

Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state’s approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on “Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]” over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state’s implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state’s point of contact for the implementation plan.

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1. Title page for the state’s SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	Missouri
Demonstration name	Section 1115 IMD Waiver for SMI
Approval date	Pending CMS
Approval period	Pending CMS
Implementation date	Pending CMS Approval

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state’s SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place “NA” in the summary cell if a prompt does not pertain to the state’s demonstration. Answers are meant to provide details beyond the information provided in the state’s special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
<p>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</p> <p>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</p>	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	<p><i>Current Status:</i> Missouri’s Hospital Licensing Law requires all hospitals in the state to maintain licensure issued by the Department of Health and Senior Services (DHSS) (Mo. Rev. Stat. § 197.040). Compliance with Medicare conditions of participation is deemed to constitute compliance with the standards for hospital licensure (Mo. Rev. Stat. § 197.005). In accordance with 19 CSR 30-20.013 Missouri licensed psychiatric hospitals must strictly meet the Medicare Conditions of Participation and surveys performed for state licensure are conducted per Medicare standards.</p> <p>Additionally, in accordance with 13 CSR 35-71.150, all Qualified Residential Treatment Programs (QRTP) must be a residential treatment agency licensed by the Department of Social Services (DSS) Children’s Division pursuant to 13 CSR 35-71 and accredited by: (i) The Commission on Accreditation of Rehabilitation Facilities (CARF); (ii) the Joint Commission (JCO); or (iii) The Council on Accreditation (COA). Agencies must apply to the Department for designation as a QRTP and demonstrate compliance with all qualifications.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone requirements already met.</p>

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<p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</p>	<p><i>Current Status:</i> The DHSS is required by statute to annually inspect each licensed hospital and make any other inspections and investigations as it deems necessary for good cause shown. The DHSS accepts reports of hospital inspections from or on behalf of governmental agencies, the joint commission, DNV and the American Osteopathic Association Healthcare Facilities Accreditation Program, provided the accreditation inspection was conducted within one year of the date of license renewal. Prior to granting acceptance of any other accrediting organization reports in lieu of the required licensure survey, the accrediting organization's survey process must be deemed appropriate and found to be comparable to the Department's licensure survey (Mo. Rev. Stat. § 197.040).</p> <p>In accordance with 19 CSR 30-20.001, initial licensure compliance surveys are announced, and complaint investigations are unannounced.</p> <p>Pursuant to 13 CSR 35-71.150, as part of the QRTP designation process, the DSS may conduct site visits, records review, and interviews with staff and residents to assess the application materials and agency qualifications in meeting all QRTP requirements. The QRTP designation is valid for a period not to exceed six years and is subject to periodic announced and unannounced monitoring.</p> <p>Once designated and contracted as a QRTP, the Department monitors to ensure compliance with contractual requirements. By contract, QRTPs must allow the Department or its authorized representative to inspect and examine its premises and/or records at any time and without limitation. In the event the Department determines the QRTP to be non-compliant, or at risk for non-compliance with contractual requirements, the Department has the right to impose special conditions or restrictions on the QRTP to bring it into compliance or to mitigate the risk of noncompliance, such as submission and implementation of a corrective action plan.</p> <p>QRTPs are contractually required to report a series of quality indicators on a quarterly basis, including, but not limited to:</p> <ul style="list-style-type: none"> • Physical restraints • Chemical restraints • Non-sedating PRN medications • Isolation/seclusion • Readmissions • Emergency discharge • Hospital admissions • Education suspensions • Critical incidents <p>This data is reviewed by the Department to identify potential opportunities to impact program improvement among</p>

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	<p>QRTPs or required corrective action.</p> <p>Additionally, in accordance with 13 CSR 35-71.150, all designated QRTPs are subject to periodic announced and unannounced monitoring which include site visits and record reviews utilizing standardized review forms to monitor and assess QRTP compliance and performance.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone requirements already met.</p>
<p>1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</p>	<p><i>Current Status:</i> Managed care organizations (MCOs) are contractually required to utilize LOCUS/CALOCUS for psychiatric inpatient hospital admissions, continued stay reviews and retrospective reviews. MO HealthNet conducts ongoing oversight of the MCO’s utilization management decisions, including review of contractually required reports of inpatient certifications/prior authorizations and discharges.</p> <p>In the fee-for-service (FFS) delivery system, all inpatient hospital admissions require admission certification. MO HealthNet contracts with Conduent for utilization management functions. Conduent utilizes the Milliman Care Guidelines® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations including those for adult and child psychiatric care. Conduent also conducts a quarterly validation review of utilization and quality of care for a statistically valid sample of certifications.</p> <p>Admission to a QRTP requires review by the Residential Care Screening Team (RCST) Coordinator and an Independent Assessor. A referral to the RCST Coordinator for possible residential treatment may be triggered by the following events:</p> <ul style="list-style-type: none"> • The child has recently entered or re-entered Children’s Division custody and is currently placed in residential treatment; • A court has ordered residential treatment or an independent assessment for residential treatment; • A Youth with Elevated Needs Staffing (YWEN) Team has recommended residential treatment; • A Team Decision Making (TDM) meeting or Placement Stability Family Support Team meeting has recommended residential treatment; • An emergency exists where the case manager and supervisor have staffed the child’s case, and the child was placed in emergency placement, either a shelter or residential facility; or • A qualified clinician such as a primary care physician or psychologist has recommended residential treatment, or the child is being discharged from a hospital setting with a qualified clinician’s recommendation for residential treatment.

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	<p>If one of these triggering events occurs, a Residential and Specialized Placement Referral (CS-9) is completed, which includes the Childhood Severity of Psychiatric Illness (CSPI). Following completion of the CS-9, the RCST Coordinator forwards approved referrals to the assigned Independent Assessor. The DSS has regional contracts with behavioral health services providers who serve as the Independent Assessor. The purpose of the Independent Assessment is to assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool, which is currently the Child and Adolescent Needs and Strengths (CANS). The assessment is in writing and determines whether the needs of the child can be met with family members or through placement in a foster family home or, if not, which setting would provide the most effective and appropriate level of care for the child in the least restrictive environment and consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child. Only children deemed to need QRTP placement through the Independent Assessment, and with concurrent of the courts, are admitted to a QRTP. While the child remains in a QRTP, the Children’s Division or contract agency submits evidence at each review and permanency hearing held for the child, that must include:</p> <ul style="list-style-type: none"> • Demonstrating that ongoing assessment of the strengths and needs of the child continues to support the determination that the needs of the child cannot be met through placement in a foster family home, that the placement in a residential setting provides the most effective and appropriate level of care for the child in the least restrictive environment and that the placement is consistent with the short- and long-term goals for the child, as specified in the Social Service Plan; • Documenting the specific treatment or service needs that will be met for the child in the placement and length of time the child is expected to need the treatment or services; and • Documenting the efforts made by the agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home. <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone requirements already met.</p>
<p>1.d Compliance with program integrity requirements and state compliance assurance process</p>	<p><i>Current Status:</i> In order to receive reimbursement for Medicaid authorized services, participating psychiatric hospitals and QRTPs must be enrolled as MO HealthNet providers. The Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit processes provider applications in full compliance with 42 CFR Part 45 Subparts B&E.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone requirements already met.</p>
<p>1.e State requirement that psychiatric hospitals and residential settings screen</p>	<p><i>Current Status:</i> In accordance with Centers for Medicare & Medicaid Services (CMS) conditions of participation and Joint Commission standards, all hospitals are required to utilize evidence-based suicide assessment tools and must conduct a physical exam within 24 hours of an individual’s admission.</p>

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<p>beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</p>	<p>Additionally, for QRTP admissions, in accordance with 13 CSR 35-71.060, the admission assessment must include the child’s medical history, including any current medical problems, developmental history and current level of functioning, and an evaluation of the child’s physical, familial, educational, social, and psychological special needs and strengths. Children must have a medical examination within 30 days before or 10 days after admission. Arrangements must also be made for a dental examination if an exam has not been received within one year before admission.</p> <p>Further, pursuant to 13 CSR 35-71.075, QRTPs must have a written health care program plan which addresses preventive medical, eye, hearing, and dental care. This plan must include admission examinations, subsequent examinations, nursing care, first-aid procedures, dispensing of medicine, basic remedial treatment and the training and implementation of the use of the universal health care precautions and the other basic principles of communicable disease prevention. The QRTP must make provisions for the services of a licensed physician to be responsible for medical care, including on site or office visits. Children must receive physical examinations in accordance with the periodicity of the Missouri EPSDT schedule. If a child shows overt signs of highly infectious disease or other evidence of ill health, the QRTP must arrange for an immediate examination by a licensed physician. Any child who has not received primary immunization prior to admission must be immunized according to the DHSS’ current guidelines. Each child shall also be given an annual dental exam, eye examination and corrective treatment as prescribed.</p> <p><i>Future Status:</i> The requirement for psychiatric hospitals to screen beneficiaries for co-morbid physical health, SUDs and suicide ideation will be added to the MO HealthNet Provider Manual.</p> <p><i>Summary of Actions Needed:</i> The Provider Manual will be updated within the first 90 days of the waiver.</p>
<p>1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.</p>	<p><i>Current Status:</i> MO HealthNet implements a variety of quality improvement activities related to behavioral health. For example, MCOs are contractually required to set a goal to improve the HEDIS Follow-up After Hospitalization for Mental Illness (30 days) each year by at least two percentage points. Additionally, MCOs are required to participate in a multidisciplinary workgroup including MO HealthNet, health plans, behavioral healthcare providers, and stakeholders that collaborate on projects aimed at improving mental health.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone requirements already met.</p>
<p>SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</p>	
<p><i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i></p>	
<p>Improving Care Coordination and Transitions to Community-based Care</p>	

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<p>2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.</p>	<p><i>Current Status:</i> Hospital Care Transition (HCT) Management: Members identified through the MO HealthNet health plan hospital discharge risk assessment and in need of transition of care assistance, receive onsite HCT management services upon admission to a hospital, at the discretion of the health plan. The services provided under the HCT program must integrate with and enhance the discharge planning and care transition activities required of the hospital by CMS. The efforts of all collaborative work must maintain the patient and caregiver goals as the cornerstone of the discharge planning and transition management process, taking into consideration the provider diagnosis, assessment, prognosis, and provider recommendations for post-acute services.</p> <p>The purpose of HCT management services is to bridge the gap between hospital and community, enhance member experience and satisfaction, improve clinical outcomes, and increase the overall value of services provided by the health plan. HCT Coordinators will collaborate with facility staff responsible for discharge planning to understand the discharge risk assessment, patient and caregiver goals of care, and provider recommendations. The HCT Coordinators assist in the transition of members' care by providing education about in-network care providers, programs they may be eligible for, and community-based resources etc. In doing so, HCT Coordinators abide by facility policies and procedures, and other applicable federal and state laws governing access to patients and secure patient data. This program does not replace the health plan's existing member care management, disease management, or utilization management programs required under the MO HealthNet contract.</p> <p>The goal of the HCT program is to achieve the following outcomes:</p> <ul style="list-style-type: none"> • Ensure patient goals of care and medical necessity serve as the basis for discharge planning and transition of care services; • Align and communicate discharge plans that are developed between the patient, responsible caregiver, hospital, and health plan. The discharge plan must be based on the patient's goals of care, medical necessity, quality, and other data available to the patient. The health plan will be responsible for communicating with the patient and identifying potential in-network care and service providers; • Reduce administrative burden and prevent unnecessary delays in discharge; • Reduce avoidable bed days and readmissions, and coordinate referrals to internal programs and community services; and • Increase communication with primary care providers, specialty providers, and caregivers regarding admission, discharge, and follow-up care. <p>MO HealthNet is piloting the Inpatient MCO Protocol for individuals with behavioral health admissions. Under this new protocol, within 48 hours of admission the hospital admissions staff sends an <i>MCO Care Planning Guidance Form</i> which notifies the MCO of the admission and initiates the MCO/Hospital discharge collaboration. MCO's are required to identify behavioral health case management staff to outreach to the inpatient unit and initiate support and connect</p>

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	<p>with the member/family during the inpatient stay and provide behavioral health care management. The inpatient care manager, MCO care manager and the assigned community support specialist (CSS) remain in contact throughout the hospitalization and collaborate to establish the discharge plan. The discharge plan must include family communication, 7-day follow-up appointments, therapy services, a psychiatric visit and a CSS discharge transition visit within 48 hours of the discharge date. The MCO care manager and/or CSS remains engaged with the member to ensure completion of clinical goals, coordination of care and transition to community treatment and/or social determinate of health services.</p> <p>In addition to HCT, community-based providers such as Certified Community Behavioral Health Organizations (CCBHO) and Community Mental Health Center Healthcare Homes (CMHC HCHs) are required to participate in transition planning for their clients. CCBHO policies and procedures must promote and describe its care coordination roles and responsibilities, and whenever possible, the development of formal agreements with community organizations and practitioners that document mutual care coordination roles and responsibilities, with particular attention to emergency room, hospital, and residential treatment admissions and discharges. Members of the CMHC HCH Care Team must provide 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. Members of the Care Team collaborate 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.</p> <p>QRTPs are required by contract, and 13 CSR 35-71.150, to provide discharge planning and family-based after care support services for at least six months post-discharge. These are intensive support services designed to facilitate and support a successful transition of the child and must include:</p> <ul style="list-style-type: none"> • Assessment, monitoring, and on-going management of a medication regimen • Therapeutic, clinical treatment services which target trauma recovery • Monitoring and evaluating day to day activities to assist with the reduction of the disability and restoration of the child's functional level • Services designed to expedite and increase the youth's inclusion into the family and community • Services to ameliorate emotional trauma • Supportive services to provide the youth opportunities to attend and have an educational program • Services intended to foster a safe and stable home environment • Crisis intervention and support to ensure the child's family has access to support in times of family crisis, 24 hours per day, seven days per week, including all holidays <p>To become designated as a QRTP, applicant agencies must submit a detailed description of its Family Engagement/Discharge Planning/Aftercare Planning programs and policies. Aftercare services include visiting the child in their</p>

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	<p>placement in-person every week for the first 30 calendar days, then at a minimum of once every two weeks for the duration of aftercare services. Greater frequency of visits may be required based on the child’s needs and capacities of the caregiver.</p> <p>Prior to the start of Qualified Residential Program Aftercare, the QRTP, in collaboration with the Family Support Team (FST), must create a detailed plan 30 days prior to discharge. This plan must include the child’s current treatment plan, discharge plan, and the supportive and adjustment services the child will need to successfully transition from the facility to the child’s identified home or community-based setting. The detailed plan, and any revisions must be submitted to the Department designee for authorization prior to aftercare services beginning.</p> <p><i>Future Status:</i> Continue HCT and requirements of CCBHOs and CMHC HCHs. Continued performance improvement initiatives with managed care plans for aftercare following inpatient psychiatric admissions.</p> <p><i>Summary of Actions Needed:</i> N/A – Milestone requirement already met.</p>
<p>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries’ housing situations and coordinate with housing services providers when needed and available.</p>	<p><i>Current Status:</i> The Division of Behavioral Health's (DBH) Recovery Services includes housing, employment, peer services, and coordination of the DBH State Advisory Council. The Director of Recovery Services oversees DBH's housing unit who works to connect homeless individuals who are challenged with behavioral health issues with safe, decent, and affordable housing options that best meet their individual and family needs. In addition to providing education and technical assistance, DBH's housing unit manages 27 U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Permanent Support Housing (PSH) grants that provides rental assistance for individuals who 1) are homeless, 2) have a serious mental illness (SMI), a chronic substance use problem, a severe and chronic developmental disability, or a diagnosis of HIV/AIDS, and 3) meet the "very low" income requirement. Projects for Assistance in Transition from Homelessness (PATH) grants support service delivery to adults (age 18 or older) with SMI, as well as those with co-occurring SUDs, who are homeless or at risk of becoming homeless. Services include community-based outreach; support services such as case management, employment skills training, psychosocial education, and group therapy; and some temporary housing services. Supported community living programs are provided for persons with mental illness who do not have a place to live or who need more structured services while in the community. Persons in these programs receive support through case management and community psychiatric rehabilitation (CPR) programs provided by administrative agents. Recovery Housing accredited by the National Alliance for Recovery Residences (NARR) is an option for individuals with SUDs who choose abstinence-based peer support housing.</p> <p>If an individual is not already linked to CCBHO/CMHC, patient is linked to the provider in their service area and CMHC/CCBHO links individuals to services post-discharge. CMHCs and CCBHOs in turn engage individuals in community support services including food and housing options, shelter placements and referrals to additional supports.</p>

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	<p>For QRTP admissions, the aforementioned Independent Assessment process will determine whether the needs of the child can be met with family members or through placement in a foster family home. The discharge planning and aftercare planning conducted by QRTPs ensures services intended to foster a safe and stable home environment.</p> <p><i>Future Status:</i> Continue current programming.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria are met.</p>
<p>2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge</p>	<p><i>Current Status:</i> Physical Health (PH) and CMHC HCHs are expected to complete follow-up, including medication reconciliation, within 72 hours of discharge from both inpatient hospitalization and emergency departments for any HCH enrollee.</p> <p>As described in Section 2.a, QRTPs are required to provide family-based after care support services for at least six months post-discharge. Aftercare staff visit the child in their placement in-person every week for the first 30 days, then at a minimum of once every two weeks for the duration of aftercare services. Greater frequency of visits may be required based on the child’s needs and capacities of the caregiver.</p> <p><i>Future Status:</i> Continued care transition requirements for CMHC HCH and PCHH.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria are met.</p>
<p>2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission</p>	<p><i>Current Status:</i> CCBHOs must provide or contract with another certified entity to provide outreach services to reduce unnecessary utilization of emergency rooms by individuals with SMI, serious emotional disturbance (SED), and/or SUD, including case managers to respond to and engage individuals who present at collaborating emergency rooms, access necessary resources to meet the individual’s basic needs on an emergency basis, and assist individuals in accessing CCBHO services on an emergency, urgent, and/or routine basis, as needed.</p> <p>As part of comprehensive care management, CMHC HCHs identify high-risk individuals and use information obtained during the enrollment process to determine level of participation in care management services.</p> <p>In addition, MO HealthNet managed care contracts require a care management assessment when a member has had three ED visits in a quarter. In addition, some MCOs have implemented a specific ED care management team focusing on frequent ED users.</p> <p>Specific to youth served within the child welfare system, Project REACH is one part of the State of Missouri's free and voluntary Educare program that provides support, resources, technical assistance, and training to childcare providers,</p>

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	<p>including extended family members who care for children receiving state childcare subsidy. Project REACH services are provided by support associates who live in the communities they serve, offering:</p> <ul style="list-style-type: none"> • Expertise in child development • Experience in early childhood education • One-on-one on-site support to childcare programs and providers • Group meetings with topics that promote healthy, safe, and age-appropriate care • Support to strengthen the relationships between childcare providers and families <p>Services also include a Family Support Worker who will visit with family and provide mobile crisis intervention and offer ongoing support.</p> <p>The Missouri Care Coordination Insight Project complements the state’s Provider Health Information Exchange Onboarding Program. The Missouri Care Insight Project was included in a HITECH Implementation Advanced Planning Document Update (IAPD) Appendix D that was submitted on April 20, 2020 and was approved on June 3, 2020. This IAPD Appendix D aligns with Missouri’s strategy for advancing Health Information Technology (HIT) and health information exchange (HIE) in Missouri by supporting the design and implementation of an HIE Onboarding Program for Medicaid Eligible Professionals (EPs) and Eligible Hospitals (EHs) aligned with Missouri’s Medicaid Promoting Interoperability Program authorized by the American Recovery and Reinvestment Act of 2009 (ARRA).</p> <p>The Missouri DSS, MO HealthNet Division (MHD) believes the technology enabled by the Missouri Care Coordination Insights Project supports state HIE needs, promotes interoperability and supports Medicaid eligible providers in achieving meaningful use. Additionally, the technology enabled through the Missouri Care Coordination Insights Project supports hospitals meeting the newest CMS requirements for Conditions of Participations requiring hospitals to send electronic patient event of Admission, Discharge, and/or Transfer to another healthcare facility or to another community provider or practitioner.</p> <p>CMS clearly states that HIE can be useful for improving care and reducing cost for Medicaid beneficiaries whose care is delivered via Medicaid providers. The objective of HIE is to leverage existing technological efficiencies to promote interoperability, improve coordination and delivery of care, enhance benefits for Medicaid beneficiaries and reduce operational and administrative burden. This approach benefits all stakeholders and aligns with federal guidelines, allowing the interoperability required for the state to meet the HIE needs of its Medicaid beneficiaries, providers and stakeholders.</p>

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	<p>With this in mind, the Missouri Care Coordination Insights Project was designed to:</p> <ul style="list-style-type: none"> • Maximize the value of state and federal investment in the Promoting Interoperability (PI) Program by leveraging certified electronic health record technology (CEHRT) to promote health care quality and exchange of electronic health information. • Increase utilization and improve interoperability of HIT and HIE among Medicaid providers • Enable Medicaid hospitals to meet CMS Conditions of Participation requiring electronic event notifications of Admission, Discharge, and/or Transfer to the healthcare facility, community provider or practitioner as identified by the patient. • Provide timely, relevant predictive analytic alerting and notification capabilities for specialized populations of interest targeting super-utilization, re-admissions and other high costs/high need beneficiary cohorts. • Enable evaluation of care coordination gaps and effective best practices. • Improve the delivery and quality of electronic HIE to support medical decision-making and care coordination. • Reduce preventable medical errors and avoid duplication of treatment. • Improve data exchange with the State’s public health reporting infrastructure. • Provide accountability in safeguarding the privacy and security of medical information. • Support Medicaid transformation and implementation of value-based payment models. • Complement and align with the State’s HIE Onboarding program. <p>As of March 2022, 86 of Missouri’s 112 acute care hospitals were connected and transmitting Admission, Discharge, and Transfer (ADT) data and another three hospitals are queued for connection. Two demonstration projects of the system’s capabilities are underway. The first involves 15,000 clients of the Missouri Department of Mental Health (DMH), Division of Developmental Disabilities and the second 3,500 clients of the MO HealthNet Primary Care Health Home operated by Truman Medical Center. The goal of both demonstrations is to improve care coordination for enrolled participants and more effective transitions of care for participants who use hospital services. The real time nature of the ADT alerts enables care managers to intervene quickly if participants use emergency room care unnecessarily.</p> <p><i>Future Status:</i> Although the IAPD funding for the Missouri Care Coordination Insights project ended in September 2021, HIDI will continue to build on the platform established and technology enabled through the IAPD project through partnerships with state agencies, Missouri’s HIEs, Missouri hospitals, and other health care providers.</p> <p>Summary of Actions Needed: Implementation of Missouri Care Coordination Insights Project as outlined in IAPD through 9/30/2021.</p>

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<p>2.e Other State requirements/policies to improve care coordination and connections to community-based care</p>	<p><i>Current Status:</i> CCBHOs are required to promote collaborative treatment planning by providing the individual’s Primary Care Provider (PCP) with relevant assessment, evaluation, and treatment plan information, seeking all relevant treatment and test results from the PCP, and inviting the PCP to participate in treatment planning.</p> <p>For all individuals in the populations of focus, CCBHO staff must inquire whether they have a PCP, assist individuals who do not have a PCP to acquire one, and establish policies and procedures that promote and describe the coordination of care with each individual’s PCP.</p> <p>For all individuals in the populations of focus, CCBHO staff must document in the individual record the name of each individual’s PCP, indicate they are assisting him or her in acquiring a PCP, or the individual refuses to provide the name of their PCP or accept assistance in acquiring a PCP.</p> <p>CCBHO policies and procedures must also promote and describe its care coordination roles and responsibilities, and whenever possible, the development of formal agreements with community organizations and practitioners that document mutual care coordination roles and responsibilities, with particular attention to emergency room, hospital, and residential treatment admissions and discharges.</p> <p>CCBHO policies and procedures ensure reasonable attempts are made and documented to track admissions and discharges of non-Medicaid eligible individuals to and from a variety of settings, and to provide transitions to safe community settings; and follow up with individuals served within 24 hours following hospital discharge.</p> <p><i>Future Status:</i> Continued requirements for CCBHOs and CMHC HCHs.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria are met.</p>
<p>SMI/SED. Topic 3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services</p>	
<p><i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i></p>	
<p>Access to Continuum of Care Including Crisis Stabilization</p>	
<p>3.a The state’s strategy to conduct annual assessments of the availability of mental</p>	<p><i>Current Status:</i> Missouri Medicaid contracts with CCBHOs to provide comprehensive behavioral health services within designated service areas. CCBHOs provide services to the following focus populations: Adults with SMI; children and adolescents with SED; children, adolescents, and adults with moderate to severe SUDs; children with</p>

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<p>health providers including psychiatrists, other practitioners, outpatient, community mental health centers (CMHC), intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state’s demonstration application. The content of annual assessments should be reported in the state’s annual demonstration monitoring reports.</p>	<p>behavioral health disorders who are in state custody; and individuals involved with law enforcement, the courts, and hospital emergency rooms who have been identified as in need of community behavioral health services. 15 counties not currently covered by a CCBHO (90 out of 115 are covered, but the state has added new CCBHOs which have filled some of this gap. If not covered by a CCBHO, CMHC would cover the geographic region. Long-term plan is for all counties in the state to be in a CCBO covered area by bringing up additional CCBHOs. January 2022 will be the next roll-out of CCBHO. The state expects to have statewide CCBHO coverage by the end of CY 2022.</p> <p>Core services for the DBH’s CPR Program (28 contracts), targeted case management (19 contracts), and supported community living (147 contracts) are provided in a community-based and consumer-centered manner. Services provided in DBH’s CPR Program for adults (28 contracts) and youth (23 contracts) are Medicaid reimbursable. The types of services provided in the CPR program include evaluation, crisis intervention, community support, medication management, and psychosocial rehabilitation. Outpatient community-based services provide the least-restrictive environment for treatment. Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services. Moderate-term placement in residential care provides services to individuals with non-acute conditions who cannot be served in their own homes. Intensive CPR programs include Enhanced Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Assertive Community Treatment for Transition Age Youth (ACT-TAY) and Integrated Treatment for Co-Occurring Disorders (ITCD). Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be a danger to themselves or others because of their mental disorder. DBH also oversees Community Mental Health Treatment (CMHT) and Offenders with Serious Mental Illness (OSMI) (29 contracts) for Department of Corrections' (DOC) offenders under community supervision and who have mental illness.</p> <p>Target populations for mental health treatment include:</p> <ul style="list-style-type: none"> • Forensic clients pursuant to Chapter 552 RSMo; • Adults, children, and youth with SMI being discharged from DBH operated inpatient facilities, being transitioned from DBH-operated or contracted residential settings, being transitioned from DBH alternatives to inpatient hospitalization; • Adults, children, and youth at risk of homelessness; • Children and youth referred through the Custody Diversion Protocol; • Individuals with a clinical or personality disorder, other than a principal diagnosis of substance use or ICF/IID, who also qualify as an adult with severe disabling SMI or children and youth with SED, as defined

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	<p>by the Department.</p> <p>DBH supports ACT, a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and/or 4) are homeless. ACT provides highly individualized, intensive services directly to consumers in their homes and communities as opposed to a psychiatric unit. ACT team members are trained in the areas of psychiatry, social work, nursing, substance use, and vocational rehabilitation. DBH contracts with nine agencies to provide ACT including seven contracts for adult ACT and seven contracts for supports ACT-TAY.</p> <p><i>Future Status:</i> MO HealthNet will partner with DMH to continue to monitor provider network capacity on an annual basis.</p> <p><i>Summary of Actions Needed:</i> MO HealthNet will submit an updated Provider Network Template annually and conduct outreach in areas where gaps in services are noted.</p>
3.b Financing plan	<p><i>Current Status:</i> Please refer to Financing Plan below.</p> <p><i>Future Status:</i> Please refer to Financing Plan below.</p> <p><i>Summary of Actions Needed:</i> Please refer to Financing Plan below.</p>
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	<p><i>Current Status:</i> The Missouri Hospital Association, through a subcontract with the DHSS, maintains a statewide license for a reporting tool platform EMResource. EMResource was initially adopted in Missouri as a tool to monitor and coordinate hospital diversion status between health care organizations, emergency medical services and dispatch centers. With the implementation of the federal Hospital Preparedness Program in 2002, EMResource was adopted statewide as the platform to collect and disseminate data and information, having the functionality to include bed availability. As Missouri’s health care preparedness program has developed, the application has expanded in functionality and continues to evolve as statewide health care coordination needs are identified. The system has the capability of tracking inpatient psychiatric bed availability as well. Hospitals utilize EMResource as well as other platforms for tracking and communicating bed availability with other hospitals and community providers. Communicating bed availability is a constantly changing and complex process.</p> <p><i>Future Status:</i> The Missouri Hospital Association will evaluate how to help hospitals participate in the new 988 system, including OpenBeds, to provide data to inform systems that promote care integration and reduce redundant workflows.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria are met.</p>

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<p>3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay</p>	<p><i>Current Status:</i> Per certification requirements, all behavioral health providers must provide a full biopsychosocial assessment that includes domains for level of care determination. DMH approves all assessments utilized by providers who do not have CARF, Joint Commission, or Council on Accreditation (COA) accreditation. Otherwise, accreditation by one of these entities provides deemed status for meeting this requirement.</p> <p>Additionally, all youth under the care of the DSS Children’s Division receive an Initial Family Assessment within four weeks of case opening to prepare for the development of the Social Service Plan to be finalized by the 30th day following the case opening date. As described in Section 1c, all children evaluated for admission to a QRTP must have an Independent Assessment created which includes completion of the CANS.</p> <p><i>Future Status:</i> Continue state approval of assessments utilized for level of care determination.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone are met.</p>
<p>3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization</p>	<p><i>Current Status:</i> CCBHOs must ensure individuals have access to crisis response services twenty-four (24) hours per day, seven (7) days per week. If CCBHO staff determine that a face-to-face intervention is required based on the presentation of an individual, then that face-to-face intervention must occur within three (3) hours; and CCBHO staff must monitor and have the capacity to report the length of time from each individual’s initial crisis contact to the face-to-face intervention and take steps to improve performance, as necessary.</p> <p>In addition, DBH funds eleven regional Access Crisis Intervention Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention, including mobile response teams, and referral for persons experiencing a behavioral health crisis.</p> <p><i>Future Status:</i> Continue with current CCBHO requirements and expansion of these providers throughout the state. The State anticipates the addition of up to seven CCBHOs.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone met.</p>
<p>SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration</p>	
<p><i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i></p>	
<p>Earlier Identification and Engagement in Treatment</p>	
<p>4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported</p>	<p><i>Current Status:</i> MO HealthNet and DBH recognize the tremendous therapeutic value of employment for working-age individuals with behavioral health disorders and is committed to enhancing employment options for those individuals. Supported Employment is an evidence-based practice that provides individualized services and supports to an individual to find competitive employment to promote stable employment. DBH works with the Department of Elementary and Secondary Education, Vocational Rehabilitation (VR) who provides job counseling, job-seeking</p>

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employment and supported programs	<p>skills, job placement, and vocational training to provide integrated services in the community behavioral health programs. The DBH provides ongoing benefits planning training for community provider staff and a web-based tool "Disability Benefits 101." DBH has 31 community behavioral health locations designated as VR funded Community Rehabilitation Programs to provide evidence based supportive employment services. DBH provides support services for mental health clients not currently eligible or ready for services from VR. MO HealthNet and DBH staff developed guidance documents on appropriate community support interventions reimbursable under CPR and CSTAR treatment programs for consumers pursuing employment.</p> <p><i>Future Status:</i> Continue with current employment programs.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria met</p>
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	<p><i>Current Status:</i> Missouri's CMHC HCHs are designed to integrate care for chronic health conditions into the CMHC setting. The CMHC HCHs assist individuals in accessing needed health services and supports, in learning to manage their health conditions, and in improving individuals' general health by monitoring health conditions, healthcare needs and intervening when health conditions are not properly controlled or managed. HCHs promote and encourage wellness, healthy lifestyles and preventative care, educate and teach persons how to better manage their chronic health conditions, educate agency staff about chronic health conditions and how to manage them, and encourage a population health approach to help improve chronic health conditions for persons served by CMHCs.</p> <p>Individuals covered by MO HealthNet are eligible to be served by a CMHC HCH if they have:</p> <ul style="list-style-type: none"> • A SMI (including children and adults receiving psychiatric rehabilitation services under the Medicaid Rehabilitation Option); or • A mental health condition and a SUD, or A mental health condition or a SUD, and one of the following chronic conditions or risk factors <ul style="list-style-type: none"> ○ Diabetes ○ Asthma/COPD ○ Cardiovascular Disease ○ Developmental Disability ○ Overweight (BM >25) ○ Use Tobacco <p>There are several CCBHCs who are also FQHCs. They include Arthur Center, Compass Health Network, COMTREA, Places for People, Preferred Family Healthcare, Swope Mental Health.</p> <p>The MO HealthNet PCHH initiative currently has more than 40 participating organizations with over 160 clinic sites.</p>

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	<p>The PCHH initiative offers comprehensive care management services for Medicaid participants who have two or more chronic health conditions including asthma/COPD, developmental disabilities, diabetes, heart disease, obesity and tobacco use). The program also emphasizes the integration of primary care and behavioral health care in order to achieve improved health outcomes.</p> <p><i>Future Status:</i> Continue and expand CMHC HCH and PCHH programs.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria are met.</p>
<p>4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI</p>	<p><i>Current Status:</i> DBH’s School-based Prevention, Intervention, and Resources Initiative (SPIRIT) program implements school-based curricula of proven effectiveness for delaying the onset of substance use and decreasing the use of substances, improves overall school performance, and reduces incidents of violence among children in kindergarten through 12th grade. To achieve these goals, prevention agencies are paired with school districts to provide technical assistance in implementing evidence-based substance use prevention programming. SPIRIT currently operates in four sites serving twelve school districts across the state. These school districts serve high-risk populations characterized by: 1) high percentage of students qualifying for reduced/free lunches, 2) low standardized test scores, 3) high prevalence of substance use, 4) low graduation rates, and/or 5) high rate of juvenile justice referrals. Screening and referral services are provided as needed. In FY 2020, 9,834 students participated in the SPIRIT program. DBH contracts with the Missouri Institute of Mental Health to conduct an annual evaluation of the SPIRIT program.</p> <p>ACT for TAY is a transdisciplinary treatment program serving individuals age 16-25 diagnosed with severe mental illness. They may also have co-occurring substance use or personality disorders. A team providing a full array of evidence-based services and best practices is the key element of successful treatment in assisting individuals to regain and maintain healthy role functioning and quality of life.</p> <p>DBH also funds other selective prevention services and early intervention activities for designated children, youth, and families. These services involve structured programming and/or a variety of activities including informational sessions and training. Target groups include youth experiencing academic failure and low-income youth and families. Programs are located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the “Bootheel.” DBH contracts with the Missouri Alliance of Boys and Girls Club sites throughout the state for implementation of SMART Moves (Skills Mastery and Resistance Training) and MethSMART. In Fiscal Year 2020, 2,960 high risk youth were served in prevention programs funded through DBH. DBH contracts with DeafLEAD for the provision of prevention services for deaf and hard of hearing youth. DeafLEAD conducts the annual Teen Institute for the Deaf attended by approximately 30 youth ages 12 to 17.</p>

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	<p>DBH contracts for Recovery Support Services providing for care coordination, peer recovery coaching, spiritual counseling, group support, recovery housing and transportation before, during, after and in coordination with other SUD service providers. These services are offered by 51 certified Recovery Support Service providers in a multitude of settings including community, faith-based and peer recovery organizations. Recovery Support programs are person-centered and self-directed. Recovery Housing certification requires the provider to also obtain accreditation through the Missouri Coalition of Recovery Support Providers/NARR. Currently, 120 Recovery Houses with over 1,200 beds are accredited. DMH receives a SAMHSA State Opioid Response (SOR) grant for the purpose of expanding access to integrated prevention, treatment, and recovery support services for individuals with opioid use disorder throughout the state, including development of local Recovery Community Centers (RCC). Four RCCs provide a peer-based supportive community that builds hope and supports healthy behaviors for individuals with Opioid Use Disorders (OUD) searching for or maintaining recovery.</p> <p><i>Future Status:</i> Continue current community-based programing.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria met.</p>
<p>4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people</p>	<p><i>Current Status:</i> Peer support services are available to individuals in behavioral health treatment to aid in the navigation of Medicaid programs and establish linkages to other community resources. Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with a mental health condition, SUD, or both. Through shared understanding, respect, and mutual empowerment, peer support specialists help people become and stay engaged in the recovery process and reduce the likelihood of a return to mental health symptoms or substance use. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of individuals seeking a successful, sustained recovery process. Missouri has over 950 active Certified Peer Specialists who work at CMHCs, Substance Use Treatment Programs, state-operated hospitals, and community recovery programs. DBH funds, through competitive bid, four consumer-operated drop-in centers that emphasize self-help for individuals with mental illness and four recovery community centers for individuals with substance use problems. Family Support Provider is a peer-to-peer service that provides support to parents/caregivers who have children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance.</p> <p><i>Future Status:</i> Continue current community-based and early intervention programs.</p> <p><i>Summary of Actions Needed:</i> N/A Milestone criteria are met.</p>

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SMI/SED.Topic_5. Financing Plan	
<p><i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state’s assessment of current availability of mental health services included in the state’s application.</i></p>	
<p>F.a Increase availability of non- hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.</p>	<p><i>Current Status:</i> Access Crisis Intervention (ACI) is part of the Missouri Model of Crisis Intervention, which also includes Emergency Room Enhancement (ERE) regional programs, Community Mental Health Liaisons (CMHL), and Crisis Intervention Teams (CIT). The purpose of ACI is to assess and provide assistance (or appropriate intervention) for an acute behavioral health crisis, link individuals to services, resources and supports, and maintain individuals in the least restrictive setting and in the community when clinically feasible. ACI provides a timely response, intervention, and referral for persons experiencing a behavioral health crisis, 24 hours per day and 7 days per week. Components of ACI include:</p> <ul style="list-style-type: none"> • 24-hour phone response/consultation • 24-hour mobile response: Face to face evaluation • Arranging next day appointments • Technical assistance to referral sources as to how to complete an involuntary commitment <p>Twenty-four-hour phone response and mobile response is provided through the DBH’s Administrative Agents (AA). The AAs either provides these services directly or through contract with a crisis services provider. Individuals contacting the 24-hour crisis hotline in their area will receive a screening and risk assessment. The crisis worker will attempt to resolve the crisis with the individual on the phone and make any needed referrals to services or social supports. If the crisis cannot be resolved over the phone, the individual will be connected with a mobile crisis mental health professional who can meet with the individual in the community for additional assessment. ACI teams work closely with CIT law enforcement officers in their service area(s).</p> <p>MCOs are required to ensure access to crisis intervention/access services, including but not limited to (1) intake, evaluation, and referral services, including services that are alternatives to out of the home placements, and (2) mobile crisis teams for on-site interventions. MCOs must also operate a 24/7 behavioral health crisis line that is staffed by Qualified Behavioral Healthcare Professionals (QBHP).</p> <p>In addition, CCBHOs must ensure individuals have access to crisis response services twenty-four (24) hours per day, seven (7) days per week. If CCBHO staff determine that a face-to-face intervention is required based on the presentation of an individual, then that face-to-face intervention must occur within three (3) hours; and CCBHO staff</p>

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	<p>must monitor and have the capacity to report the length of time from each individual’s initial crisis contact to the face-to-face intervention and take steps to improve performance, as necessary.</p> <p>In addition, CMHLs assist law enforcement and the courts in addressing the behavioral health issues of individuals who come to the attention of the justice system. The CMHL model saves valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays and improves outcomes for individuals with behavioral health issues. In 2019, the 31 CMHL’s received 16,188 referrals from law enforcement. This is up from 13,497 in 2018 and 9,292 in 2017. There are currently 31 CMHL positions who have assigned coverage areas in Missouri.</p> <p>In both Springfield and Kansas City, the CIT program, a partnership with law enforcement statewide benefits from access to 24/7 Triage Centers. These centers help transition law enforcement from being the primary behavioral health response unit, so that they can instead get back to the community to keep people safe. Those in crisis can be stabilized more successfully before returning to community.</p> <p>Lastly, mental health courts are a problem-solving court designed to engage defendants with mental health disorders in treatment in lieu of incarceration. Mental health courts teams typically involve judges, prosecutors, defense attorneys, treatment providers and law enforcement. Missouri currently has mental health courts operating in Columbia, Independence, Springfield, Kansas City, Carthage, and St. Louis.</p> <p>Missouri currently has eight operational behavioral health crisis centers (Kansas City, Raytown, Springfield, St. Louis, Joplin, St. Louis, Wentzville, Jefferson City) which are available to triage, assess, and provide immediate resources. These centers provide law enforcement with options beyond the ER or jail and there are potential cost savings due to redirecting the individuals to services more appropriately matched for their level of need and preventing unnecessary or overuse of other community resources.</p> <hr/> <p><i>Future Status:</i> Continued operation of current community-based programming.</p> <p>Missouri was a recipient of the CMS Mobile Crisis Planning Grant and is currently conducting a needs assessment to explore and determine the appropriate authority vehicle to expand access to Medicaid mobile crisis. This work will also include development of statewide standards, provider training, and establishment of a statewide billing mechanism. This work will continue through December 2022.</p> <p>The state plans to expand behavioral health crisis centers to an additional nine locations: Independence, Kirksville, Hannibal, Cape Girardeau, Rolla, St. Joseph, Columbia, Poplar Bluff, and West Plains.</p>

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	<p>Justice Reinvestment Initiative (JRI) Crisis Response Work Group (January 2021): This work group focuses on supporting diversion from traditional criminal justice case processing for nonviolent offenders with behavioral health conditions (mental health disorders, SUDs, or both) that are significant factors in bringing them into contact with the justice system. The goal is to promote fiscal, public safety, social and health benefits for participants, communities, justice systems, health systems, and taxpayers, including:</p> <ul style="list-style-type: none"> ▪ Expansion of law enforcement diversion: <ul style="list-style-type: none"> ○ Includes expansion of Community Behavioral Health Liaisons (CBHLs), Behavioral Health Crisis Centers (CBHLs), 988, CIT, and education on the crisis response initiatives through weekly, virtual Lunch & Learn sessions and Sequential Intercept Model (SIM) mapping sessions. <ul style="list-style-type: none"> ▪ 50 CBHLs were added in FY22; ▪ 12 BHCCs are being added in FY22; ▪ 988 will be added in July 2022; ▪ 24 Lunch & Learn sessions were conducted. Recordings can be found at: https://www.mobhc.org/resources/crisis-response-resources ▪ An application has been submitted to the Missouri Foundation for Health to assist with coordination of SIM mapping sessions in each county. ▪ Expansion of prosecution and court diversion <ul style="list-style-type: none"> ○ Includes promotion of mental health courts, education on pre-plea treatment courts, and education on prosecution diversion programs. <ul style="list-style-type: none"> ▪ A request was submitted to the Treatment Courts Coordinating Commission to include mental health courts statutorily and in considerations for funding; ▪ Lunch & Learn sessions on court diversion programs and prosecution diversion programs; ▪ Presentations at annual conferences for the MO Association of Treatment Court; Professionals (MATCP) conference and MO Association of Prosecuting; Attorneys (MAPA). ▪ Expansion of juvenile diversion: <ul style="list-style-type: none"> ○ Includes working with schools, juvenile offices, and behavioral health treatment providers on diversion programs <ul style="list-style-type: none"> ▪ Addition of Youth Behavioral Health Liaisons (YBHLs); ▪ Parent training for resource knowledge and access to services; ▪ Training for school personnel on Behavioral Risk Assessments ▪ Expansion of law enforcement assistance programs: <ul style="list-style-type: none"> ○ Includes educating first responders on the First Responder Provider Network and expansion of Post Critical Incident Seminars (PCIS) and first responder peer support programs

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	<ul style="list-style-type: none"> ▪ 41 clinicians are represented on the First Responder Provider Network; ▪ 4 PCIS events have been conducted in a collaboration with the MO State Highway Patrol and DMH; ▪ DOC has replicated the PCIS model for DOC staff and will conduct their first PCIS in May 2022; ▪ Peer support training for law enforcement is being conducted statewide.
	<p><i>Summary of Actions Needed:</i> Implementation of activities associated with CMS Mobile Crisis Planning Grant.</p>
<p>F.b Increase availability of on- going community-based services, e.g., outpatient, CMHCs, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.</p>	<p><i>Current Status:</i> CCBHOs must demonstrate a continued commitment to adopting new evidence-based, best, and promising practices, such as:</p> <ul style="list-style-type: none"> • ACT; • Supported employment; • Supported housing; • Parent-Child Interaction Therapy; • Dialectical Behavior Therapy; • Multi-systemic Therapy; and • First Episode Psychosis. <p>CCBHOs must also adopt with fidelity, a model for providing integrated treatment for co-occurring disorders approved by the Department.</p>
	<p><i>Future Status:</i> Continued operation of current community-based programming.</p>
	<p><i>Summary of Actions Needed:</i> N/A - Milestone criteria are met.</p>

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SMI/SED. Topic 6. Health IT Plan	
<p><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”¹ The HIT Plan should also describe, among other items, the:</i></p> <ul style="list-style-type: none"> • <i>Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i> • <i>Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i> <p><i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i></p>	
Statements of Assurance	
<p>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period</p>	<p>Missouri has a high level of electronic health record (EHR) adoption among behavioral health providers and continues to implement initiatives to encourage further adoption of HIE needed to achieve the goals of the Demonstration. The State has four Health Information Networks (HINs). In February 2020, the Missouri DSS, MHD received funding from CMS to develop and implement a HIE Onboarding Program. This HIE Onboarding Program provides federal funding to cover some of the onboarding costs for healthcare service providers to participate in HIE with Missouri HINs. The onboarding funding covers some costs related to first-year HIN subscription fees and interface development. The program's goal is to provide significant help to 40 MO HealthNet enrolled hospitals and 1,000 providers currently using EHRs become fully connected to an HIN by September 2021.</p> <p>Through the HIE Onboarding Program, the provider and the HIN are required to implement the following at a minimum:</p> <ul style="list-style-type: none"> • Bi-directional query-based exchange between the provider EHR system and the chosen HIN. • An ADT interface, with the requirement for the provider to send ADT data to the chosen HIN. • Providers may request assistance with two additional items: <ul style="list-style-type: none"> ○ Assistance with public health reporting, including immunizations, syndromic surveillance, electronic case reporting, and registry reporting. ○ Ability to receive care management alerts from the chosen HIN. <p>MO HealthNet shares Medicaid claims data with the HINs, making it available to healthcare providers for viewing and consumption into their EHRs to improve care coordination among providers, MO HealthNet and state agencies, including the Missouri DHSS, and the Missouri DMH. Additionally, the State has leveraged HIT to advance care coordination and improve clinical outcomes through its CMHC HCHs, PCHHs and CCBHCs. MCOs are also contractually required to implement HIT initiatives that support behavioral and physical health integration; for example, they are required to have one integrated information system platform for care management and utilization</p>

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	<p>management that provides both physical and behavioral health information, including but not limited to claims data, notes and prior authorizations.</p> <p>Since the State’s last State Medicaid Health Information Technology Plan (SMHP) update, members of the Missouri Medicaid Enterprise (MME) including MO HealthNet, DMH and DHSS have engaged in the following:</p> <ul style="list-style-type: none"> • Development of an enterprise strategy and technical architecture to support the exchange of health information between the state agencies and healthcare service providers through an HIN. • Development and implementation of an HIE platform within the Missouri Medicaid Information System (MMIS) to support connection and bi-directional HIE with HINs. • Procurement of a Medicaid Business Intelligence Solution and Enterprise Data Warehouse that will capable of supporting bi-directional exchange with HINs and population health management analytics. The solution is currently being implemented. • Development and implementation of a connection between DHSS and Missouri Health Connection (MHC) to support the exchange of public health information between DHSS and Missouri healthcare service providers. • Creation of a working group that includes MME state agencies and the four Missouri HINs to develop and refine Missouri’s strategies for interoperability and state agency participation in bi-directional data exchange with Missouri providers.
<p>Statement 2: Please confirm that your state’s SUD Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>This HIT Plan is aligned with the State’s broader Medicaid Health IT Plan. MO HealthNet, DHSS, and the DMH have a collaborative agreement to develop and implement health IT and HIE for their shared client base. The departments worked with the Office of Administration ITSD to develop an overall strategy for connecting the State department systems to the HIE for the purpose of sharing clinical and claims data and for exchanging public health information to support State program functions including case management and coordination of care.</p>

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<p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)² and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.</p>	<p>The State will review the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B for potential inclusion in the MCO contracts. Currently, MCOs are contractually required, in accordance with Executive Order 07-12, signed by the Governor on March 2, 2007 to support interoperable health information systems and products so long as the maintenance of exchange of health information includes provisions to protect member privacy as required by law.</p>

Prompts	Summary
	<p><i>To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states “for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers.” For more on the availability of this “HITECH funding,” please contact your CMS Regional Operations Group contact.³</i></p> <p><i>Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established “No Wrong Door System.”⁴</i></p>
<p>Closed Loop Referrals and e-Referrals (Section 1)</p>	

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1.1 Closed loop referrals and e- referrals from physician/mental health provider to physician/mental health provider	<p><i>Current State:</i> CCBHOs are required to maintain an HIT system including use of EHRs. Additionally, as of 2016, 96% of CMHCs had EHRs and 80% of public health agencies participated in an HIE. The State has four HINs which support interoperability and closed loop referrals. MHD implemented an HIE Onboarding Program under the HITECH Act. By September 30, 2021, MHD subsidized connections between 93 Medicaid providers representing about 550 provider locations and the HIN of their choice.</p> <p><i>Future State:</i> The State continues to encourage provider participation in HIN. Plans are underway to improve data quality, streamline connections, and strengthen Missouri’s HIN ecosystem.</p> <p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
1.2 Closed loop referrals and e- referrals from institution/hospital/clinic to physician/mental health provider	<p><i>Current State:</i> In addition to the EHR and HIN activities described in Section 1.1, The DMH 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 use to identify needed interventions.</p> <p>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:</p> <ul style="list-style-type: none"> • 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 PDL and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement 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 trait data; and • Determine medication adherence information and calculate MPRs. <p>Additionally, each CMHC HCH must 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 CMC HCH participants, and maintain a mutual awareness and collaboration to identify individuals seeking emergency department services who might benefit from connection with a CMHC HCH, and encourage hospital</p>

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	<p>staff to notify the area CMHC HCH staff of such opportunities.</p> <p>The aforementioned Missouri Care Coordination Insights Project will establish and optimize interoperability, connectivity, and exchange of data and insights between hospitals, the Missouri Hospital Association (MHA)/Hospital Industry Data Institute (HIDI), Missouri HINs and key MHD stakeholders. This includes onboarding hospitals not participating in the Medicaid EHR incentive program, but whose providers may exchange health information with Medicaid EHR eligible professionals and hospitals to support hospitals’ exchange and sharing of information. It also includes a pilot demonstration project to share ADT alerts and notifications with at least one primary care health home (PCHH) provider network and with one or more of the managed care plans delivering care to Missouri Medicaid participants.</p> <p><i>Future State:</i> Other possible applications of the technology developed under the Missouri Care Coordination Insights Project are being explored include:</p> <ul style="list-style-type: none"> • Developing watchlist capability for state case managers responsible for the health care of children in the state’s protective custody, • onboarding stand-alone psychiatric hospitals and developing functionality to help communicate psychiatric treatment capacity and mitigate patient boarding, and • adding alert functionality for patients with history of opioid overdose, SUD, OUD, AUD and substance affected infants. <p><i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project technology.</p>
<p>1.3 Closed loop referrals and e- referrals from physician/mental health provider to community based supports</p>	<p><i>Current State:</i> EHRs have the capability to send this information. The volume of providers utilizing closed loop referrals and e-referrals to community-based supports is unknown. Additionally, health homes provide referrals to community and social services supports which involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, etc. Health home providers monitor continuing Medicaid eligibility using the Family Support Division’s (FSD) eligibility website and data base.</p> <p><i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri’s HIN ecosystem.</p> <p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
<p>Electronic Care Plans and Medical Records (Section 2)</p>	
<p>2.1 The state and its providers can create and use an electronic care plan</p>	<p><i>Current State:</i> As described above, the State requires all CMHC HCH and PCHH providers and CCBHOs to implement and use an EHR. Additionally, a 2015-2016 survey of providers revealed 96% of responding CMHCs had adopted EHRs. Additionally, 109 hospitals reported full EHR implementation, only 21 reported partial implementation and 15 were nonresponsive to the survey. MO HealthNet also maintains a web based EHR called CyberAccess, which is accessible to all enrolled Medicaid providers, including CMHCs. At the provider level,</p>

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	<p>CyberAccess offers patient-specific histories, risks, gaps-in-care, reporting, and treatment alerts at the point of care. The goal is to provide a clear understanding of the patient’s previous care and indicators to encourage potential quality of care improvements among all connected partners. MO HealthNet has furthered this effort by sharing Medicaid medical and pharmacy claims data through the HINs for consumption into participating provider EHRs. Combined, these activities have dramatically increased the amount of data available in electronic format among and across settings.</p> <p><i>Future State:</i> The State will continue to encourage increased provider adoption of EHRs, including through continued operation of the Medicaid EHR Incentive Program as part of the CMS Promoting Interoperability Program.</p> <p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
<p>2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers</p>	<p><i>Current State:</i> As described above, CyberAccess is accessible to all enrolled Medicaid providers, including CMHCs, primary care practices, hospitals and schools. The tool is a HIPAA-compliant portal that enables providers to: (a) Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes); (b) View dates and providers of hospital emergency department services; (c) Identify clinical issues that affect an enrollee’s care and receive best practice information; d) prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment; e) electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services; (f) identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issued and transmit a prescription electronically to the enrollee’s pharmacy of choice; (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.</p> <p>Additionally, the Missouri Coalition for Community Behavioral Healthcare has partnered with Netsmart as the state’s care coordination and population health management solutions provider to support the CMHC HCH program. Following the success of Netsmart’s year-long pilot program with facilities including New Horizons, Compass Health, and Truman Behavioral Health, all CMHCs in Missouri began using the Netsmart population health management solution. The population health management solution offers nurse care managers a view of both physical and behavioral patient health data that integrates directly into the provider workflow. Additionally, the solution provides alerts and auto-generated tasks to inform clinical decision making.</p> <p>The Missouri Coalition for Community Behavioral Healthcare is also working with Netsmart on an Enterprise Data Warehouse and Analytics Solution to provide enhanced ability to review data within the existing solution</p>

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	<p>deployments to allow for ad-hoc query capabilities, allowing access to new data sets such as the following:</p> <ul style="list-style-type: none"> • Demographics • Programs and Episodes • Metabolic (vitals, labs, health factors) • Eligibility • Alerts • Staff and organization assignments • Hospitalizations and ER visits • Health Risk Profile information • Claims feeds from data not already directly utilized in CareManager such as Pharmacy information • Daily snapshot of the Population Health metrics at the client level for purposes of historical analysis <p>This solution is currently being piloted with seven agencies.</p> <p><i>Future State:</i> Potential expansion of aforementioned Enterprise Data Warehouse and Analytics Solution to additional agencies pending outcomes of pilot with existing seven agencies.</p> <p><i>Summary of Actions Needed:</i> Analysis of findings from pilot to determine potential plan for expansion to additional agencies.</p>
<p>2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p><i>Current State:</i> As previously described, CCBHOs are required to maintain an HIT system including use of EHRs; CMHCs also have a high rate of EHR adoption. These systems allow access to both youth and adult records. Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation such as assessments, therapy notes, and medication information.</p> <p><i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri’s HIN ecosystem.</p> <p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
<p>2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p><i>Current State:</i> As previously described, CCBHOs are required to maintain an HIT system including use of EHRs; CMCHs also have a high rate of EHR adoption. These systems allow access to both youth and adult records. Therefore, as an individual transitions from youth-oriented services to adult behavioral health services the new treatment teams will have real time access to treatment plans as well as other clinical documentation such as assessments, therapy notes, and medication information.</p> <p><i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri’s HIN ecosystem. .</p>

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	<i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	<i>Current State:</i> The State’s HINs can provide ADT notification to participating providers. HIDI currently has a core ADT message ingestion and encounter processing framework with established connections to 86 Missouri hospitals through direct and HIE-facilitated connections. It also includes flexible interfaces to support ADT connectivity either directly or through one of Missouri’s HINs and a flexible user-friendly ADT Encounter Notifications Portal delivering predictive analytic alerts and care coordination notifications to designated users at connected hospitals, <u>extensible to targeted non-hospital provider and payer stakeholders.</u>
	<i>Future State:</i> The technology enabled through the aforementioned Missouri Care Coordination Insights Project will expand the use of HIDI’s existing ADT platform through additional onboarding, and the design, development and implementation (DDI) of additional infrastructure to effectively support care coordination needs and interests among MO HealthNet’s stakeholders. The DDI will focus on enhancements to current solution capabilities to include fully automated watchlist processing, and additional outbound modalities to integrate alerts and notifications into clinical workflow. HIDI’s core care alerts and notifications combine the timeliness of ADT messaging with HIDI’s extensive hospital discharge database and applied analytics expertise. Users receive predictive alerts based on validated analytic models to inform care providers prospectively about presenting patients who are highly likely to experience a utilization event. HIDI’s platform allows individual users to modify alert subscription to focus only on populations of interest and gives users the option to both create and submit custom watch lists thus providing MHD and/or its contracted MCOs a mechanism to receive timely notification of care transitions for targeted patient groups. Users are able to customize events of interest to focus on just discharges, just admissions or all transitions of care for a select group of patients.
	<i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project technology.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA,	<i>Current State:</i> MO HealthNet and DHSS have conducted internal reviews of patient consent and allowable data uses through the HIN. Additional functionality was added to CyberAccess to filter the claims data to comply with restrictions in federal and state law on sharing certain types of data without additional patient consent beyond the HIPAA-defined consent required for treatment, payment, and operations. Processes are in place to capture consent during the Medicaid enrollment process for all Medicaid participants, which allows Medicaid providers access to <u>clinical data for their patients.</u> Consent is also captured in provider EHRs.
	<i>Future State:</i> Continued operation of current programming.
	<i>Summary of Actions Needed:</i> N/A – milestone met.

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42 CFR part 2 and state laws)	
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	<p><i>Current State:</i> DMH facilities, providers and regional offices are supported by the Customer Information Management, Outcomes, and Reporting (CIMOR) system. CIMOR is an enterprise medical information system that collects and stores a wide range of information used in supporting the DMH business areas, including clinical information (e.g., assessments, screenings), results, follow on diagnoses, and treatment plans. CIMOR shares information with multiple systems and agencies such as DSS/MHD, Medicare and the Social Security Administration.</p> <p>Provider EHRs incorporate all clinical documentation, including intake, assessment and screening tools.</p> <p><i>Future State:</i> Continued efforts to encourage provider participation in HIN, including via the aforementioned work toward strengthening Missouri’s HIN ecosystem.</p> <p><i>Summary of Actions Needed:</i> Implement planning and quality improvement projects in collaboration with HINs, members of the Missouri Medicaid Enterprise, and other stakeholders.</p>
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	<p><i>Current State:</i> MO HealthNet covers telehealth services. MO HealthNet allows any licensed health care provider, enrolled as a MO HealthNet provider, to provide telehealth services if the services are within the scope of practice for which the health care provider is licensed. The services must be provided with the same standard of care as services provided in person. MCOs are also contractually required to participate in Show-Me ECHO (Extension for Community Healthcare) which uses videoconferencing technology to connect teams of interdisciplinary experts with primary care providers. Show-Me ECHO participants include child and adolescent behavioral health specialist support for primary care; this Child Psych ECHO program integrates medical, pharmacological and psychological considerations into the treatment of the behavioral health patient.</p> <p>In response to the COVID-19 public health emergency (PHE) the State expanded telehealth access, including <u>permitting reimbursement for the delivery of services through audio-only technologies.</u></p> <p><i>Future State:</i> The State has convened a workgroup including representatives from MHD, DMH, DHSS and providers to review telehealth policies post-PHE.</p> <p><i>Summary of Actions Needed:</i> Continued operation of telehealth workgroup and implementation of policies in response to workgroup activity and recommendations.</p>

Prompts	Summary
Alerting/Analytics (Section 6)	
<p>6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment⁵)</p>	<p><i>Current State:</i> The State’s CMHC HCH and PCHH providers monitor individual and population health status and service use to determine adherence to or variance from treatment guidelines. HIT is leveraged to conduct these efforts and outreach is conducted to enrollees at risk of or having already disengaged from treatment.</p> <p>MCOs are also tasked with development of care coordination programming to further assure enrollee treatment engagement.</p> <p><i>Future State:</i> The technology enabled through aforementioned Missouri Care Coordination Insights project supports development, testing and implementation of enhanced HIDI ADT portal features and functionality to allow Medicaid care managers to utilize MHA/HIDI’s predictive alerting and care coordination notifications and new Medicaid-centric predictive analytics models. MHA/HDI’s core care alerts and notifications combine the timeliness of ADT messaging with HIDI’s extensive hospital discharge database and applied analytics expertise. Users receive predictive alerts based on validated analytic models to inform care providers prospectively about presenting patients who are highly likely to experience a utilization event in the near future, such as excessive ED utilization, hospital readmission subject to penalty, etc. HIDI’s platform allows individual users to modify alert subscription to focus only on populations of interest and gives users the option to both create and submit custom watch lists thus providing MHD and/or its contracted MCOs a mechanism to receive timely notification of care transitions for targeted patient groups. Users are able to customize events of interest to focus on just discharges, just admissions or all transitions of care for a select group of patients.</p> <p><i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project.</p>
<p>6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis</p>	<p><i>Current State:</i> The State utilized Community Mental Health Block Grant funds for development of first episode psychosis programing. Participating agencies include CCBHOs, which as previously described have HIT requirements.</p> <p><i>Future State:</i> Continued CCBHO operation of first episode of psychosis programming and associated requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>
Identity Management (Section 7)	

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7.1 As appropriate and needed, the care team has the ability to tag or link a child’s electronic medical records with their respective parent/caretaker medical records	<i>Current State:</i> The State’s eligibility and enrollment system can link children and parents on the same case. EHRs have linkage capabilities as well; the volume of providers utilizing this functionality is currently unknown. CCBHOs and CMHCs currently track adult and child behavioral health records in the same EHR that includes all family members receiving services and the ability for appropriate sharing of information among treatment teams.
	<i>Future State:</i> Continued operation of current programming
	<i>Summary of Actions Needed:</i> N/A – milestone met
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	<i>Current State:</i> Provider EHRs capture multiple episodes of care and link episodes of care accordingly.
	<i>Future State:</i> Master patient index (MPI) enhancements are a component of the aforementioned Missouri Care Coordination Insights Project. This includes evaluation and updates to the HIDI Master Patient Index algorithms to utilize the Missouri Department Client Number (DCN) and other identifiers to maximize matching with the Medicaid population.
	<i>Summary of Actions Needed:</i> Continued development of Missouri Care Coordination Insights Project.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.