(o) of the Affordable Care Act and as described by CMS.
- The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.
PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12) which sets forth the authority for the submission and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children’s Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individual full content that reflects the characteristics of the particular states’ program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children’s Health Insurance Program to assess program implementation, improve quality and accountability across the programs. Under the Privacy Act of 1974, any personally identifiable information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0936-1158. The time required to complete this information collection is estimated to range from 1 hour to 60 hours per response (see below), including the time to review instructions, reformat existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Office, Mail Stop C4-06-05, Baltimore, Maryland 21244-1856.

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