Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Missouri

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Missouri Department of Social Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, July 1, 2012. You may submit comments on this proposal to MO-MedicareMedicaidCoordination@cms.hhs.gov.

Financial Model to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

Managed Fee-For-Service

Demonstration Proposal

Submitted by

Missouri Department of Social Services

MO HealthNet Division

May 31, 2012

A. Executive Summary

Under this proposed financial alignment demonstration program, Missouri proposes that Medicare agree to share with the state the savings that Medicare realizes as a result of the state's investment in its two Health Home programs. The state anticipates that the savings calculation that Medicare will use will mirror the methodology developed for use by Medicaid.

The state of Missouri MO HealthNet Division (MHD) previously applied for and received formal approval from the Centers for Medicare and Medicaid Services (CMS) to implement two Health Home programs under Section 2703 of the Affordable Care Act (ACA).

The goals of the Missouri Health Home programs include the following:

- reduce inpatient hospitalization admissions, readmissions and inappropriate emergency department (ED) visits;
- improve coordination and transitions of care to improve patient outcomes;
- implement and evaluate the Health Home model as a way to achieve accessible, high quality holistic health care;
- demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model, and
- support practice sites by increasing available resources and thereby improve quality of clinician work life.

Implemented in January 2012, the Health Home programs provide care coordination services to eligible Medicaid beneficiaries that meet the program criteria, including those beneficiaries who are dually eligible for Medicare and Medicaid. The first approved program the Community Mental Health Center (CMHC) Health Home program, targets Medicaid beneficiaries, including duals, who have serious mental illness (SMI) or mental illness or substance abuse disorder in combination with another chronic condition. The second approved program, the Primary Care (PC) Health Home program targets Medicaid beneficiaries, including those dually eligible for Medicare and Medicaid, who have specific somatic chronic conditions. These initiatives promise to be successful in improving the care of beneficiaries and reducing costs to both Medicare and Medicaid.

The matrix below provides information on key aspects of the demonstration proposal, which are discussed in greater detail throughout this application.

Target Population (All full benefit Medicare-Medicaid	There are **6,380** adult individuals who are dually eligible for Medicare and Medicaid that are eligible to participate in a Health Home program based on meeting the clinical criteria for the CMHC Health Home program or the Primary Care Health Home program

enrollees/subset/etc.)	(out of the **42,634** beneficiaries eligible for Health Homes). The dual eligibles participating in the Health Homes are the target population for this demonstration.
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	There are **168,229** statewide full benefit Medicare-Medicaid enrollees in MO HealthNet.
Total Number of Beneficiaries Eligible for Demonstration	The total number of MO HealthNet beneficiaries eligible to participate in this demonstration are the 5,093 beneficiaries that are dually eligible for Medicare and Medicaid and currently enrolled in a Health Home program.
Geographic Service Area (Statewide or listing of pilot service areas)	The Health Home programs are statewide initiatives that are available to all eligible beneficiaries who receive care in Health Homes. Health Home services are available in all geographic areas within Missouri.
Summary of Covered Benefits	Through both of the Health Home programs, eligible beneficiaries including those receiving long term care services in the community setting receive state plan Medicaid and federal Medicare services plus the following support services, as needed: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care (including appropriate follow-up from inpatient to other settings), Individual and Family Support Services (including authorized representatives), and Referral to Community and Social Support Services. Neither the Health Home programs nor this Financial Alignment Demonstration will change the other covered benefits in Medicaid or Medicare including covered services, rates, grievance procedures (which the health homes will assist the patient in navigating) and eligible providers.
Financing Model	Designated Health Homes receive a per member per month (PMPM) payment from the State of Missouri for providing the services described above. Providers continue to receive fee-for-service payments for all other services provided to individuals who are dually eligible for Medicare and Medicaid. Additionally providers may be eligible to share with the state any net savings achieved through the provision of Health Home services. Potential shared savings distribution levels are adjusted based on Health Home performance on quality measures. CMS has approved the Missouri's payment methodology under Section 2703 of the ACA in two separate State Plan Amendments.

	Missouri seeks to share with CMS savings that the Health Homes generate for Medicare as a result of the state's investment in the Health Homes. The savings methodology will be developed in conjunction with CMS.
Summary of Stakeholder Engagement/Input (Provide high level listing of events/dates – Section D asks for more detailed information)	Missouri engaged stakeholders in mid-2011 in the development of its Health Home program under Section 2703 of the ACA in coordination with the Missouri Medical Home Collaborative (MMHC) which received input from multiple state provider associations, medical groups, professional organizations, insurers and beneficiary advocates. The state held over 25 advisory committee meetings with and continues to engage various consumer, advocacy, and provider organizations in the design, implementation and performance of the Health Home programs. The state held two public meetings on April 10, 2012 and on April 12, 2012 and posted the application for a 30-day public comment period.
Proposed Implementation Dates(s)	The state implemented the CMHC Health Homes on January 1, 2012 and the Primary Care Health Homes was implemented in a phased process between January 1, 2012 and April 1, 2012. The state proposes to commence the demonstration immediately effective upon demonstration approval by CMS, but no later than October 1, 2012. The implementation of the shared savings arrangement with Medicare will begin on the date of implementation of the financial alignment demonstration.

B. Background

i. Discussion of overall vision and/or rationale for proposed demonstration,

The goal of this demonstration project is to provide integrated care management and support services to individuals who are dually eligible for Medicare and Medicaid and served by Missouri's Health Home programs. Missouri believes that these services will lead to improved delivery and quality of care, and reduced costs to both Medicare and Medicaid for the participating population.

In Medicare, there are approximately 3.2 million individuals dually eligible for Medicare and Medicaid under age 65 with a Medicare per member per month (PMPM) cost of $639 and a Medicaid PMPM cost of $485. These high costs are due in part to beneficiary burden of illness, and also due to the highly fragmented and often uncoordinated care that these beneficiaries receive. In addition, disparate funding sources and payer systems contribute to the less-than-optimally effective treatment being provided to individuals who are among the most vulnerable served by both Medicare and Medicaid. Untreated or poorly treated medical and/or behavioral

illness is a major cause of unnecessary expenditures leading to avoidable emergency department (ED) visits and avoidable hospitalizations.

In an attempt to address these systemic issues and overcome the barriers to high quality care, Missouri requested and received approval from CMS for two separate State Plan Amendments (SPAs) to allow provision of Health Home services to MO HealthNet participants, including individuals dually eligible for Medicare and Medicaid. The two Health Home programs are:

- The Community Mental Health Center (CMHC) Home Health program designed for individuals with serious mental illness (SMI) or a combination of mental health issues and another chronic condition. There are currently 29 CMHCs participating in the Missouri CMHC Health Home program.
- The Primary Care (PC) Health Home program designed for patient with complex chronic conditions. There are currently 24 Primary Care Health Home organizations in the state, with most operating multiple Health Home sites.

Please see Appendix A for a list of all of the Community Mental Health Centers participating in the CMHC Health Home program and Appendix B for a list of all of the organizations participating in the Primary Care Health Home program.

Both of these Health Home programs provide an alternative approach to the delivery of health care services that promises better patient experience, better patient outcomes and lower costs than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home (PCMH) model, but has been customized to meet the specific needs of low-income patients with multiple chronic medical conditions. Both the CMHC Health Home program and the Primary Care Health Home program rely upon the same care model and offer the same core services. The programs differ, however, in terms of the eligibility criteria, the members of the care team, the care team goals, the measures used to assess progress towards those goals, and the amount of the PMPM payment.

The Missouri Department of Mental Health (DMH) oversees Health Home services for individuals with serious mental illness (SMI) provided by Community Mental Health Centers while the MO HealthNet Division (MHD) oversees Primary Care Health Home services for individuals with predominantly somatic chronic conditions. Both of these Health Home programs offer dually eligible participants the standard Medicaid benefit package and standard Medicare benefits supplemented with comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referrals to community and social support services. The Health Home financial alignment demonstration program will do nothing to impact the Medicare coverage of or restrict access to inpatient rehabilitation facilities (IRF) for dually eligible beneficiaries. Additionally, the Health Home financial alignment demonstration program will have no impact on the network of

inpatient rehabilitation facilities (IRF). Under this proposal, the Health Home will be responsible for the coordination of all Medicare and Medicaid covered services, including Medicare and Medicaid long term care services outside of primary care and behavioral health such as home and community-based (HCBS) services, developmental disabilities services and waiver case management. Individuals receiving additional waiver services through a home and community-based services (HCBS) waiver or other state waiver program will continue to receive these services as usual but the Health Home will take responsibility for coordinating such services as appropriate. Additionally if dually eligible beneficiaries participating in the Health Home programs are enrolled in a Part D plan, then they will continue to receive their pharmacy benefit through their chosen Medicare Part D plan. Participation in Health Homes does not have any impact on the dually eligible beneficiaries' enrollment in the Part D plans. The Health Home providers seek to provide the highest level of medication therapy management (MTM) services to the beneficiaries enrolled in the Health Home programs without providing duplicative services. The Health Homes will seek to coordinate any MTM services provided to the dually eligible individual with any medication management services being offered through the beneficiary's Part D plan though his/her local pharmacy.

Specific performance goals for Health Homes include:

- reduce inpatient hospitalization admissions, readmissions and inappropriate ED visits;
- improve coordination and transitions of care to improve patient outcomes;
- implement and evaluate the Health Home model as a way to achieve accessible, high quality holistic health care;
- demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model, and
- support practice sites by increasing available resources and thereby improve quality of clinician work life.

These programs currently serve and plan on continuing to serve all categorically needy Medicaid participants who are not institutionalized long term who meet the programs' eligibility requirements, including those who are dually eligible for Medicaid and Medicare.

Missouri seeks to share with CMS savings that the Health Homes generate as a result of the state's investment in the Health Homes. Missouri will, in turn, share these savings with providers to incentivize and reward improvements in service delivery and quality of care. Missouri will accomplish this goal by offering providers performance incentive payments if there are cost savings that result from the provision of Health Home services across the entire program. To avoid incentivizing clinically inappropriate reductions in service as a way to reduce costs, the amount of the incentive payment will be determined by the individual Health Home's performance on clinical process outcome indicators. In this manner, participating Health Homes

are incentivized to reduce costs, but only while maintaining or improving the quality and clinical outcomes of the care provided. The shared savings incentive payments will be paid in each subsequent year based on the savings and performance realized in the prior year across both the Medicare and Medicaid programs.

ii. Detailed description of the Medicare-Medicaid enrollee population

Missouri proposes to provide integrated care management and support services for eligible beneficiaries. The eligibility criteria for each of the programs are as follows:

- The CMHC Health Home Program will enroll non-institutionalized, categorically needy individuals, including those who are dually eligible for Medicare and Medicaid, who also have:
    - serious mental illness (SMI);
    - a mental health condition or substance abuse disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, substance use disorder, developmental disability, overweight (BMI >25);
    - a substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, developmental disability (DD), overweight (BMI >25); or
    - a mental health condition or a substance use disorder and tobacco use (tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD).

- The Primary Care Health Home Program will enroll non-institutionalized, categorically needy individuals including those who are dually eligible for Medicare and Medicaid who also have:
    - diabetes (a chronic condition that also puts persons at risk for other chronic conditions such as heart disease)
    - two chronic conditions, or
    - one chronic condition and the risk of developing another from the following list: asthma, diabetes, heart disease, BMI over 25, a developmental disability, or tobacco use (tobacco use is considered an at-risk behavior for chronic conditions such as asthma and CVD).

There are currently 168,229 dually eligible individuals in the State of Missouri. Of the total dually eligible population, 11,935 are currently enrolled in a Health Home program with 5,809 participating in the CMHC Health Home program and 6,170 participating in the Primary Care Health Home. Individuals were initially identified by the state for enrollment through review of paid claims history. This demonstration is designed to serve non-institutionalized beneficiaries that meet the above criteria including individuals who are dually eligible for Medicare and

Medicaid and those dual eligibles who are receiving Home and Community-Based waiver services. Health Home services are anticipated to keep subsequent new episodes of nursing home admissions of Health Home members brief and transitional with a rapid return to community care. Table One below details the current enrollment in the Health Home programs.

Table One: Current Enrollment in Health Home Programs

	Overall	Individuals receiving LTSS in institutional settings	Individuals receiving LTSS in HCBS settings
Total number of beneficiaries in the state eligible to participate in either Health Home program	43,632	0	11,189
Total number of beneficiaries who are dually eligible for Medicare and Medicaid that are eligible to participate in either Health Home program	15,007	0	6,380
Overall total enrollment in Health Homes	35,117	0	9,111
Total Enrollment in the CMHC Health Home Program	17,337	0	5,423
Total Enrollment in the Primary Care Health Home Program	17,780	0	3,688
Individuals age 65+ enrolled in either Health Home program	3,391	0	1,767
Individuals age 65+ enrolled in the CMHC Health Home program	708	0	534
Individuals age 65+ enrolled in the Primary Care Health Home program	2,683	0	1,233
Individuals under age 65 enrolled in either Health Home program	31,726	0	7,344
Individuals under age 65 enrolled in the CMHC Health Home program	16,629	0	4,889

Individuals under age 65 enrolled in the Primary Care Health Home program	15,097	0	2,455
Duals enrolled in the CMHC Health Home program	5,809	0	2,849
Duals enrolled in the PC Health Home program	6,170	0	2,244
Total number of dual eligible enrolled in both Health Home programs	11,979	0	5,093

C. Care Model Overview

i. Description of proposed delivery system/programmatic elements, including:

The Missouri Health Home model builds on the PCMH model as a means to achieving accessible, high quality care for low-income patients with chronic conditions. The model emphasizes patient-centered care planning, the use of a patient registry, claims and EMR data analytics to stratify health risk, and the provision of care management, care coordination and transitional care services as a means of improving the quality of patient care and health outcomes.

While the CMHC Health Home and the Primary Care Health Home programs differ in terms of their respective eligibility criteria, goals and measures and the amount of the PMPM payment, both programs rely upon the same care model and serve the same core functions. The core functions of the Missouri Health Home programs include:

1. Comprehensive Care Management;
2. Care Coordination;
3. Health Promotion;
4. Comprehensive Transitional Care (including appropriate follow-up from inpatient care to other settings);
5. Individual and Family Support Services (including authorized representatives), and
6. Referral to Community and Social Support Services.

For a detailed discussion of each core competency of the Health Home, please see Appendix C.

In order to facilitate care coordination or services, Medicaid automatically informs the Health Home when an enrollee has received services at the Emergency Department or in an inpatient setting. Unfortunately, Missouri does not have access to the Medicare data feeds which would

provide this same level of coordination for the dually eligible population that relies primarily on Medicare for such services. While Missouri seeks access to such Medicare data under this proposal, in order to enhance the level of coordination for the dually-eligible population in the absence of such information, the Health Home programs will work with local hospitals to secure memorandum of understanding (MOUs) in which hospitals will agree to notify the Health Homes when any dually eligible beneficiaries enrolled in the program receive services at their facilities. Health Home services # 2, 4, 5, and 6 above are anticipated to reduce the incidence of subsequent new episodes of nursing home admissions and when new nursing home admissions do occur keep them brief and transitional with rapid return to community care. While the state of Missouri will not require Health Homes to adopt any specific technologies, the proposal will clarify that Health Homes may adopt technologies that they deem appropriate to enhance patient care and facilitate the coordination of patient care across care settings.

Geographic Distribution: The Health Home programs are currently operating statewide and will continue to do so under this demonstration. Missouri will continue to contract with Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and primary care clinics operated by hospitals to provide Health Home services. All designated providers are currently and will continue to be required to meet state qualifications. The Missouri HealthNet Division and the Missouri Department of Mental Health reviewed applications submitted by eligible provider entities in the state and selected sites upon the merits of the applications while ensuring appropriate geographic distribution. There are a total of 24 Primary Care Health Homes, including most FQHCs in the state. There are 29 CMHCs participating in the CMHC Health Home program. This widespread participation enables the state to serve individuals eligible for the program residing in every county within Missouri.

Practice sites are and will continue to be physician or nurse practitioner-led and have care teams comprised of a primary care physician (i.e., family practice, internal medicine, pediatrics) or nurse practitioner, psychiatrist at the CMHCs, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), a Nurse Care Manager, Care Coordinator and the practice administrator or office manager.

The team is supported by the Health Home Director. In addition, other optional team members may include a nutritionist, diabetes educator, pharmacist, public school personnel and others as appropriate and available. Optional team members are identified for inclusion at the request of the beneficiary, responsible caregiver or by the Care Manager. Since this demonstration serves a dually eligible population, the optional team members may include Medicare-only providers and specialists. In these cases, as with all optional team members, the designated Health Home Care Manager and Care Coordinators are responsible for locating and conducting outreach to these

Medicare-only providers. The Health Home programs also recognize that in some instances for an individual with a significant disability, his/her specialist may serve as his/her primary point of contact with the medical system. However, the Health Home programs believe that it is important for that individual to have a team that will look at the patient's needs holistically and not just through the lens of the specialist and will work to coordinate the care of the specialist and the other members of the Health Home care team.

All members of the team will be responsible for ensuring that the care provided is person-centered, culturally competent and linguistically capable. Beneficiaries are at the center of care planning and participate in the development of their care plans and are encouraged to be active in the management of their care. The Health Homes will ensure that the beneficiaries, including those that a dually eligible for Medicare and Medicaid, are fully informed of all of their care options (including the option to not participate in the Health Home), and have the right to a second opinion, have the ability to schedule appointments with care team members, have the right to choose an advocate to be present at the meetings and have the right to accept or refuse treatment. The Health Home Director, Nurse Care Manager, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), and Care Coordinator's time will be covered under the appropriate PMPM rates for the CMHC Health Homes and the Primary Care Health Homes as described in the Payment Methodology section below. The standard benefits package of direct services provided by the primary care practices and the CMHCs will continue to be paid through Medicaid and Medicare fee-for-service arrangements, as will payments for all other Medicaid and Medicare services provided outside of the Health Home.

Health Home sites are and will continue to be supported in transforming service delivery by participating in statewide learning activities. Each Health Home organization is required to participate in a learning collaborative, specifically designed to help practices transform into Health Homes and provide care using a whole-person approach that integrates primary care, behavioral health, and other needed services and supports. Learning activities are and will continue to be supplemented with monthly practice team calls to reinforce the learning sessions, practice coaching, and monthly practice reporting (data and narrative) and feedback. The learning collaborative has been funded by the Missouri Foundation for Health and the Health Care Foundation of Greater Kansas City. Given providers' varying levels of experience with practice transformation approaches, the state will continue to assess providers to determine learning needs.

Enrollment methodology: For the purposes of the initial enrollment into the Health Home programs, Missouri used the state's comprehensive Medicaid electronic health record and claims data to identify individuals who were eligible for either the CMHC Health Home program or the Primary Care Health Home program and were currently receiving services from Health Home

providers. These individuals were automatically enrolled into the appropriate Health Home program and auto-assigned to their existing providers. Upon enrollment, individuals assigned to a Health Home were informed by the state via U.S. mail and other methods as necessary of the Health Home program, the individual's ability to select a different Health Home provider at any time, and were provided a listing of all available Health Homes throughout the state. The notice also describes how an individual may opt out of participating in the Health Home program at any time.

Going forward, beneficiaries who were not auto-enrolled in Health Homes may be referred to the program by their providers. When referring a beneficiary to the Health Home program, the Health Home submits an application to the state on behalf of the beneficiary for review and approval. Once the application is approved, the state notifies the individual using the same notification process described above. Additionally individuals with qualifying chronic conditions who are not currently receiving services at a Health Home may request to be part of a Health Home by contacting the state. Potentially eligible individuals receiving services in the ED or as an inpatient of a hospital with a memorandum of understanding (MOU) with a participating Health Home will be notified by the hospital about the Health Home program and referred to an appropriate Health Home provider.

When an eligible individual is assigned to a Health Home provider, the provider will be informed by the state regarding a beneficiary's enrollment in the Health Home program. The Health Home will notify other identified treatment providers (e.g., primary care and specialists such as OB/GYNs) about the goals and types of Health Home services as well as encourage participation in care coordination efforts.

In order to qualify as a Health Home, provider candidates were required to meet the following criteria by the date of application submission:

- have a substantial percentage (not less than 25%) of their patient panel enrolled in MO HealthNet or be uninsured;
- provide a Health Home that is capable of overall cost effectiveness;
- have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process;
- have patient panels assigned to each primary care clinician;
- actively utilize MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for MO HealthNet participants;
- utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;

- meet the minimum access requirements of third-next-available appointment within 30 days and same-day urgent care;
- have completed Electronic Medical Record (EMR) implementation and been using the EMR as its primary medical record solution for at least six months prior to the beginning of health home services, and
- agree to participate in a learning collaborative program.

ii. Description of proposed benefit design and how the model will align the full array of Medicare and Medicaid services, including discussion of who will be accountable for managing the full range of services.

Individuals dually eligible for both Medicare and Medicaid participating in either the CMHC Health Home program or the Primary Care Health Home Program will continue to have access to the full range of services and providers, including Medicare-only providers, to which they are entitled through both Medicare and the Medicaid State Plan through the traditional fee-for-service payment model. This comprehensive package of covered services including services provided exclusively by Medicare providers and waiver services will be managed and coordinated by the beneficiary's Health Home care team.

iii. Description of whether the program will add new supplemental benefits and/or other ancillary/supportive services (e.g., housing, non-emergency transportation, etc.) or modify existing services.

In addition to the core services offered through traditional fee-for-service Medicare and Medicaid, the Health Homes offer participants comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services in exchange for a per member per month fee paid by the state. These services will improve the overall provision of care to the member and will provide greater ongoing beneficiary support, reducing the need for long-term care services and supports.

iv. Discussion of how evidence-based practices will be employed as part of the overall care model.

Both the Primary Care Health Home program and the CMHC Health Home program are built upon the foundation of the evidence-based Chronic Care Model (CCM) for improving the quality of care for individuals with chronic conditions. Developed by the MacColl Institute, the Chronic Care Model (CCM) outlines the basic elements that should to be included at each level of the health care system in order to foster high quality care at a lower cost. Primary Care Health Homes will all implement SBIRT, an evidence based practice for prevention and early intervention in risky alcohol and drug use. Both PC and CMHC Health Homes will receive

training in Motivational Interviewing. All CMHC health homes are required to do systematic metabolic screening and monitoring. All Health Home members are continuously monitored for over 12 disease management quality indicators and adherence to 6 classes of medication. CMHC Health Homes use an evidence-based prescriber feedback intervention for improving the use of behavioral health medications that has won awards from SAMHSA, URAC, and the APA. As part of this project Missouri will work to obtain Medicare Part D data from CMS and integrate it into this proven intervention.

In addition to relying on an evidence-based architecture, the Health Home programs require all participating Health Homes to have at least one site participate in the ongoing learning collaborative. The learning collaborative is designed to facilitate practice transformation and introduce Health Home providers to evidence-based strategies to support their care of individuals with chronic conditions. Health Homes participate in both face-to-face learning sessions, and on monthly webinars, and also have access to online resources, including reports that profile clinical performance using practice-reported clinical data. In order to ensure that Health Homes are appropriately trained to provide high quality care to individuals who are dually eligible for Medicare and Medicaid, the program will offer a webinar-based training for Health Home providers around delivering services and coordinating the care of this unique population. The webinar will also include relevant information about the Medicare requirements related to medication coverage under Part B and the medication therapy management services provided to beneficiaries through Part D plans and about the range of HCBS services that are available to support individuals who are dually eligible for Medicare and Medicaid who wish to remain in the community and how to refer patients for LTSS assessments and to "options counselors" when appropriate. In addition, the Health Home program staff will host monthly conference calls for all of their providers during which they will solicit questions from the providers particularly with regard to the care and management of the dually eligible populations they serve.

Finally, the measures of clinical performance that the Health Home providers are required to report on throughout the demonstration are evidence-based and many of them have national Medicaid benchmark data available. These clinical performance measures will be used to determine the amount of savings that the providers may share in with the state, if the Health Home program is able to generate savings. The programs' calculations of savings will not be based on individualized provider savings but rather on the total savings created by all of the providers within each Health Home program (CMHC and Primary Care).

v. As applicable, description of how the proposed model fits with:

(a) ***current Medicaid waivers and/or State plan services available to this population;***

Under the demonstration, individuals dually eligible for Medicare and Medicaid will continue to access all of the services traditionally offered through fee-for-service Medicare and Medicaid.

However, if enrolled in a Health Home program that was created through a state plan amendment, the beneficiary will receive additional Health Home services and the Health Home providers will be responsible for assisting the beneficiary in managing and coordinating all of the beneficiary's usual benefits.

If beneficiaries are eligible for home and community-based waiver services, they may both access Health Home services and continue to receive services through the existing waivers without any impact on their eligibility. Currently the state serves beneficiaries who are dually eligible for Medicare and Medicaid in the following eight waivers: Comprehensive Waiver (a waiver to establish and maintain a community based system of care for individuals with mental retardation and developmental disabilities that includes a comprehensive array of services that meets the individualized support needs of individuals in a community setting), Community Support Waiver, Autism Waiver, Partnership for Hope Waiver (for persons with developmental disabilities), AIDS Waiver, Medically Fragile Adult Waiver, Aged and Disabled Waiver and Independent Living Waiver. Finally, an Adult Day Care Waiver is currently pending approval from CMS.

In the case of a dually eligible beneficiary, the Health Home Care Coordinator and Care Manager will have regular communication with that beneficiary's waiver Care Manager as well as any nursing home coordinators or house doctors. Additionally, the Health Home team will work to identify any gaps in the long-term care of a dually eligible individual and connect him/her with the appropriate long-term care supports. Since Health Homes will be proactively determining the need for Home and Community-Based waiver services within the dually eligible population, they are likely to identify such needs early and potentially avoid costly nursing home stays.

(b) ***existing managed long-term care programs;***

Missouri does not currently operate a managed long-term care program.

(c) ***existing specialty behavioral health plans;***

Missouri does not currently contract with specialty behavioral health plans.

(d) ***integrated programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs;***

Beneficiaries receiving care through a Special Needs Plan or through a Program for All-inclusive Care for the Elderly (PACE) are not eligible to participate in the Health Home programs.

(e) ***other State payment/delivery efforts underway***

Missouri is currently participating in the multi-payer Missouri Medical Home Collaborative and it is through this involvement that Home Homes are eligible and are participating in a learning

collaborative. Missouri does not currently have any other state payment reform efforts underway that will have any impact on the individuals who are dually eligible for Medicare and Medicaid and enrolled in a Health Home program.

(f) ***other CMS payment/delivery initiatives or demonstrations***

Missouri does not currently participate in any CMS payment/delivery initiatives or demonstrations that will have any impact on the individuals who are dually eligible for Medicare and Medicaid and enrolled in a Health Home program.

D. Stakeholder Engagement and Beneficiary Protections

i. Discussion of how the State engaged internal and external stakeholders during the planning process and incorporated input into its demonstration proposal.

Missouri has actively engaged both internal and external stakeholders, including consumers throughout the planning and implementation process of the Health Home programs. The state described its planning efforts in multiple forums involving consumer, provider, and health plans stakeholders, CMS Regional Office staff, state agency representatives, employer, foundation, and health service researchers including at two public meetings that specifically solicited public feedback on this demonstration program The first public meeting was held by the MO HealthNet Oversight Committee on April 10, 2012. Please see Appendix D for the agenda. The second public meeting was held by the Missouri Mental Health Commission on April 12, 2012. Please see Appendix E for the minutes. Additionally, the demonstration application was posted for public comment for the required 30-day period starting on April 23, 2012. On April 25 a small revision was made to the cover page to include the appropriate contact information for comments and the comment period deadline. A summary of the six public comments received and how the state has incorporated the feedback from those commented into this proposal is included in Appendix F.

The Missouri Medical Home Collaborative (MMHC) Council played a central role in the early stakeholder engagement process, with large meetings occurring in November and December of 2010, and in January and June of 2011. A list of attendees from the initial November 2010 meeting is provided in Appendix G. The MMHC created a Steering Committee to focus upon the detailed planning activity. This group has met five times to date, including in March, May, June, and November of 2011, and January of 2012. The initial membership list is provided in Appendix H. In addition, provider organizations played an intensively active role in program design and implementation, participating in standing work groups and working closely in collaboration with state agency staff. These work groups continue to meet on a regular basis with state staff. Separate work groups continue to operate for the Primary Care and CMHC Health Home programs, chaired by MO HealthNet Division and Department of Mental Health

staff respectively. Finally, the state has presented to many other bodies on its Health Home planning and implementation work. A list of these organizations and some detail regarding their composition is provided in Appendix I. If this demonstration project is approved, Missouri will include a beneficiary who is dually eligible for Medicare and Medicaid on the Steering Committee.

ii. Description of protections that are being established, modified, or maintained to ensure improved beneficiary experience and access to high quality health and supportive services necessary to meet the beneficiary's needs.

In order to ensure improved beneficiary experience and access to high quality health and supportive services, the Health Homes will ensure that all care provided through and coordinated by them will meet the beneficiaries' needs and preferences, allow for involvement of caregivers, and be in an appropriate setting, including in the home and community. Additionally, the beneficiaries will be meaningfully informed about their care options, including their decision to participate in or opt out of a Health Home program.

The Health Homes will ensure access to all services in a manner that is sensitive to the beneficiary's language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately. If dually eligible individuals participating in the Health Home programs or their designees feel that their choices or rights are not being observed, then they will have access to the appeals and grievance processes for either Medicare or Medicaid. This demonstration project will do nothing to change the Medicare grievance and appeals process or the Medicaid grievance and appeals process that are already in place. Rather, the Health Homes will provide support to beneficiaries that are dually eligible for Medicare and Medicaid that are interested in filing a grievance or an appeal and help them decide which grievance and appeals process (Medicare or Medicaid) best meets their needs.

To ensure that beneficiaries are satisfied with the services provided by the Health Home, the program provides beneficiaries with the freedom to choose their Health Home providers, change their Health Home providers at any time and to opt out of the Health Home program entirely at any time without penalty. Upon enrollment, individuals assigned to a Health Home will be informed by the state via U.S. mail and other methods as necessary of all available Health Homes throughout the state. The notice will describe beneficiary choice in selecting a Health Home and clearly describe the process for changing Health Home providers and for opting out of the Health Home program at any time without jeopardizing eligibility and coverage of existing Medicaid and Medicare services.

Additionally if a beneficiary applies for participation in a Health Home and the state denies the request, or if at any time any MO HealthNet services have been denied, reduced or terminated,

beneficiaries have the right to request a State Fair Hearing. The state is responsible for communicating this right to beneficiaries in a letter outlining the hearing and appeals process. In the denial notice sent to beneficiaries, the state informs them of the opportunity to request a hearing in writing or by phone at the beneficiary's own expense. The beneficiary must contact the Participant Services Unit within 90 days of the date on the denial letter in order to exercise the right to a fair hearing.

Once the beneficiary has requested a hearing, the state will provide him/her with a hearing form designed to gather information about the request. Once the state receives the completed hearing form, the state will schedule a hearing. Hearings are held on the phone. Beneficiaries may either go to the local Family Support Division office for the hearing or have the hearing from home. The beneficiary is allowed have anyone present at the hearing that he/she would like. The beneficiary may also choose to have another person speak for him/her at the hearing. Asking for a hearing will not affect the beneficiary's eligibility. Beneficiaries will receive the hearing decision in the mail. If the beneficiary does not agree with the decision, then he/she may ask for an appeal.

At the quarterly public meetings held by the MO HealthNet Oversight Committee, the Committee will present to the public an update of all Health Home activities, the program outcomes and summary information about the volume and types of complaints, appeals and grievances received regarding the Health Home programs. Further, the Committee meetings will include as a standing item on the agenda a request for consumer and dually eligible beneficiary feedback and suggestions for the Health Home programs and the financial alignment demonstration.

Missouri is committed to protecting patient privacy and ensuring that all enrollees have access to their own health records and their care plans in a usable and understandable format. The Health Home staff will provide training and support patients in their use of Cyber Access, the web-based tool that enables patients to access their records online. Additionally, ACS (a Xerox company) is willing to provide one-on-one support to patients who need greater support navigating the site. As such, the Health Home programs will ensure that patients enrolled in the program, including those who are dually eligible for Medicare and Medicaid will have access to their own health records. Any unauthorized access of any patient medical record is strictly prohibited.

iii. Description of the state's plans for continuing to gather and incorporate stakeholder feedback on an ongoing basis during implementation and throughout the demonstration, including how the State will inform beneficiaries about this demonstration. Discuss how information will be provided in languages other than English and in alternative formats for individuals with disabilities.

Personnel from the MO HealthNet Division and the Department of Mental Health have established a process for meaningful beneficiary input in which they will invite beneficiary, provider, consumer advocate and private payer representatives on the Steering Committee of the Missouri Medical Home Collaborative to review practice data submissions and analysis by the Missouri Foundation for Health, as well as the status of practice transformation activities in conjunction with the learning collaborative. The Steering Committee will meet every six months to review the performance of and provide feedback to the Health Home programs. Missouri will include at least one beneficiary who is dually eligible for Medicare and Medicaid as a member of the Steering Committee. A CMS representative will also be invited to join the Steering Committee.

Missouri is committed to providing enrollee materials that are accessible and understandable to the beneficiaries who will be enrolled in the plans, including those with disabilities, speech and vision limitations, and limited English proficiency. As such, Missouri will meet its obligation under the ADA to provide effective communication and auxiliary aids for people with disabilities**.** This demonstration project will benefit from Missouri Department of Social Services' (MO DSS') experience working as the state entity for Medicaid in Missouri. MO DSS has experience in producing materials that are understandable and accessible to Medicaid beneficiaries, and are Section 508 compliant. MO DSS is aware of the requirements that include methods of communicating with enrollees who do not speak English as a first language, accommodating enrollees with physical disabilities, different learning styles and capacities, and enrollees who are visually and hearing impaired. All MO DSS enrollees and potential enrollees are informed that information is available in alternative formats and how to access those formats. Currently, MO HealthNet's beneficiary website includes materials for Health Home participants in both English and Spanish. In-person and telephonic interpreter vendors, as well as written translation vendors, are provided. All entities currently designated as Health Homes are required to have deaf services available. American Sign Language (ASL) interpreters and Braille materials are provided. Notices include language clarifying that oral interpretation is available for all prevalent languages and how to access such services. Interpreters with Mental Health expertise will be provided when necessary and available. The process by which the State will inform beneficiaries (and their representatives) about this demonstration is described in Section D, ii above.

E. Financing and Payment

i. Description of proposed State-level payment reforms, including identification of the financial alignment model(s) that will be used.

In addition to existing fee-for-service payment for direct services, Missouri currently offers Health Home providers a per member per month (PMPM) clinical management fee to fund

Health Home functionalities that are not covered by any of the currently available Medicaid or Medicare funding mechanisms.

Additionally the state offers approved Health Homes performance incentive payments if there are cost savings as a result of the Health Home program. To avoid incentivizing clinically inappropriate reductions in service as a way to reduce costs, the amount of the incentive payment will be determined by the individual Health Home's performance on clinical process outcome indicators. In this manner, participating Health Homes are incentivized to reduce costs, but only while maintaining or improving the quality and clinical outcomes of the care provided. The shared savings incentive payments will be paid in each subsequent year based on the savings and performance realized in the prior year.

Through this demonstration project, Missouri seeks to partner with Medicare to create a similar shared saving arrangement such that if any savings accrue to Medicare as a result of the Health Home programs, then Medicare will share such savings with the Missouri, which in turn will share a portion of those savings with the Health Home providers.

ii. In either financial alignment model, describe how payments will be made to providers, including proposed payment types; financial incentives; risk sharing arrangements; etc.

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

Missouri pays approved Health Homes a clinical care management per member per month (PMPM) payment to cover the costs of staff primarily responsible for delivery of services not covered by other reimbursement (Primary Care Nurses, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), and Administrative Support staff) whose duties are not otherwise reimbursable by MO HealthNet. This reimbursement model is designed to only fund Health Home functionalities that are not covered by any of the currently available Medicaid or Medicare funding mechanisms. Nurse Care Manager and Behavioral Health Consultant (for the Primary Care Health Home program) or Primary Care Physician Consultant (for the CMHC Health Home program) duties often do not involve face-to-face interaction with Health Home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Missouri's Health Home model includes significant support for the leadership and administrative functions that are required to transform traditional Primary Care and CMHC service delivery systems to the new

data-driven, population-focused, person-centered Health Home requirements.

The criteria required for a Primary Care Health Home to receive a monthly PMPM payment is:

A. a dually eligible individual is identified as meeting Primary Care Health Home eligibility criteria on the state-run Health Home patient registry;
B. the beneficiary is enrolled as a Health Home member by the billing Health Home provider;
C. at a minimum the beneficiary has received care management monitoring for treatment gaps; or another Health Home service was provided and documented by a Health Home Director and/or a Nurse Care Manager; and,
D. the Health Home will report and thereby confirm that the minimal service required for the PMPM payment occurred on a monthly Health Home activity report.

The PMPM payment is $58.87 for the Primary Care Health Home program. Please see Appendix J for the structure of personnel and responsibilities within the Primary Care Health Home.

The criteria required for a CMHC Health Home to receive a monthly PMPM payment are the same as those for a Primary Care Health Home. However, the PMPM payment differs and is $78.74. Please see Appendix K for the structure of personnel and responsibilities within the CMHC Health Home.

The PMPM proposed does not cover the full training and technical assistance costs of implementing Health Homes in Missouri. Missouri Foundations, providers and state agencies are spending over $1,500,000 to fund expert consultation, technical assistance, learning collaboratives, and other training required for Section 2703 Health Home planning, development and implementation. The state is not seeking funding for these costs, but only the opportunity to share in any savings that are realized by the Medicare program as a result of the investment. In addition to sharing in the Medicare savings, Missouri requests the following:

- CMS provision of Medicare reports to Health Homes that could be used by Health Homes to inform their engagement of dually eligible beneficiaries served by Health Homes. Missouri specifically requests that the reports that are being produced for practices participating in the MAPCP demonstration also be made available to Missouri Health Homes.
- CMS provision of Medicare data files that can be used by the state for analysis and coordination of care.

F. Expected Outcomes

i. Description of the ability of the State to monitor, collect and track data on key metrics related to the model's quality and cost outcomes for the target population, including

beneficiary experience, access to care, utilization of services, etc., in order to ensure beneficiaries receive high quality care and for the purposes of the evaluation.

The ultimate goal of the Health Home project is to offer better, more coordinated care to beneficiaries in a way that improves quality and reduces costs. In order to evaluate Health Home performance and ensure that beneficiaries are, in fact, receiving high quality care, Missouri has implemented a quality process using select quality measures described below in Section F (ii) to assess quality process improvements and clinical outcomes. This evaluation process is designed to:

1. evaluate the Health Home model as a means to delivering accessible, high quality integrated care, and
2. ensure that the Health Homes shared savings incentive has not resulted in clinically inappropriate reductions in service as a way to reduce costs.

As described in response to the question that follows, Missouri has developed a comprehensive measurement set to assess Health Home performance at both the provider and aggregate program level. For registry-based, claims-based and audit-based measures, assessment will occur both at the individual practice level, and at the aggregate level for all participating Health Homes. For registry and claims-based measures, the State will track change over time to assess whether statistically significant improvement has been achieved. For registry-based measures for which national Medicaid and Medicare benchmark data are available comparisons will be made to regional and national benchmarks, even though such benchmarks are not specific to persons with chronic conditions. Missouri will collect and/or provide such data to CMS to inform program management and evaluation.

The Primary Care and CMHC Health Homes Work Groups, as well as the Steering Committee of the Missouri Medical Home Collaborative, will approach the Health Home transformation process for the participating providers as an ongoing quality improvement exercise. Using a combination of evaluation data, information from the learning collaborative Quality Improvement Advisor who will be reviewing regularly submitted practice narrative and data reports, and feedback provided to the Health Homes Work Groups and the Collaborative Steering Committee by practice and consumer advocate representatives, Missouri will assess what elements of its Health Home practice transformation strategy are working – and which are not. Critical attention will be paid to a) critical success factors, some of which have already been identified in the literature, and b) barriers to practice transformation.

Missouri agrees to provide CMS with a description of any changes to the State Plan that would affect Medicare-Medicaid enrollees during the three years of this demonstration program (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.) and of State supplemental payments to providers (e.g., disproportionate share hospitals (DSH)) during the

three-year period. A summary of relevant DSH payments are provided in Appendix L.

ii. List potential improvement targets for measures such as potentially avoidable hospitalizations, 30-day readmission rates, etc.

Primary Care Health Home Clinical Performance Measures:

Missouri has already begun using the measures listed below to assess the progress of the Primary Care Health Home program. The state will consider including metrics such as measures of the access and utilization of services that are specific to the dually eligible population enrolled in the Health Home programs. For example, the programs may measure the percentage of health home beneficiaries that access long-term support services, different HCBS waiver services, home health, and nursing homes and skilled nursing facilities.

The current complete measure specifications and benchmarks are provided in Appendix M.

Goal #1: Improve Health Outcomes for persons with Chronic Conditions:

- Reduce Ambulatory Care-Sensitive Condition Admissions
- Reduce Emergency Department Visits
- Reduce Hospital Readmission
- Increase Hospital Discharge Follow-up
- Reduce SNF utilization (days per 1,000 members per year)

Goal #2: Improve Behavioral Healthcare:

- Reduce Illicit Drug Use
- Reduce Excessive Alcohol Consumption
- Screen for Depression
- Screen for Substance Abuse

Goal #3: Increase Patient Empowerment and Self-Management:

- Patient Use of Personal Electronic Health Records (EHRs) or practice EMR patient portal
- Satisfaction with Services

Goal #4: Improve Coordination of Care:

- Increase Hospital Discharge Follow-up:
- Use of CyberAccess per member

Goal #5: Improve Preventive Care:

- Body Mass Index (BMI) Control
- Adult Weight Screening and Follow-Up

Goal #6: Improve Diabetes Care:

- Adult Diabetes Control
- Blood Pressure (BP) Management in Diabetes Patients
- Adherence to Prescription Medications for Persons with Diabetes

Goal #7: Improve Asthma Care:

- Adult Asthma Appropriate Use of Medication
- Adherence to Prescription Medications for Persons with Asthma

Goal #8: Improve Cardiovascular Disease (CVD) Care:

- Hypertension Control
- Coronary Artery Disease (CAD) Lipid Level Control
- Adherence to Prescription Medications for Persons with CVD.

CMHC Health Home Clinical Performance Measures:

Missouri has already begun using the measures listed below to assess the progress of the CMHC Health Home program. The complete measure specifications and benchmarks are provided in Appendix N.

Goal #1: Improve Health Outcomes for Persons with Mental Illness

- Reduce Ambulatory Care-Sensitive Condition Admissions.
- Reduce Emergency Department Visits
- Reduce Hospital Readmission
- Reduce Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers
- Increase Hospital Discharge Follow-up
- Reduce SNF utilization (days per 1,000 members per year)

Goal #2: Reduce Substance Abuse

- Reduce illicit drug use
- Reduce Excessive Alcohol Consumption

Goal #3: Increase Patient Empowerment and Self-Management:

- Patient Use of Personal Electronic Health Records (EHRs) or practice EMR patient portal

- Satisfaction with Services

Goal #4: Improve Coordination of Care:

- Increase Hospital Discharge Follow-up
- Use of CyberAccess per member

Goal #5: Improve Preventive Care:

- Body Mass Index (BMI) Control
- Metabolic Screening

Goal #6: Improve Diabetes Care:

- Adult Diabetes Control
- Metabolic Screening

Goal #7: Improve Asthma Care:

- Adult Asthma Appropriate Use of Medication
- Adherence to Prescription Medications for Persons with Asthma:

Goal #8: Improve Cardiovascular Disease (CVD) Care:

- Hypertension Control
- Coronary Artery Disease (CAD) Lipid Level Control
- Adherence to Prescription Medications for Persons with CVD
- Statin Use for Persons with CAD

iii. Discussion of the expected impact of the proposed demonstration on Medicare and Medicaid costs

Through Missouri's recently implemented Health Home programs, Missouri plans to accomplish the goal of improved service delivery and quality of care by improving the alignment between payment incentives and clinical outcomes. Missouri expects its Health Home programs to result in an entirely different beneficiary experience for Health Home program participants, inclusive of those dually eligible for Medicare and Medicaid, as well as to significantly impact service utilization patterns across the board but particularly including emergency department, inpatient hospital and skilled nursing facility care.

Drawing upon Missouri Medicaid's experience with its Chronic Care Improvement Program (CCIP), a disease management program implemented in 2007, Missouri expects to realize savings through this Medicare and Medicaid demonstration, especially considering the added

coordination of all Medicare and Medicaid services. Missouri anticipates that there could be short-term increases in costs associated with addressing unmet beneficiary needs. However, savings associated with reductions in SNF utilization, potentially avoidable hospitalizations and readmissions, and non-urgent use of emergency department services would be expected to accrue thereafter. Missouri's CCIP program generated savings during its second year. Specifically, savings were driven by reductions in inpatient admission rates and more significant reductions in emergency room visit rates.

The outcomes observed in CCIP have shown that coordinated care management and investments in primary and preventive care services can produce savings. Thus, under this proposed demonstration Missouri expects to see an increased use of primary care practitioners, increased use of behavioral health services, increased use of home visits, increased monitoring of medication adherence, increased focus on post-hospital follow-up care and increased family/caregiver support. Missouri also expects to see decreased skilled nursing facility admissions, reduced lengths of stay for skilled nursing facility episodes, reduced hospital readmissions, reduced emergency room visits, a reduction in duplicative or unnecessary tests and more appropriate use of specialty services.

Missouri will also utilize its managed pharmacy services and tools to improve medication adherence and ensure proper medication therapy management (MTM). It is expected that increased medication adherence will result in increased pharmacy utilization with medical cost offsets from reduced emergency room visits and reduced inpatient hospital admissions. However, it is also expected that MTM will reduce certain prescription utilization ensuring the most effective pharmacy protocol and eliminating unnecessary prescriptions.

Prior Program Experience

The State of Missouri has prior program experience within its fee-for-service Medicaid program to draw on for outcomes and financial results. This program experience is highlighted below.

Chronic Care Improvement Program

In 2007 the State of Missouri designed and implemented a disease management program known as the Chronic Care Improvement Program (CCIP). The CCIP targeted individuals with one or more of the following conditions:

- Asthma
- At-Risk Cardiac (ATC), included cardiovascular disease, hypertension without heart failure and hyperlipidemia
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes

- Gastro-esophageal Reflux Disease (GERD)
- Heart Failure (HF)
- Sickle Cell Anemia

The purpose of the CCIP was to provide continuity of care and to manage chronic conditions for this vulnerable population. Mercer conducted a financial savings analysis of this program based on actual experience using a control group methodology and found the following in the second year of the program:

- Excluding the dually eligible, the calendar year 2008 return on investment (ROI) was 1.6:1 or a 2.0% net savings ($16.7 million)
- ROI for Asthma and Diabetes were 1.6:1 and 3.0:1, respectively

Savings were driven by an overall reduction in trend compared to the control group as a result of significant reductions in ED utilization and a reduction in inpatient hospital admissions. This analysis was also conducted inclusive of the dual eligibles with overall results closer to breakeven. However, the analysis only included Medicaid costs and any savings generated as a result of reductions in inpatient hospital and ED utilization would not have been captured in the analysis. With the ability to capture Medicaid and Medicare costs, we would expect to see overall savings from the CCIP including the dually eligible.

In addition, specific to the CMHC population enrolled in CCIP, the State experienced actual year over year savings in pharmacy and hospital inpatient services.

The Behavioral Pharmacy Management™ Program

In 2003, the State of Missouri launched The Behavioral Pharmacy Management™ (BPM) program serviced by Care Management Technologies (CMT). The BPM program from CMT is designed to optimize therapeutic outcomes of pharmacological treatment, ensure appropriate use of psychotropic medications, reduce the risk of adverse events and improve the cost-effectiveness and quality of treatment received by patients with mental illness. CMT applies proprietary algorithms in review of pharmacy claims data for the purposes of evaluating the quality and appropriateness of the prescription and administration of psychiatric and related medications to State of Missouri Medicaid members and identifies patients at risk due to inappropriate use of medications. When CMT identifies a pattern of practice inconsistent with Quality Indicators™, relating to the treatment of an individual, CMT communicates with the treatment provider to alert the provider to concerns such as polypharmacy and dosages outside therapeutic ranges. The health care provider remains responsible for treatment decisions. CMT evaluated the results of the BPM program from January 2007 to December 2008. The methodology for calculating cost avoidance compared actual costs following the mailed

intervention to the actual costs of individuals who have not yet received the intervention and are continuously eligible for pharmacy benefits during the evaluation period (excluding the dually eligible). The actual data from the comparison group indicates how, in the absence of the intervention, costs would increase or decrease. When compared to the costs for the comparison group not yet intervened on, any cost decreases following the intervention suggest that pharmacy costs were avoided. Overall, the BPM program yielded cost avoidance figures of $48 and $68 PMPM for adults and children, respectively, and a total cost avoidance of approximately $35 million during the evaluation period.

Estimated Savings As previously discussed, dually eligible patients have high costs in both the Medicare program ($639 PMPM) and the Medicaid program ($485 PMPM). Missouri's Health Home programs are designed to provide optimal care management across the array of services a dually eligible individual may need to allow for better coordinated care and support to the patient, resulting in higher quality and reduction of unnecessary or avoidable health care costs. Specifically, the Health Home programs are likely to reduce unnecessary or avoidable ED visits as well as avoidable hospitalizations, readmissions and use of skilled nursing facilities. As Medicare is the primary payer for these services for dually eligible members, the majority of program savings are likely to accrue to the Medicare program.

Financial Impact Analysis of the Primary Care Health Homes Program on Medicaid Spending

Missouri has conducted financial impact analysis to the Medicaid program of the Health Home program as shown in Table Two below. Because the individuals described in this demonstration are dually eligible and these services are provided by Medicare, the savings are likely to be higher as Medicare typically reimburses providers at a higher rate than Medicaid.

Table Two: Estimated net Medicaid savings from the Primary Care Health Home due to reduced utilization of Inpatient and ED care

	Assumed Reduction in Utilization	Average Admission	Medicaid Cost Per Day or ED Visit	Estimated Savings based on assumption of utilization without Health Home	Estimated Replacement Cost Factor	Net Estimated Savings
Inpatient Hospital	15.4%	3 days	$1672.62	$19.6 million	6%	$18.4 million

ED	23.5%	n/a	$343.37	$2.0 million		$2.05 million

Based on the experience of the MO HealthNet Division with the Chronic Care Improvement Program, the state estimates that the Section 2703 Health Home program for primary care sites will yield Medicaid cost savings over the year prior to the Health Home program (Year 0). These savings rates are net of the costs of the Health Home program, including the per-member, per-month payment to primary care providers enrolled as Health Home sites.

In calendar year 2010, total Medicaid health care costs for participants with at least two chronic conditions as listed in Section 2703 of the Affordable Care Act averaged $10,777.81 per-member, per-year (PMPY). The state estimates that the Section 2703 Health Home program for Primary Care Health Homes will yield the following rates of Medicaid cost savings over the year prior to the Health Home program (Year 0):

- Year 1 = 1.89% savings over Year 0;
- Year 2 = 3.78% savings over Year 0, and
- Year 3 = 5.67% savings over Year 0.

Based on prior year claim data, the state projects the Primary Care Health Home population to be 25,372 participants, inclusive of those dually eligible for Medicare and Medicaid.

Year 1, Federal Fiscal Year 2012:

Average PMPY cost =	$10,777.81		
Savings rate =	1.89%		
PMPY savings =	$203.70		
Health Home Population =	25,372		
Estimated Medicaid cost savings for Health Home patients =	$5,168,292		
For the portion of FFY 2012 in which the SPA is effective (January - Sept. 2012) =	75%		
Estimated Medicaid cost savings for Primary Care Health Home patients =	$3,876,219	x 90% FMAP =	**$3,488,597**

Year 2, Federal Fiscal Year 2013:

Average PMPY cost =	$10,777.81

Savings rate =	3.78%		
PMPY savings =	$ 407.40		
Health Home Population =	25,372		
Estimated Medicaid cost savings for Health Home patients =	$5,168,292		
Estimated Medicaid cost savings for Primary Care Health Home patients =	10,336,584	x 90% FMAP =	$9,302,925

For the Primary Care Health Home program, Missouri will annually perform an assessment of cost savings using a control group comparison of Medicaid primary care practices serving clinically similar populations, but not participating as Health Homes. Control group practices will be similar to participating practices to the extent that it is feasible to do so. They will be identified by practice type (e.g., FQHC), geographic region, and number of Medicaid beneficiaries with serious mental illness or two or more chronic conditions. Savings calculations for the providers will be risk-adjusted, truncated claims of high-cost outliers annually exceeding 3 standard deviations of the mean, and will net out the value of supplemental payments made to the participating sites during the measurement period.

Financial Impact Analysis for the CMHC Health Home Program on Medicaid Spending

The Missouri DMH and its statewide CMHC providers have been engaged in care coordination and disease management for general medical conditions in persons with severe mental illness (SMI) since 2004. As a result, Missouri is able to model anticipated Medicaid savings in the §2703 Health Homes for Chronic Conditions when provided by CMHCs based on actual historic savings in previous projects.

Analysis #1 – Cost Savings for New Patients Just Entering CMHC Services: Total Medicaid costs were examined pre- and post-enrollment in CMHC management services. The persons selected were 636 patients who were newly enrolled in Missouri Medicaid's CMHC program. Patients were included if they had nine months of Medicaid claims in each of the two preceding years, a diagnosis of severe mental illness, a history of psychiatric hospitalization or multiple ER visits, and functional limitations as a result of their mental illness. The exact enrollment date for CMHC services varied from client to client, which minimized the impact of bias due to changes in the healthcare delivery system at specific points in time or over the study period. Average total monthly Medicaid costs were calculated for the month of CMHC enrollment, the 24 months prior to enrollment, and the 24 months after enrollment for each client. Linear regression trend lines were then calculated on those pre-CMHC service and post-CMHC service cost data.

The total per member per month (PMPM) health care utilization for the 12 month prior to the

implementation of the community mental health case management program was approximately $750 PMPM these costs rose steadily to $1,750 PMPM in the month prior to enrollment into the program, following a brief spike at the initiation of services, after approximately one month of being enrolled, the PMPM costs fell to $1,250. Please see Appendix S for a graph depicting the change in per member per month costs before and after the implementation of the program.

Analysis #2 – Cost Savings of persons already receiving CMHC services and then had a health home model implemented that is similar to the proposed §2703 Health Home model.
In this project, Missouri Medicaid contracted with APS to implement a health home model (*Chronic Care Improvement Program "CCIP"*) for more than 86,000 patients statewide in both primary care and CMHC-based health homes, including dual eligibles. There were 6,500 clients in CMHCs that were eligible for APS CCIP. Due to funding limitations, less than 20% of CMHC patients at the time were actually enrolled in the APS program. CMHCs provided approximately 8% of the overall health homes in this project. The cost of the CMHC services was included in the pre/post period costs.

It is important to note that the cohorts used in both of the preceding analyses included dual eligibles in the intervention groups, however the analyses did not include the Medicare costs. If the analyses had included Medicare costs, it is believed that there would have been additional proportional savings in these costs as well. Missouri did not explicitly flag which patients were dual eligibles or attempt to model how their inclusion impacted the overall savings. However, approximately 34% of the clients and service will be dual eligible at any given time in Missouri's CMHC programs. Taken together for the § 2703 CMHC Health Home, the state conservatively estimated including the cost of the CMHC Health Home intervention:

- Year 1 will yield 3% savings over year 0 total costs trended forward
- Year 2 will yield 6% savings over year 0 total costs trended forward
- Year 3 will yield 10% savings over year 0 total costs trended forward

SFY2010 Total Medicaid Healthcare Costs for CMHC SMI patients were:

Adults:	$1,616 PMPM
Children:	$1,070 PMPM
Age Weighted Average:	$1,471 PMPM

Estimated savings off-trend including the cost of the CMHC Health Home program:

- Year 1: $ 44 PMPM
- Year 2: $88 PMPM
- Year 3: $147 PMPM

For the CMHC Health Home program, Missouri will annually perform an assessment of cost

savings using a pre/post-period comparison as all CMHCs participate in the Health Home program, resulting in a lack of a control group population for the CMHC Health Home program. Historical trend will be developed from populations prior to the CMHC Health Home implementation using the same eligibility criteria as is now in place for the CMHC Health Home program. This historical trend will be applied to the calendar year 2010 baseline from the same population to project expected costs to the performance period to compare actual costs of the CMHC Health Home program. Total savings will be calculated net of the CMHC Health Home program costs. Shared savings among the provider groups will be calculated consistently with the process described for the Primary Care Health Home program.

CMS Shared Savings Calculation

Missouri will work with its actuaries to request, analyze and refine the integrated Medicare and Medicaid data sets necessary to develop detailed three-year financial projections and savings estimates. Missouri looks forward to working in collaboration with CMS in establishing a methodology for shared Medicare savings produced through the Health Home programs and enhancing the quality and efficiency of services provided to these beneficiaries. As part of these ongoing discussions with CMS, Missouri respectfully requests the consideration of the following in projecting estimated savings and in establishing a shared savings methodology:

- A baseline period for the Health Home programs of calendar year 2010 to reflect programs already in place to manage care for the dually eligible population and implementation steps related to Health Homes during calendar year 2011
- Separate shared savings methodologies for the CMHC and Primary Care Health Home populations
    - A control group methodology for the Primary Care Health Home population to establish trend from the baseline period as comparison to the performance period
    - A pre/post methodology for the CMHC Health Home population to established trend from the baseline period as comparison to the performance period (all CMHCs participate in the Health Home program and no control group is available)
- Inclusion of the Medicare Part D costs in the savings methodology to reflect the state's management efforts related to these services
- Inclusion of only short-term SNF stays as the institutionalized population is not eligible for the Health Home programs

These considerations mirror the requests made to CMS in negotiation of the Medicaid only

shared savings methodology. It is the state's intent to have consistent calculations conducted on all populations in the Health Home programs to the extent possible.

G. Infrastructure and Implementation

i. Description of State infrastructure/capacity to implement and oversee the proposed demonstration. States should address the following: staffing, expected use of contractors, and capacity to receive and analyze Medicare data as part of a linked database.

Because of the implementation of the Health Home program during the first quarter of CY 2012, Missouri has already developed the necessary infrastructure to implement and oversee the program's operations. In brief, the state's Medicaid agency, MO HealthNet, under the leadership of Ian McCaslin, MD is the entity responsible for overseeing the success of both the Primary Care Health Home program and the CMHC Health Home program. Samar Muzaffar, MD MPH and Joe Parks, MD are the co-directors of the Health Home program with Dr. Muzaffar being primarily responsible for overseeing the Primary Care Health Home program, and Dr. Parks being primarily responsible for overseeing the CMHC Health Home program. Mark Stringer, the Director of the Division of Comprehensive Services for the Department of Mental Health is also intimately involved in the leadership of the CMHC Health Home program. Dr. Muzaffar has eight staffers and Dr. Parks has seven staffers contributing to their respective programs and share three additional staff between them. Appendix O provides an organizational chart that details the state's staffing infrastructure for ongoing Health Home program management. In addition, the state is utilizing contractors for technical support, including Mercer Government Human Services Consulting (actuarial services) and Bailit Health Purchasing (technical content support).

The fact that both Health Home programs have been implemented and are fully operational demonstrate that Missouri has the necessary infrastructure and capacity to implement and oversee the proposed model. If the demonstration project is approved, Missouri will dedicate the necessary staffing resources and potentially use appropriate contractors to receive and analyze Medicare data as part of a linked database.

ii. Initial description of the overall implementation strategy and anticipated timeline, including the activities associated with building the infrastructure necessary to implement the proposed demonstration. States should identify key tasks, milestones, and responsible parties, etc.

The Health Home programs have already been implemented. The state implemented the CMHC Health Home program on January 1, 2012 and the Primary Care Health Home program was implemented in a phased process between January 1, 2012 and April 1, 2012. Please see Appendix P for a detailed timeline for additional administrative tasks that will be necessary

under this demonstration project.

H. Feasibility and Sustainability

i. Identification of potential barriers/challenges and/or future State actions that could impact the state's ability to successfully implement the proposal and strategies for addressing them.

The Health Home programs have already been implemented. The state implemented the CMHC Health Home program on January 1, 2012 and the Primary Care Health Home program was implemented in a phased process between January 1, 2012 and April 1, 2012. Therefore there are not any barriers to the implementation of the programs. The state's goal is to continue the health home program beyond the eight (8) quarters of the demonstration project. However, it still remains to be seen whether the programs will succeed and the Health Homes will be able realize the savings that are anticipated under the model. In order to support the transformation process and maximize the potential for success, the state has offered the Health Homes numerous opportunities for support, including through participation in the learning collaborative described elsewhere.

The state anticipates that it will need to negotiate the terms of share savings arrangement with CMS prior to sharing with Health Homes any Medicare savings that the Health Homes generate.

ii. Description of any remaining statutory and/or regulatory changes needed within the State in order to move forward with implementation.

Since the Health Home programs have already been implemented, the state does not anticipate making any changes to the state statute or regulation as a result of this demonstration project.

iii. Description of any new State funding commitments or contracting processes necessary before full implementation can begin.

The state anticipates that it will need to negotiate the terms of the shared savings arrangement with CMS prior to sharing with Health Homes any Medicare savings that the Health Homes generate.

iv. Discussion of the scalability of the proposed model and its replicability in other settings/States.

While Missouri benefits from strong support for the program and experience in practice transformation, Missouri has relied upon the Chronic Care Model, which is a nationally recognized model of care. There are currently 24 Primary Care Health Homes and 29 CMHC Health Homes operating in the state of Missouri. If the Health Homes demonstrate strong clinical performance and generate cost savings, it is expected that other sites and potentially

other states would be interested in adopting this model.

The Missouri Health Home model will be of particular interest to states with large fee-for-service programs, and also to states that are interested in care transformation involving CMHCs. Finally, the Missouri Health Home program is one of the few Medicaid-organized shared savings programs in the country. New payment arrangements are of particular interest nationally. All of what Missouri is doing is potentially replicable.

Already some replication work is under way. For example, the Center for Medical Home Improvement's Education, Translation and Stakeholder (ETS) Core, working with AHRQ, CMS, the National Association of State Mental Health Program Directors (NASMHPD) and others will lead the effort to translate effective practices in the Missouri CMHC- Health Home program to other settings. Missouri will develop and disseminate a Resource Guide on implementing health homes in CMHCs. Missouri will also pursue publishing the results in the academic medical peer reviewed literature. This research will advance the emerging literature related to the integration of medical and behavioral health care.

v. Letters of support from Governor's Office and any other relevant governmental and non- governmental stakeholders as appropriate, such as Congressional delegation; other relevant State agencies (Will not count against page limit.)

See letters of support in Appendix S.

I. Additional Documentation (as applicable)

The state will provide the following appendices to this proposal:

A. Community Mental Health Centers participating in the CMHC Health Home program
B. Organizations participating in the Primary Care Health Home program
C. Core Competencies of the Health Home
D. Public Meeting #1: The MO HealthNet Oversight Committee: April 10, 2012 Agenda
E. Public Meeting #2: Missouri Mental Health Commission; April 12, 2012 Meeting Summary
F. Summary of public comments received by Missouri
G. Attendees from the initial November 2010 meeting of the Missouri Medical Home Collaborative (MMHC) Council
H. Missouri Medical Home Collaborative Steering Committee membership
I. Summary of Other Health Home Stakeholder Engagement Activities
J. Primary Care Health Home Structure and Staffing
K. Community Mental Health Center Health Home Structure and Staffing
L. Summary of DSH payments per CMS conversation

M. Primary Care Health Home Performance Measures
N. CMHC Health Home Clinical Performance Measures:
O. Organizational chart that describes the state's staffing infrastructure for ongoing Health Home program management
P. The Implementation Timeline for the Health Home Programs
Q. The CMHC State Plan Amendment (effective January 1, 2012)
R. The Primary Care State Plan Amendment (effective January 1, 2012)
S. Letters of Support
T. A graph depicting the per member per month savings resulting from the implementation of the community mental health case management program.

J. Interaction with Other HHS/CMS Initiatives

The Missouri Health Home Program has incorporated concepts and best practices from the Million Hearts Campaign and the Partnership for Patients to support the Health Home providers. For example, on May 24, 2012, select Health Homes will participate in a training session sponsored by the Million Hearts Campaign on the "ABCs of Million Hearts." This session will provide information to participating health home providers on the use of aspirin for high-risk patients, blood pressure control, cholesterol management, and smoking cessation.

With regard to the Partnership for Patients, the Missouri Foundation for Health, the state is utilizing CSI Solutions (CSI) to run the learning collaboratives for both of the Health Home programs. CSI is working with Primaris which is involved in the Partnership for Patients and together they bring tools from the Partnership for Patients initiative to the learning collaboratives to support the Health Home providers in the areas of care transitions and reducing hospital readmissions. CSI and Primaris are working to sponsor speakers for the Health Home providers and plan to broker several regional meetings among area hospitals and the Health Homes to further facilitate the integration of the Health Home activities and the Partnership for Patients' care transitions activities. Missouri does not currently have any plans to incorporate and/or build upon the HHS Action plan to reduce Racial and Ethnic Health Disparities as part of the Health Homes demonstration project.

Appendix A

List of Community Mental Health Centers participating in the CMHC Health Home program:

Adapt of Missouri, Inc.
BJC Behavioral Health St. Louis
BJC Behavioral Health Farmington
Bootheel Counseling Services
Burrell Behavioral Health SA10
Burrell Behavioral Health - SA 12
Clark Community Mental Health Center
Community Counseling Center
Comprehensive Health Systems
Comprehensive Mental Health Services
Community Treatment, Inc.
Crider Health Center, Inc.
East Central Missouri Behavioral Health
Family Counseling Center, Inc.
Family Guidance Center
Hopewell Center
Independence Center
Mark Twain
New Horizons
North Central Missouri MHC
Ozark Center
Ozark Medical Center
Pathways Community Behavioral Healthcare
Places For People
Preferred Family Healthcare, Inc.
ReDiscover
Swope Health Services
Tri-County Mental Health Services
Truman Medical Center Behavioral Health

Appendix B:

List of all of the organizations participating in the Primary Care Health Home program

Name of Organization	Provider Type
Betty Jean Kerr People's Health Centers	FQHC
Citizens Memorial Healthcare	Hosp Based RHCs
Community Health Center of Central Missouri	FQHC
Fitzgibbon Hospital	Hosp Based RHC
Access Family Care	FQHC
Crider Health Center	FQHC
Family Care Health Centers	FQHC
Family Health Center of Boone County	FQHC
Fordland Clinic	FQHC
Grace Hill Health Centers	FQHC
Jordan Valley Community Health Center	FQHC
Katy Trail Community Health	FQHC
Missouri Highlands Health Care	FQHC
Myrtle Hilliard Davis Comprehensive Health Centers	FQHC
Northwest Health Services	FQHC
Southeast Missouri Health Network	FQHC
Swope Health Services	FQHC
Truman Medical Centers	Hosp Based Clinics
University of Missouri Health System	Hosp Based Clinics
CoxHealth	Hosp Based Clinic
Northeast Missouri Health Council	FQHC
Samuel U. Rodgers Health Center	FQHC
Skaggs Regional Medical Center	Hosp Based RHCs
Southern Missouri Community Health Center	FQHC

Appendix C

Core Competencies of the Health Home

Comprehensive Care Management. Comprehensive care management services are provided by the Nurse Care Manager, Primary Care Physician Consultant (for the CMHC Health Home program), with the participation of other team members and the support of Health Home Administrative Support staff and the Health Home Director. The services involve:

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

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

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

services also assist clients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Health Home Director, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), and Nurse Care Manager each participate in providing Health Promotion activities.

3. **Comprehensive Transitional Care (including appropriate follow-up from inpatient to other settings).** In conducting comprehensive transitional care, a member of the care team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The care team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing beneficiary and family member ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management. The Health Home Director, Primary Care Physician Consultant (for the CMHC Health Home program) or Behavioral Health Consultant (for the Primary Care Health Home program), Nurse Care Manager, and Care Coordinator all participate in providing Comprehensive Transitional Care activities, including, whenever possible, participating in discharge planning.
4. **Individual and Family Support Services (including authorized representatives)**. Individual and family support services activities include, but are not limited to: advocating for individuals and families, and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to help support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus is to increase health literacy, ability to self-manage care and to facilitate participation in the ongoing revision of their care/treatment plan. For individuals with developmental disabilities (DD), the care team will refer to and coordinate with the approved DD case management entity for services more directly related to habilitation services and for services more directly related a particular healthcare condition. Nurse Care Managers and Care Coordinators will provide this service.

5. **Referral to Community and Social Support Services.** Referral to community and social support services, including long-term services and supports, involves providing assistance for beneficiaries to obtain and maintain eligibility for health care, disability benefits, housing, personal need and legal services, as examples. For individuals with DD, the care team will refer to and coordinate with the approved DD case management entity for this service. The Nurse Care Manager and Administrative Support staff

and/or Care Coordinator will provide this service.

Appendix D:

Public Meeting #1: The MO HealthNet Oversight Committee:

April 10, 2012 Agenda

MO HEALTHNET OVERSIGHT COMMITTEE

April 10, 2012

TENTATIVE AGENDA

James C. Kirkpatrick State Information Center

600 West Main Street

Jefferson City, MO

12:00 – 12:15	Welcome/Introductions/Minutes	Corinne Walentik, MD, MPH, Chair Tim McBride, Ph.D, Vice Chair
12:15 – 12:20	Director's Update	Ian McCaslin, MD, MHD
12:20 – 12:30	MO HealthNet Enrollment by Eligibility Category	Emily Rowe, FSD
12:30 – 1:15	Spenddown Documentation	Alyson Campbell, FSD
1:15 – 2:00	Non-emergency medical transportation	Marga Hoelscher, MHD Theresa Valdes, MHD
2:00 – 2:15	Break	

2:15 – 3:00	New Opportunities:	
	Strong Start for Mothers and Newborns	Paul Stuve, MHD
	Initiative to Reduce Avoidable Hospitalizations	
	Among Nursing Facility Residents	Ian McCaslin, MD, MHD
	Provider Preventable Conditions	Samar Muzaffar, MD, MHD
3:00 – 3:15	Emergency Psychiatric Demonstration	Joseph Parks, MD, DMH
3:15 – 3:30	Health Homes / Shared Savings Update	Samar Muzaffar, MD, MHD
3:30 – 4:00	Open Public Comment	
4:00	Adjourn	

Appendix E:

Public Meeting #2: **MISSOURI MENTAL HEALTH COMMISSION**

April 12, 2012 Meeting Summary

Telepresence Meeting
Jefferson City, Truman Office Building-Room 510
Kansas City, Fletcher Daniel Building-Room 503
St Louis, Wainwright Building-Room 923
Joplin, Joplin Regional Office, Sneddon Room

PRESENT

- Dennis Tesreau
- Kathy Carter
- David Vlach, M.D.
- Neva Thurston
- Gary Duncan
- Steve Roling

ABSENT

- No one

STAFF

- Keith Schafer, Department Director
- Jan Heckemeyer, DMH Deputy Director
- Monica Hoy, Director's Office
- Heather Eisterhold, Director's Office
- Bob Bax, Legislative/Public Affairs
- James Jackson, Human Resources
- Benton Goon, Joplin Recovery
- Donna Siebeneck, Admin
- Steve Reeves, Divisions of ADA/CPS
- Laurie Epple, Divisions of ADA/CPS
- Nora Bock, Divisions of ADA/CPS
- Judy Finnegan, Children's Office
- Brent McGinty, DMH Admin Director
- Lynne Fulks, DMH Budget and Finance
- Vicki McCarrell, Division of DD
- April Maxwell, Division of DD
- Rikki Wright, General Counsel
- Cathy Welch, Director's Office
- Bernie Simons, Division of DD
- Joe Parks, Clinical Director's Office

- Virginia Selleck, Division of CPS
- Debra Walker, Legislative/Public Affairs
- Mark Stringer, Division of ADA/CPS
- Leigh Gibson, Constituent Services
- VA Rowe-Pearson, OA, ITSD

GUESTS

- Vickie Epple, Division of ADA and CPS
- Greg Kramer, Life Skills
- Betty Farley, MO P & A
- Melanie Highland, OA Budget and Planning
- Deb Miller, MACDDS
- Matt Ferguson, Director, Joplin Regional Office
- Denise Norbury, REO CPS and ADA
- Janet Manus, Center for Behavioral Medicine

TOPIC/ ISSUE	DISCUSSION
CALL TO ORDER/ INTRODUCTIONS APPROVAL OF MINUTES OPEN DISCUSSION	• Kathy Carter, Secretary called the Missouri Mental Health Commission Meeting to order at 10:05 a.m. on April 12, 2012. The meeting was held by Telepresence at the following locations: Jefferson City, Truman Office Building-Room 510; Kansas City, Fletcher Daniel Building-Room 503; St Louis, Wainwright Building-Room 923; Joplin, Joplin Regional Office, Sneddon Room • Introductions were made. • Steve Roling made a motion to approve the minutes of the March 8, 2012 Mental Health Commission Meeting. David Vlach seconded the motion and the minutes were approved with minor revisions. • Neva commented on the successful first annual DD Conference that was held on March 15th and 16th. • Monica Hoy reminded Commissioners to submit their Personal Disclosure Report to the Ethics Commission by May 1, 2012. • The Spring Training Institute will be held on May 31 and June 1. • Monica Hoy reminded the Commissioners about the May 3rd Triumph through Tragedy Dinner in Joplin. • The second quarter Performance Measures update is usually held at the May Commission meeting. However since the commission will be in Joplin, it is difficult to ask division staff to attend. The Commissioners have agreed to combine the 2nd and 3rd quarter Performance Measures at the August Commission meeting.
LEGISLATIVE UPDATE	Bob Bax discussed and distributed the legislative update. Handout is located at http://dmh.mo.gov/about/diroffice/commission/2012MeetingSchedule.htm
BUDGET DISCUSSIO N 2013 UPDATE	Lynne Fulks and Brent McGinty discussed and distributed the budget update. Handout is located at http://dmh.mo.gov/about/diroffice/commission/2012MeetingSchedule.htm

TOPIC/ ISSUE	DISCUSSION
BUDGET DISCUSSIO N 2014	Keith Schafer, Bernie Simons and Mark Stringer discussed potential budget ideas regarding the 2014 Budget. More detail will be provided at the July retreat.
HCH UPDATES, NEW INITIATIVES MEDICARE/ MEDICAID DUAL ELIGIBLE'S CARE COORDINATION AND SHARED SAVINGS PAYMENT	Joe Parks updated the Commission on two things: where we are with the health home initiative and the CMHC's homes in particular and give you an initial briefing on our next proposal that we will be sending into CMS, which is to have them give us a shared savings payment based on our reduction in cost in dual eligible expenditures for Medicare. Thirty four percent of people in CMHC health homes and approximately 25% of people in primary care health homes are dual eligibles. For those people Medicare pays the bulk of the hospital, the pharmacy, and the outpatient services. Dr. Parks provided a summary of the health homes project. This is a health home for chronic conditions for persons in Medicaid. It targets people with either a serious mental illness or two chronic conditions and allows the state to collect 90/10 match to pay for care coordination and disease management services for this subpopulation of people who are much sicker than most. It is an outgrowth and modification of what has been going on Nationally referred to as person centered medical homes. The major difference being that for person centered medical homes that are built mostly out of a commercial population perspective it is usually a small per member per month fee of around $3 - $9 that is paid to all covered lives in a practice. The difference on health homes for chronic conditions is it does not give the opportunity to give a disease management care coordination payment for everybody in Medicaid. It targets the payment at people with multiple chronic conditions. So you pay a higher per member per month for a smaller much sicker more targeted population. This became available July 2011. We were the first state to get approval for both primary care health homes and for community mental health center health homes nationally. To date there are only two other states that have been approved (Rhode Island and New York). We received approval for the CMHC plan in October 2011 and primary care plan in late November and launched both of them in January 2012. We have auto enrolled between 18,000 and 19,000 people that were identified as being eligible with a chronic condition. All of whom cost more than $11,000 annually in a previous year were auto enrolled in our CMHC health homes. On the primary care side we did staggered auto enrollment starting in January and ending on April 1 at about 27 different primary care practices state wide, constituting all of the FQHCs and about half a dozen other primary care clinics primarily affiliated with safety net hospitals. They auto enrolled approximately 20,000 people. Both of the health home models focus on integrating behavioral healthcare with primary healthcare. Both of the models provide funding for a nurse care manager for every 250 people enrolled. They provide funding for a care coordinator for every 500 people enrolled. On the primary care side they provide for a behavioral health consultant, and a mental health professional that assists with identifying and addressing

TOPIC/ ISSUE	DISCUSSION
	behavioral health conditions that come to primary care. On the CMHC side they provide funding for a modest amount of primary care physician consultant time, not to provide primary care, but to guide the care coordination and disease management efforts being done by the CMHCs. We are National Leaders in doing this work. It is an outgrowth of our outreach to chronic care DM3700 and an outgrowth to our earlier work of ACA Mo HealthNet chronic care improvement program. In each of these previous initiatives the CCIP program and the DM3700 we have been successful on the CMHC side of saving about $300 per member per month starting about 6 months in. We are able to achieve savings because we have very sick people. The average annual cost of medical services for people in the CMHC health home in the year prior to enrollment was $26,000. We booked savings both based on the enhanced match revenue and also on what we believe is a proven track record of expectable savings we will achieve from reducing polypharmacy, reducing emergency room use, reducing hospital use and getting care more concentrated within a smaller book of consistent providers instead of bouncing. The advantage of this initiative besides the obvious of improving care and saving money is that it has been transformational both with our relationship with MoHealthNet, as well as transformational for our providers. Our CMHCs are much more deeply involved with the FQHCs and other primary care practices statewide. We just ended with the open enrollment start up phase, we are now entering the transformational phase on how they view their role and how they do their staff work. We have added nurse care mangers on the treatment teams. Our most immediate item we are working on this month is that the nurses we have hired have primarily been clinic and hospital nurses. We are in the process of having a long dialogue with them about thinking about themselves as public health nurses, doing population management. We are putting in a proposal to CMS to measure the savings they get on the dual eligibles. About 34% of the people are dual eligibles and have the bulk of their benefit paid for by Medicare. CMS is open to dual coordination proposals and shared savings agreement and we are about to submit a proposal. I cannot tell you the amount of the savings, we are in the process of projecting them through MESER. We anticipate they will be substantial, as I said these people are costing $26,000 per year, it is 34% of them we are saving about $300 per member per month and we think the service costs us around $80 per member per month, so there should be a substantial amount saved to split with CMS. They require that we announce this and seek feedback at a public meeting. The key points are: 1) The dual eligibles involved have already been informed of the new HH services and have been receiving them since January 1; 2) This new proposal will not change any of the benefits paid under Medicare prior to January 1; 3) This new proposal will not change the Medicare provider panel or rates that existed prior to January 1.

TOPIC/ ISSUE	DISCUSSION
	Please provide any feedback. Question: What happens if the ACA goes down? Could this still survive? Answer: We would probably use the same continuance plan that we have for sustainability after the first eight quarters. We actually put up enough funds to make our usual 35/65 match and the difference between 35/65 and 10/90 is going to budget savings for two years. We believe much of what we are paying for as a health home PMPM could be paid for either through target case management or a Medicaid administrative payment to providers. We believe it is likely that even if it goes down they will at least let the current projects complete rather than stop everything.
PUBLIC COMMENT	No public comment.
DIVISION AND SECTION UPDATES	**Division of Alcohol and Drug Abuse** Nora Bock provided an update on the Division of Alcohol and Drug Abuse. • Nora updated the commission on the Vivitrol project with the City of St Louis Adult Felony Drug Court with Commissioner James Sullivan. Individuals accepted into the St Louis Adult Felony Drug Court are given the option of utilizing Vivitrol as part of their substance abuse treatment. To date 5 clients have received their first injection while they were confined in the City Justice Center. Commissioner James Sullivan is holding his first Medication Assisted Treatment Docket with those clients today, April 12. • On March 15, a proposal was submitted to help fund a two year study involving the St Louis Adult Drug Court. The St Louis project is serving as a precursor to the proposal we hope to receive approval for through support from Alkermes, the manufacturer of Vivitrol. Under the leadership of Dr. Parks, staff of MIMH prepared the proposal and, if funded, will serve as the lead investigator for the project. We have not received feedback from Alkermes on the status of the proposal. • At the beginning of April the Divisions of ADA and CPS held their first joint meeting between the Advisory Councils. The invited guest was Justice William Ray Price. He gave feedback on the successes of the drug courts that are increasing across the states. He also discussed family courts, mental health courts, which are much smaller in number, but are starting to demonstrate good results. **Division of Comprehensive Psychiatric Services** Steve Reeves provided an update on the Division of Comprehensive Psychiatric Services. • Steve commented on the combined ADA/CPS State Advisory Committee joint meeting. He congratulated Bianca Farr and Rosie Anderson Harper for coordinating the meetings. The group came up with some recommended name possibilities for the integrated Division. • The Psychiatric Stabilization Center has received their CMS survey. They were denied their initial certification. They had numerous deficiencies that need to be addressed and are being addressed. The deficiencies were in the area of appropriate documentation of medical records and proper oversight of clinic departments. The PSC will be working with BJC and SSM to correct the deficiencies and the department has offered consultation as well. They are expecting to have the deficiencies corrected and reapply in June. Until such time that they receive their CMS certification, they can't be reimbursed for services from Medicaid and Medicare.

TOPIC/ ISSUE	DISCUSSION
	• The Joint Commission visited Metropolitan in St Louis. Their exit survey was on April 5, 2012. Several deficiencies were found by TJC at Metropolitan, not only in the joint commission standard, but also several in the conditions of participation for CMS. The most significant findings were in life safety code and fire safety standards. We are currently working on correcting these deficiencies. • The Chief Operating Officer for our SORTS program in Farmington announced his retirement. His replacement is Dr. Melissa Ring who currently serves as COO at Southeast Mental Health Center. She will be COO over both. We will look for an individual who has clinical and legal experience dealing with sexual predators and make them Director of Clinical Services. **Division of Developmental Disabilities** April Maxwell provided an update on the Division of Developmental Disabilities: • A letter was sent out earlier to CMS informing that the Department would be reducing the Hab Center census by 27%. By June 30, 2012 our census on campuses will be 503. Last July our total campus census was at 575 and today they are at 530. The following Hab Center census to date is: o DDTC – 156 o Bellefontaine – 139 o Marshall – 97 o SEMORS – 73 o Higginsville – 55 o Nevada - 10. • The Department has 27 expected moves by the end of June and will reach the 503 by the end of June. • The Partnership for Hope Waiver is currently up to 1,300 individuals and 94 counties including St Louis City. **Children's Update** Judy Finnegan provided the update on the Children's Office. The handout is located at http://dmh.mo.gov/about/diroffice/commission/2012MeetingSchedule.htm
FUTURE MEETINGS	The next Mental Health Commission Meeting is scheduled for May 4, 2012. This meeting will be held in Joplin at the Holiday Inn in conjunction with the May 3rd Triumph Through Tragedy Event.
ADJOURN	Neva Thurston made a motion that the meeting adjourn. David Vlach seconded the motion. The Mental Health Commission adjourned at 12:40 p.m. Kathy Carter, Secretary

Appendix F

Summary of Changes to Proposal Based on Feedback from the Public Comment Period

Missouri posted a draft of its Financial Alignment Proposal to the state's website on April 23, 2012 for the required 30-day public comment period. On April 25th a small revision was made to the cover page to include the appropriate contact information for comments and the comment period deadline. The state also held two public meetings during which it discussed the Financial Alignment Proposal: one on April 10, 2012 and the other on April 12, 2012. Missouri received six public comments from the following organizations:

1. Pharmaceutical Research and Manufacturers of America (PhRMA), submitted on May10, 2012;
2. National Association of Chain Drug Stores, submitted on May 22, 2012;
3. The Rehabilitation Institute of St. Louis (HealthSouth), submitted on May 24, 2012; and
4. Sandata Technologies, LLC, submitted on May 24, 2012;
5. Paraquad, submitted on May 25, 2012; and
6. Legal Services of Eastern Missouri, Inc. (LSEM), submitted on May 25, 2012.

The leadership from both MO HealthNet and the Department of Mental Health reviewed and discussed the comments. The summaries below provide a description of the key clarifications and changes that were made to reflect the stakeholder's concerns.

1. **Clarify that if dually-eligible beneficiaries are participating in the Medicare Part D program prior to enrollment in the Health Home programs, enrollment in the Health Home program will do nothing to impact their Part D benefit.** The revised proposal includes language to clarify that if dually eligible beneficiaries participating in the Health Home programs are enrolled in a Part D plan, then they will continue to receive their pharmacy benefit through their chosen Medicare Part D plan. Participation in Health Homes does not have any impact on the dually eligible beneficiaries' enrollment in the Part D plans.

2. **Clarify that pharmacy management activities coordinated by Health Homes are designed to complement Part D's existing infrastructure and quality assurance mechanisms.** The Health Home providers seek to provide the highest level of medication therapy management (MTM) services to the beneficiaries enrolled in the Health Home programs without providing duplicative services. The proposal clarifies that Health Homes will seek to coordinate any MTM services provided to the dually eligible individual with any medication management services being offered through the beneficiary's Part D plan by his/her local pharmacy. Additionally, the proposal clarifies that the state will offer a training webinar to the Health Home providers focused on issues relevant to providing care for the dually eligible population. This training webinar will include relevant information about the Medicare requirements related to medication coverage under Part B and the medication therapy management services provided to beneficiaries through Part D plans.

3. **Clarify the Health Home financial alignment demonstration program will do nothing to impact the Medicare coverage of or restrict access to inpatient**

rehabilitation facilities (IRF) for individuals that are dually eligible for Medicare and Medicaid. The proposal clarifies that the Health Home Financial Alignment Demonstration program will do nothing to impact the Medicare coverage of or restrict access to inpatient rehabilitation facilities (IRF) for dually eligible beneficiaries. Dually eligible beneficiaries participating in the Health Home programs will continue to maintain the same access to inpatient rehabilitation facilities as dually eligible beneficiaries not participating in the demonstration. However, those individuals participating in the Health Homes program will have the additional benefit of having their IRF services coordinated by the Health Home care team.

4. **Clarify that the Health Home financial alignment demonstration program will have no impact on the network of inpatient rehabilitation facilities (IRF).** The proposal clarifies that participation in the Health Home programs will not limit or restrict in any way an individual's ability to access necessary and appropriate care at an IRF.

5. **Consider the use of appropriate technologies to enhance patient care.** The proposal clarifies that the State of Missouri requires Health Homes to use certain technologies, such as the Statewide Electronic Health Records Registry and electronic medical records. Health Homes may adopt technologies that they deem appropriate to enhance patient care and facilitate the coordination of patient care across care settings.

6. **Missouri recognizes the value of patient preferences and Health Homes will seek to engage the consumer and incorporate patient preferences into the decision-making process whenever possible.** Consistent with the approved State Plan Amendment, Health Home programs will measure the patients' overall "Satisfaction with Services" on an annual basis using questions from the validated CG CAHPs 1.0 Adult Primary Care Survey. This tool will be used to ensure that individuals are satisfied with the care that is being provided and will certainly indicate whether they are comfortable with clinical decisions being made such as whether they are discharged to the care setting of choice. The questions that will be used for these purposes are as follows:
    - #6: In the last 12 months, when you phoned this doctor's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you thought you needed?
    - #17 In the last 12 months, how often did this doctor give you easy to understand instructions about taking care of these health problems or concerns?
    - #19 In the last 12 months, how often did this doctor show respect for what you had to say?
    - #20 In the last 12 months, how often did this doctor spend enough time with you?

7. **Clarify that Health Homes will support patients in the use of Cyber Access.** Missouri is committed to ensuring that patients have access to their medical records information and their care plans in a usable and understandable format. The proposal

clarifies that Health Home staff will provide training and support patients in their use of Cyber Access. Additionally, ACS (a Xerox company) is willing to provide one-on-one support to patients who need greater support navigating the site.

8. **Clarify that the current appeals and grievance processes for both Medicare and Medicaid will remain the same.** The proposal clarifies that if dually eligible individuals participating in the Health Home programs or their designees feel that their choices or rights are not being observed, then they will have access to the appeals and grievance processes for either Medicare or Medicaid. Additionally, the Health Home will provide them with the support necessary to determine which appeals/grievance process is most appropriate for them.

9. **Ensure that consumers have regular and ongoing input into the Health Home programs and the financial alignment demonstration.** In response to comments, the state will work to ensure that at least one beneficiary who is dually-eligible for Medicare and Medicaid is included on the Steering Committee. This Steering Committee will meet to review the Health Home programs every 6 months. Further, the quarterly public meetings held by the MO HealthNet Oversight Committee (which includes two patient advocates and one consumer representative) meetings will include as a standing item on the agenda a request for consumer and dually eligible beneficiary feedback and suggestions for the Health Home programs and the financial alignment demonstration.

10. **Clarify that Missouri will meet its obligation under the ADA to provide effective communication and auxiliary aids for people with disabilities.** The proposal strengthened its language about expectations that the Health Home programs will meet obligations under the ADA. All entities currently designated as Health Homes are required to have deaf services available.

11. **Clarify that Health Homes will coordinate with home and community-based service (HCBS) providers.** The proposal clarifies that Health Homes will coordinate with HCBS providers. Additionally the Health Homes will receive training on the range of HCBS services that are available to support individuals who are dually eligible for Medicare and Medicaid who wish to remain in the community and how to refer patients for LTSS assessments and to "options counselors" when appropriate.

12. **Clarify that Missouri has strong quality-based performance measures in place to ensure that Health Home reductions in cost do not compromise quality.** While Health Homes will be incentivized to provide cost-effective and efficient care, the program incentivizes the Health Homes to perform well against a number of quality- based performance measures. Specifically, the amount of the incentive payment that a provider gets will depend on the quality of care given as demonstrated by performance on the quality measures outlined in the proposal. Missouri believes that this balanced approach will not in any way harm the patients they serve, but instead provide high quality, coordinated care at an affordable cost.

13. **Clarify that the Health Home will coordinate closely with all providers providing care to a dually eligible individual, including Medicare-only**

providers and specialists. The proposal clarifies that dually eligible individuals have access to the full range of primary care and specialist services. Even if the specialist is not part of the Health Home care team, the Health Home will be responsible for coordinating the care provided to the patient by that specialist. Additionally, Health Homes recognize that in some instances for an individual with a significant disability, his/her specialist may serve as his/her primary point of contact with the medical system. However, the Health Home programs believe that it is important for that individual to have a team that will look at the patient's needs holistically and not just through the lens of the specialist and will work to coordinate the care of the specialist and the Health Home care team.

14. **Clarify that the incentive payments to Health Home providers will be calculated based on the aggregate savings within each Health Home program.** The proposal clarifies that the programs' calculations of savings will not be based on individualized provider savings but rather on the total savings created by all of the providers within each program. Missouri will only provide its CMHC Health Home providers with incentive payments if the CMHC Health Home program as a whole saved money during the measurement period. Similarly the Missouri will only provide its primary care Health Home providers with incentive payments if the primary care Health Home program as a whole saved money during the measurement period. If the Health Home program generates savings, then the size of the incentive payment will be determined by the individual provider's relative size and its performance on the quality measures described in the proposal.

15. **Clarify that the enrollee will be at the center of care planning process that takes place with the Health Home care team.** The beneficiary will
    a. be fully informed of all care options;
    b. have the right to a second opinion;
    c. be able to schedule appointments with the care team;
    d. have the right to choose an advocate to be present at the meetings, and
    e. have the right to accept or refuse treatment.

16. **Include additional measures of care coordination.** The state will consider including additional measures of care coordination during future enhancements of the programs. For example, the state may consider requiring Health Homes to track contacts made with the individual and/or hospital staff during the hospitalization to help facilitate continuity of care and a smooth discharge to the setting of the individual's choice.

17. **Add additional language to the enrollment letters to ensure that beneficiaries have information about how to opt-out of the Health Home programs.** In response to comments from stakeholders, Missouri will add additional information about the process for opting-out of the Health Home to the enrollment letters sent to beneficiaries when they are enrolled in a Health Home program.

18. **Provide the public with information about the appeals and grievances that**

relate to the Health Homes program. In response to comments, the Health Homes will agree to provide the public with information about appeals and grievances filed that relate to the Health Home programs. At the quarterly public meetings held by the MO HealthNet Oversight Committee, the Committee will present to the public summary information about volume and types of complaints, appeals and grievances received regarding the Health Home programs.

19. **Include measures that are specific to individuals who are dually eligible for Medicare and Medicaid.** The state will consider including access and utilization measures specific to the dually eligible population enrolled in the Health Home programs such as the percentage of health home beneficiaries that access long-term support services, different HCBS waiver services, home health, and nursing homes and skilled nursing facilities.

Appendix G:

Missouri Medical Home Collaborative (MMHC)
Meeting Attendees - November 8, 2010

Organization	Representative Attending
American College of Physicians MO Chapter MU Center for Health Ethics	David A Fleming, MD
American Academy of Pediatrics- Missouri Chapter	Robert Steele, MD Johanna Derda Johanna Echols Blaine Sayre, MD
Anthem Blue Cross & Blue Shield MO	Wayne Meyer, MD Veryl Alexander
AOA - Missouri Association of Osteopathic Physicians and Surgeons, Inc.	Brian Bowles
Barnes Jewish Hospital	Ann Abad Melanie Lapidus
Children's Mercy Family Health Partners	Elizabeth S. Peterson, MD
CIGNA HealthCare of Mid-America	Evan Peters
CIGNA HealthCare of St. Louis	Jordan Ginsburg, MD Diane Schilling
Citizen's Memorial Hospital	Tim Wolters
Community Health Center of Central Missouri	Alan Stevens
Cox Health	Tim Fursa, MD
Edward Jones	Kim Grbac Mary Ellen Bartells
Esse Health	Thomas Hastings, MD
Freeman Health System	Lisa Nelson
Group Health Plan & Coventry - St. Louis Coventry Health Care/GHP	Scott Spradlin, MD Ryan Voisey
Hannibal Regional Hospital	Julie Leverenz Tim Polley Sarah Boleach
HealthCare USA	Dan Paquin
Hermann Area District Hospital	Ellen Schaumberg (also for MARHC)
Mercy Medical Group	Tom Hale, MD
Missouri Academy of Family Physicians	Jennifer Bauer

Organization	Representative Attending
Missouri Association of Rural Health Clinics (MARHC)	Ellen Schaumberg (also for Hermann) Tom Warner Doug Easler David Winton
Missouri Care (MO Care)	Stacy Meyer
Missouri Care Health Plan/Harmony Health Plan	Vijay Kotte
Missouri Health Advocacy Alliance	Brian Colby
Missouri Highlands	Sherilyn Clark
Missouri Primary Care Association	Angela Herman Kathy Davenport Janice Pirner
MO HealthNet Division	Ian McCaslin, MD Julie Creach George Oestreich Joe Parks
Molina Healthcare of Missouri	Joanne Volovar
Monsanto	Carolyn George Plummer Mark D'Amico
Schnucks	Ed Keady
SSM Health Care-St. Louis	Mark Renken
St. Louis Area Business Health Coalition	Louise Probst
St. Louis University School of Medicine	Gillian Stephens, MD
UnitedHealthcare of the Midwest, Inc.	Robert W. Smith, MD Karen E Miller Shannon Nelson Deborah Waedekin
University of Missouri Center for Health Policy Office of Continuing Education	Karen Edison, MD
University of Missouri School of Medicine at Columbia Division of General Internal Medicine	Robert Lancey, MD
University of Missouri	Suzanne Hart Laura Schopp

Appendix H:

Missouri Medical Home Collaborative Steering Committee

Organization / Practice Affiliation	Representative
Anthem Blue Cross & Blue Shield of MO	Walter Bielefeld Ruth Meyer Hollenback
Community Health Center of Central MO (FQHC)	Katherine Friedebach, MD
Coventry Health Care/GHP	Scott Spradlin, MD DO FACOI Ryan Voisey
Cox Health RHC (Private Hospital Provider RHCs)	Nancy Bolduc Janice Jones, APRN
Crider Health Center (CMHC, Wentzville)	Karl Wilson, Ph.D.
Esse Health (St. Louis)	Rob Richman
Family Care Health Center (FQHC)	Heidi Miller, MD
Freeman Health System (Joplin)	Daxton Holcomb
Hermann Area Health System	Ellen Schaumberg
HealthCare USA	Pam Victor
Kneibert Clinic (Independent RHC)	Tom Warner
Missouri Care (Aetna)	John Esslinger, MD
Missouri Dept. of Mental Health	Joe Parks, MD
Missouri Health Advocacy Alliance	Susan Hinck
MO HealthNet Division	Ian McCaslin, MD
Pathways Midwest Behavioral Healthcare (CMHC Central MO)	Mel Fetter President, CEO
Patients First Health Care	Kelly Bain, MD
Sam Rodgers Health Center	Dan Purdom, MD
SSM Health Care	Tom Hanley, MD Mark Renken
St. Louis Area Business Health Coalition	Louise Probst
UnitedHealthcare	Karen Miller Shannon Nelson Robert Smith, MD
University of Missouri School of Medicine at Columbia, Division of Internal Medicine	David A Fleming, MD, FACP Robert Lancey, MD, FACP, FAAP

Organization / Practice Affiliation	Representative
Missouri Foundation for Health	Web Brown Cynthia Hayes Terry Plain
Bailit Health Purchasing, LLC (consultant)	Michael Bailit Marge Houy Christine Hughes

Appendix I:

Summary of Additional Stakeholder Groups Engaged in the Program Development Process

Missouri solicited input on the two Health Home programs from internal and external stakeholders, including consumers and beneficiaries through the following organizations. These organizations will continue to get updates and be consulted on the implementation of the Health Home programs on an ongoing basis.

Name of Organization	Purpose/ Mission	Membership of Organization	Consumer/ Beneficiary Involvement?
Psychiatric Services State Advisory Council	A council that advises the state and make recommendations to improve the system of care in mental health	25 members appointed by the Director of the Division of Comprehensive Psychiatric Services including: • mental health consumers, including parents of children receiving services and family members. • representation is required from the following state agencies: Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing and Mental Health.	Yes
Mental Health Commission	Statutorily mandated public commission overseeing DMH activities	Comprised of seven members, including: • a physician recognized as an expert in the treatment of mental illness; • a physician recognized as an expert in the evaluation or habilitation of the mentally retarded and developmentally disabled; • a representative of groups who are consumers or families of consumers interested in the services provided by the department in the treatment of mental illness; • a representative of groups who are consumers or families of consumers interested in services provided by the department in the habilitation of the mentally retarded; • a person recognized for his or her expertise in general business matters and procedures; • a person recognized for his interest and expertise in dealing with alcohol and drug abuse, and • a person recognized for his interest or expertise in community mental health services.	Yes

Name of Organization	Purpose/ Mission	Membership of Organization	Consumer/ Beneficiary Involvement?
Missouri Commission on Autism Spectrum Disorders	State-wide commission for oversight of autism spectrum related services	24 members including: • four members of the general assembly, with two members from the senate and two members from the house of representatives. • the director of the Department of Mental Health, or his or her designee; • the commissioner of the Department of Elementary and Secondary Education, or his or her designee; • the director of the Department of Health and Senior Services, or his or her designee; • the director of the Department of Public Safety, or his or her designee; • the commissioner of the Department of Higher Education, or his or her designee; the director of the Department of Social Services, or his or her designee; • the director of the Department of Insurance, Financial Institutions and Professional Registration, or his or her designee; • two representatives from different institutions of higher learning located in Missouri; • an individual employed as a director of special education at a school district located in Missouri; • a speech and language pathologist; • a diagnostician; • a mental health provider; • a primary care physician; • two parents of individuals with autism spectrum disorder, including one parent of an individual under the age of eighteen and one parent of an individual over the age of eighteen; • two individuals with autism spectrum disorder, and • a representative from an independent private provider or non-profit provider or organization.	Yes

Name of Organization	Purpose/ Mission	Membership of Organization	Consumer/ Beneficiary Involvement?
Assessment & Improvement (QA&I) Advisory Group	Advises MO HealthNet (Missouri Medicaid) on quality improvement efforts associated with managed care	• state agency staff (MO HealthNet, , DMH, Family Support Division) • provider organizations (DentaQuest, Children's Mercy Family Health Partners, MHA, BA+) health plans (Missouri Care, Harmony, HealthCare USA, Molina Health Care) • legal services organizations (LAWMO, Legal Services Southern MO, Mid-MO Legal services, Legal Services Western MO)	No
Behavioral Health Task Force	A task force of the QA&I Advisory Group, Advises MO HealthNet (Missouri Medicaid) on Behavioral Health Issues	• Same as for the Assessment & Improvement (QA&I) Advisory Group	No
Missouri Association of Public Administrator s	an association representing Missouri Public Administrators	• an organization comprised of County Public Administrators from each county in Missouri	No
National Council for Community Behavioral Healthcare	an association representing Missouri behavioral health organizations	• Behavioral health organizations operating in the state of Missouri	No
Missouri Foundation for Health	To support health related project in the state of Missouri	• a non-profit foundation that helps develop and fund programs through grants to eligible organizations in the region	No

Name of Organization	Purpose/ Mission	Membership of Organization	Consumer/ Beneficiary Involvement?
Missouri Primary Care Association	An association representing Missouri primary care providers	• Primary care providers operating in the state of Missouri	No
Missouri Association of Assisted Living Facilities	An association representing Missouri assisted living facilities	• Assisted Living Facilities operating in the state of Missouri	No

Appendix J

Primary Care Health Home Structure and Staffing

Team Member	FTE/Cost	PMPM	Team Member Role
Nurse Care Manager	1 FTE/250 enrollees $105,000/year	$35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Primary care health home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases, treatments & medications h. Track required assessments and screenings i. Assist in implementing MHD health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes

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

Team Member	FTE/Cost	PMPM	Team Member Role
Primary Care Health Home Director Administrative support	1 FTE/2500enrollee $90,000/year Non-PMPM paid staff training time Contracted services	$8.87	a. Provides leadership to the implementation and coordination of Health Home activities b. Champions practice transformation based on Health Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Health Home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives referral tracking f. Training and technical assistance g. Data management and reporting h. Non-PMPM paid staff training time
Care Coordination	1 FTE/750 enrollees $65,000/year	$7.22	a. Referral tracking b. Training and technical assistance c. Data management and reporting (can be separated into second part time function) d. Scheduling for Primary Care Health Home team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending Medical Records for care coordination
TOTAL PMPM		**$58.87**	

Appendix K

Community Mental Health Center Health Home Structure and Staffing

Team Member	FTE/Cost	PMPM	Team Member Role
Nurse Care Manager	1 FTE/250 enrollees $105,000/year	$35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Health Home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases, treatments & medications h. Track required assessments and screenings i. Assist in implementing DMH Net health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes
Primary Care Physician Consultant	1hr/enrollee/year $150/hr	$12.50	a. Participates in treatment planning b. Consults with team psychiatrist c. Consults regarding specific consumer health issues d. Assists coordination with external medical providers

Team Member	FTE/Cost	PMPM	Team Member Role
Health Home Director	1 FTE/500 enrollees $115,000/year	$19.17	a. Provides leadership to the implementation and coordination of Health Home activities b. Champions practice transformation based on Health Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Health Home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives
Administrative Support	1 FTE support staff/500 enrollees Non-PMPM paid staff training time Contracted services	$12.07	a. Referral tracking b. Training and technical assistance c. Data management and reporting d. Scheduling for Health Home team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending medical records for care coordination
TOTAL PMPM		**$78.74**	

Appendix L

DSH Payments

DSH Payment data will be provided annually.

Appendix M

Performance Measure Specifications for the Primary Care Health Homes

Goal #1: Improve Health Outcomes for persons with Chronic Conditions:

- **Ambulatory Care-Sensitive Condition Admissions:** age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 65 years and over 75 years. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Emergency Department Visits:** Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measure. The algorithm is a nationally recognized method of calculating preventable ED visits. The state will identify hospital ED visits through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Hospital Readmission:** Missouri will calculate the percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Hospital Discharge Follow-up: :** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from the primary care provider. The state will rely on a combination of claims data and EMR data submitted by the practices in their monthly primary care health home reports. The state's benchmark goal is to have 80% of hospital-discharged members have telephonic or face-to-face contact with a care manager made within three days of discharge and performed medication reconciliation with input from PCP.
- **A SNF utilization measure is being developed**

Goal #2: Improve Behavioral Healthcare:

- **Reducing illicit drug use:** Missouri will calculate the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days. The state will rely on EMR data submitted by the practices in their monthly Primary Care Health Home reports. the state's benchmark goal is to have less than 7.1% of adults reporting use of any illicit drug during the past 30 days. This goal is consistent with the Healthy People 2020 goal.
- **Reducing Excessive Alcohol Consumption:** Missouri will calculate the proportion of adults (18 and older) reporting excessive drinking in the previous 30 days. The state will rely on EMR data submitted by the practices in their monthly Primary Care Health Home reports. The state's benchmark goal is to have less than 25.3% of adults reporting excessive drinking

during the past 30 days. This goal is consistent with the Healthy People 2020 goal.

- **Screening for Depression:** Missouri will calculate the percentage of patients 18 years of age and older receiving depression screening through the use of a standardized screening instrument within the measurement period. The state will rely on EMR data submitted by the practices in their monthly Primary Care Health Home reports. The state's benchmark goal is to have 90% of adults receiving depression screening through the use of a standardized screening instrument within the measurement period.
- **Screening for Substance Abuse:** Missouri will calculate the percentage of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary. The state will rely on EMR data submitted by the practices in their monthly reports. The state's benchmark goal is to have 90% of adults receiving screening for substance abuse using a standardized tool with a follow-up plan documented, as necessary.

Goal #3: Increase Patient Empowerment and Self-Management:

- **Patient Use of Personal Electronic Health Records (EHRs) or practice EMR patient portal:** Missouri will use CyberAccess or its successor or information from the practices' EMR patient portals to determine the extent to which patients use their personal electronic health records. The state will calculate the measures using the following formula: Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period. Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90. The benchmark goal is greater than 25% use.
- **Satisfaction with Services:** Missouri will rely on responses from CG-CAHPS 1.0 Adult Primary Care Surveys Adult Questions #6, 17, 19, and 20 and calculate patient satisfaction scores using the following formula:
    - Numerator = number questions with response of 3-usually or 4-always;
    - Denominator = total number of questions with any answer.

  Results of the CAHPS survey will be aggregated by Primary Care Health Home and across the entire statewide initiative. Final report will benchmark individual Primary Care Health Home performance compared to other Primary Care Health Homes and the statewide average and identify individual items for performance improvement. The state's benchmark goal is satisfaction greater than 80%.

Goal #4: Improve Coordination of Care:

- **Hospital Discharge Follow-up:** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within three days of discharge and performance medication reconciliation with input from PCP. The state's benchmark goal is 80% of members**.**
- **Use of CyberAccess per member:** Missouri will calculate number of times that CyberAccess was opened per member per month using the standard management report available within the Cyber Access tool. The state's benchmark goal is one CyberAccess utilization per member each month.

Goal #5: Improve Preventive Care:

- **Body Mass Index (BMI) Control:** Missouri will calculate the percentage of patients with documented BMI between 18.5 and 24.9. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is 80% of patients having a BMI within the healthy range.
- **Adult Weight Screening and Follow-Up:** Missouri will calculate the percentage of patients aged 18 years or older with a calculated BMI in the past three months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the EMR to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is 80% of patients with a BMI outside of parameters with a documented follow-up plan.

Goal #6: Improve Diabetes Care:

- **Adult Diabetes Control:** Missouri will calculate the percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%. Missouri will use data analytics of the diagnostic and service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >60% of treatment is within guidelines of care.
- **Blood Pressure (BP) Management in Diabetes Patients:** Missouri will calculate the percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg. Missouri will use data analytics of the diagnostic and service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >65% had a blood pressure reading within the recommended range.
- **Adherence to Prescription Medications for Persons with Diabetes:** Missouri will calculate the percentage of members on medication for diabetes in the past 90 days with a medication possession ratio (MPR) > 80%. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >90% of care is provided consistent with treatment guidelines.

Goal #7: Improve Asthma Care:

- **Adult Asthma Appropriate Use of Medication:** Missouri will calculate the percentage of patients 18 to 50 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease

registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >70% of care is provided consistent with treatment guidelines.

- **Adherence to Prescription Medications for Persons with Asthma:** Missouri will calculate the percentage of adherence to prescription medications for asthma and/or COPD. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >90% of care is provided consistent with treatment guidelines.

Goal #8: Improve Cardiovascular Disease (CVD) Care:

- **Hypertension Control:** Missouri will calculate the percentage of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least two office visits, with blood pressure adequately controlled (BP < 140/90) during the measurement period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >50%.
- **Coronary Artery Disease (CAD) Lipid Level Control:** Missouri will calculate the percentage of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100). Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's disease registry to assess and monitor. The state's benchmark goal is >70% of patients will have their lipid level adequately controlled.
- **Adherence to Prescription Medications for Persons with CVD:** Missouri will calculate the percentage of adherence to CVD medications and anti-hypertensive medications. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims to assess and monitor the extent to which a specific individuals' health care is consistent with treatment guidelines. The state's benchmark goal is >90% of care provided is consistent with treatment guidelines.

Appendix N

CMHC Health Home Clinical Performance Measures:

Missouri has already begun using the following measures to assess the progress of the CMHC Health Home program:

Goal #1: Improve Health Outcomes for Persons with Mental Illness

- **Ambulatory Care-Sensitive Condition Admissions:** age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 65 years and over 75 years. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Emergency Department Visits:** Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measure. The algorithm is a nationally recognized method of calculating preventable ED visits. The state will identify hospital ED visits through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Hospital Readmission:** Missouri will calculate the percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology. The state will identify hospital discharge events through analysis of administrative claims. The state's benchmark goal is NCQA's most recently published 50th percentile regional rate for Medicaid managed care and for Medicare Advantage.
- **Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers:** Missouri use data analytics of the diagnostic & service utilization information in administrative claims to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. Specifically, Missouri will calculate the percentage of patients maintaining adherence to Antipsychotics, Antidepressants and Mood Stabilizer medications using the following formula: Numerator = number of members on that class of medication in the past 90 days with medication possession ratios (MPR) > 80% / Denominator = number of all members on that class of medication in the past 90 days. The state's benchmark goal is greater than 90% medication adherence.
- **Hospital Discharge Follow-up:** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within three days of discharge and performed medication reconciliation with input from the primary care provider (PCP). The state will rely on a combination of claims data and EMR data submitted by the practices in their monthly Health Home reports. The state's benchmark goal is to have 80% of hospital-discharged members have telephonic or face-to-face contact with a care manager made within three days of discharge and performed medication reconciliation with input from PCP.

- **A measure SNF utilization measure is being developed**

Goal #2: Reduce Substance Abuse

- **Reduce illicit drug use:** Missouri will calculate the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months. The state will rely on annual status reports submitted by the practices and use the following formula: Numerator = number of adults who report using illicit drugs in the previous 12 months / Denominator = total number of adults in the past 12 months x 100. The state's benchmark goal is to have fewer than 5% of adults reporting use of any illicit drug during the past 12 months.
- **Reduce Excessive Alcohol Consumption:** Missouri will calculate the proportion of adults (18 and older) reporting excessive drinking in the previous 12 months. The state will rely on annual status reports submitted by the practices and use the following formula: Numerator = number of adults who report drinking excessively in the previous 12 months /Denominator = number of all adults in the past 12 month x 100. The state's benchmark goal is to have fewer than 9% of adults reporting excessive drinking during the past 12 months.

Goal #3: Increase Patient Empowerment and Self-Management:

- **Patient Use of Personal Electronic Health Records (EHRs) or practice EMR patient portal:** Missouri will use CyberAccess or its successor or information from the practices' EMR patient portals to determine the extent to which patients use their personal electronic health records. The state will calculate the measures using the following formula: Numerator = number of times Direct Inform was used (patients online EHR record was opened) in a 90-day period. Denominator = number of patients actively enrolled in the Health Home at any point during the 90 days x 90. The state's benchmark goal is greater than 25% use.
- **Satisfaction with Services:** Missouri will rely on responses from Mental Health Statistic Improvement Program (MHSIP) survey and calculate patient satisfaction scores using the SAMHSA National Outcome Measures (NOMS) specifications. The state's benchmark goal is greater than 90% satisfaction.

Goal #4: Improve Coordination of Care:

- **Hospital Discharge Follow-up:** Missouri will calculate the percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within three days of discharge and performance medication reconciliation with input from PCP. The numerator will be aggregated from the monthly Health Home report using the following formula: Numerator = number of patients contacted (phone or face-to-face) within 72 hours of discharge and Denominator = number of all patients discharged x 100**.** The state's benchmark goal is to have 80% of members receive care coordination within three days**.**
- **Use of CyberAccess per member:** Missouri will calculate number of times that CyberAccess was opened per member per month using the standard management report available within the Cyber Access tool. The state's benchmark goal is one cyber access utilization per member each month.

Goal #5: Improve Preventive Care:

- **Body Mass Index (BMI) Control:** Missouri will calculate the percentage of patients with documented BMI between 18.5 and 24.9. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home's EMR to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. The state's benchmark goal is 80% of patients having a BMI within the healthy range.
- **Metabolic Screening:** Missouri will calculate the percentage of patients with documented metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG) in the last 12 months. Missouri will rely on the following formula: Numerator: number of current enrollees with a documented metabolic screening in the last 12 months and Denominator: total enrollees. The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. The state's benchmark goal is 80% completion.

Goal #6: Improve Diabetes Care:

- **Adult Diabetes Control:** Missouri will calculate the percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%. Missouri will use data analytics of the diagnostic and service utilization information in Health Home EMRs to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines using the following formula: Numerator = for a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and a documented HbA1c in the previous 12 months for whom the most recent documented HbA1c level is .8% Denominator = for a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and having a documented HbA1c in the previous 12 months. The state's benchmark goal is >70% of treatment is within guidelines of care.
- **Metabolic Screening:** Missouri will calculate the percentage of patients with documented metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG) in the last 12 months. Missouri will rely on the following formula: Numerator: number of current enrollees with a documented metabolic screening in the last 12 months and Denominator: total enrollees. The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. The state's benchmark goal is 80% completion.

Goal #7: Improve Asthma Care:

- **Adult Asthma Appropriate Use of Medication:** Missouri will calculate the percentage of patients 18-50 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home Disease Registry to assess and monitor the extent to which a specific individual's health care is

consistent with treatment guidelines. Missouri will use the following formula: Numerator = for a given 90-day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry and a prescription for a controller medication and Denominator = for a given 90-day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry. The state's benchmark goal is >70% of care be provided consistent with treatment guidelines.

- **Adherence to Prescription Medications for Persons with Asthma:** Missouri will calculate the percentage of adherence to prescription medications for asthma and/or COPD. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Missouri will use the following formula: Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% and Denominator = number of all members on medication for asthma/COPD in the past 90 days. The state's benchmark goal is >90% of care be provided consistent with treatment guidelines.

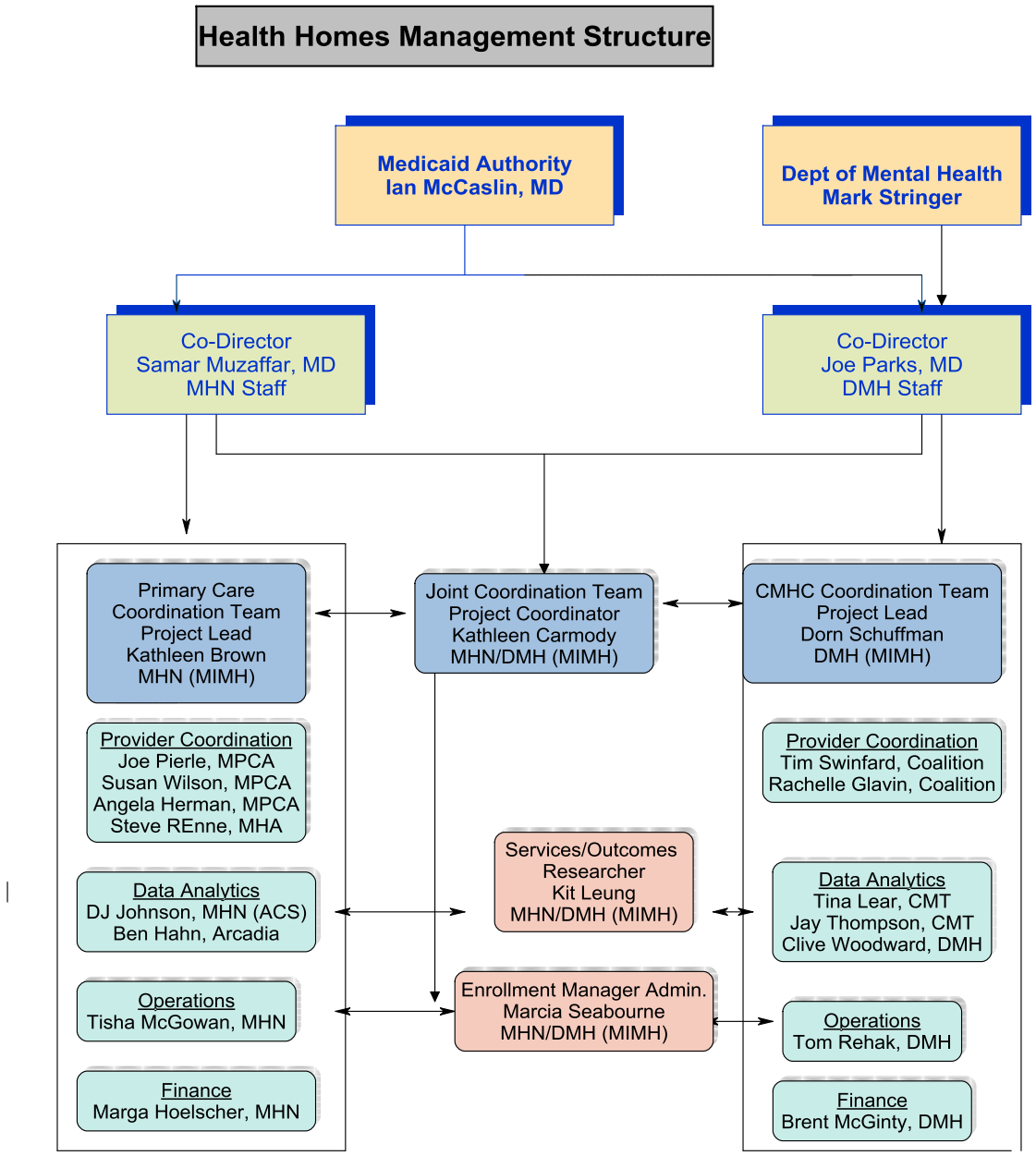
Goal #8: Improve Cardiovascular Disease (CVD) Care:

- **Hypertension Control:** Missouri will calculate the percentage of patients aged 18 to 85 years and older with a diagnosis of hypertension who have been seen will for at least two office visits, with blood pressure adequately controlled (BP < 140/90) during the measurement period. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home disease registry to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. The state will use the following formula: Numerator = for a given 90-day period number of patients between the age of 18 to 85 years old identified as having hypertension in health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90 and Denominator = for a given 90-day period number of patients between the age of 18 to 75 years old identified as having hypertension in the Health Home disease registry who had two documented episodes of care in the previous 12 months. The state's benchmark goal is >90%.

- **Coronary Artery Disease (CAD)) Lipid Level Control:** Missouri will calculate the percentage of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100). Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information from the Health Home disease registry to assess and monitor. The state will use the following formula; Numerator = for a given 90-day period number of patients between the age of 18 years or older identified as having cardiovascular disease in health home registry months where the most recent documented LDL level in the previous 12 months is < 100 and Denominator = for a given 90-day period number of patients between the age of 18 years and older identified as having cardiovascular disease in health home registry The state's benchmark goal is >70% of patients will have their lipid level adequately controlled.

- **Adherence to Prescription Medications for Persons with CVD:** Missouri will calculate the percentage of adherence to CVD medications and anti-hypertensive medications. Missouri will utilize data analytics of the diagnostic and service utilization information in administrative claims to assess and monitor the extent to which a specific individual's health care is consistent with treatment guidelines. The state will use the following formula: Numerator = number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% and Denominator = number of all members on that class of medication in the past 90 days. The state's benchmark goal is >90% of care provided is consistent with treatment guidelines.
- **Statin Use for Persons with CAD:** Missouri will assess the use of statin medications by persons with a history of CAD (coronary artery disease) utilizing data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. The state will use the following formula: Numerator = for a given 90-day period number of patients identified as having coronary artery disease in health home registry and a prescription for a statin and Denominator = for a given 90-day period number of patients coronary artery disease in health home registry. The state's benchmark goal is >70%.

Appendix O:



The Health Homes Management Structure is as follows. Ian McCaslin, MD Medicaid Authority, manages Co-Director Samar Muzaffar, MD, of MHN with Co-Director Joe Parks, MD, of DMH, who is also managed by Mark Stringer with the Department of Mental Health. Dr. Muzaffar and Dr. Parks co-direct the joint coordination team project coordinator Kathleen Carmody, of MHN/DMH/MIMH who works with each of the coordination team project leads for Primary Care and CMHC Coordination Teams. Dr. Muzaffar manages the Primary Care coordination team project lead Kathleen Brown, of MHN/MIMH, and the Provider Coordination by MPCA staff Joe Pierle, Susan Wilson, Angela Herman, and MHA staff Steve Renne. Dr. Muzaffar also manages Data Activities by DJ Johnson of MHN/ACS/Xerox, and Ben Hahn of Arcadia. Dr. Muzaffar manages operations by Tisha McGowan of MHN and finance by Marga Hoelscher of MHN. Dr. Parks manages the CMHC Coordination Team Project Lead Dorn Schuffman of DMH/MIMH, Provider Coordination by Tim Swinfard and Rachelle Glavin of the Coalition, Data Analytics by Tina Lear and Jay Thompson of CMT, with Clive Woodward of DMH. Dr. Parks also manages Operations by Tom Rehak of DMH, and finance by Brent McGinty of DMH. The data analytics members of each the Primary Care and CMHC teams work with the Services/outcomes researcher Kit Leung of MHN/DMH/MIMH and the operations members of each team work with the Enrollment manager administrator Marcia Seabourne of MHN/DMH/MIMH.

Appendix P:

Workplan/Timeline for the Health Home Programs

Timeframe	Key Activities/Milestones	Responsible Parties
Summer 2011-December 2011	Ramp-up period (CMHC and primary care practices began hiring care managers and began the process of practice transformation)	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
Fall 2011	Pre-work for the Learning Collaboratives	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
January 1, 2012	Effective date of CMHC and Primary Care SPA	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
April 2012	State development of information for state-specific financial modeling of Medicare shared savings tool	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
April-May 2012	Public Stakeholder Meetings	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
April 16, 2012	**State Public Notice and Posting of Proposal**	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
April 16-May 15, 2012	State Public Comment Period	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
May 16-21, 2012	State Incorporates Public Comments, Revises Proposal	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
Spring/Early Summer 2012	Modeling for Missouri Complete	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
May 21, 2012	**State Submits Demonstration Proposal**	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
May 23, 2012	CMS Public Notice and Posting of Proposal	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
May 23-June 22, 2012	CMS Public Comment Period	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)

Timeframe	Key Activities/Milestones	Responsible Parties
May 23-June 27, 2012	CMS/State review of public comments	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
June 23-July 22, 2012	MOU Development and Finalization	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
June 23-July 22, 2012	Development of Comparison Group Methodology	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
July 23-27, 2012	**Signing of MOU**	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
July 28-August 25, 2012	Development of Final Agreement	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
July 28-August 25, 2012	Readiness Review (Concurrent with Development of Final Agreement)	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
August 25-31, 2012	**Signing of Final Agreement**	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
September 1, 2012	Beneficiary Notification and additional outreach by State to Medicare-Medicaid enrollees eligible for health home services but not receiving services from a health home provider	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)
October 1, 2012	**Demonstration Start / Implementation – Year 1**	The Department of Mental Health (CMHC) and MO HealthNet Division (PC)

Appendix Q:

The CMHC State Plan Amendment
(effective January 1, 2012)

MEDICAID MODEL DATA LAB

Id: MISSOURI
State: Missouri
Health Home Services Forms (ACA 2703)

TN#: MO-11-0011 | Supersedes TN#: MO-00-0000 | Effective Date: 01/01/2012 | Approved Date: 10/20/2011

Transmittal Numbers (TN) and Effective Date

Supersedes Transmittal Number (TN) 00-0000 **Transmittal Number (TN) 11-0011**
Effective Date 01/01/2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☑ **Health Home Services**

How are Health Home Services Provided to the Medically Needy? Not provided to Medically Needy

i. Geographic Limitations

Health Homes will be provided as follows: Statewide Basis.
If Targeted Geographic Basis: N/A

ii. Population Criteria

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

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

from the list of conditions below:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease

☑ BMI Over 25
☑ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

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

- A serious and persistent mental health condition;
- A mental health condition and one other chronic condition (asthma, cardiovascular disease, diabetes, substance use disorder, developmental disability, overweight (BMI >25);
- A substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, developmental disability (DD), overweight (BMI >25); or
- A mental health condition or a substance use disorder and tobacco use (tobacco us is considered an at-risk behavior for chronic conditions such as asthma and CVD).

Individuals eligible for Health Home services and identified by the state as being existing service users of a Health Home will be auto-assigned to eligible providers based on qualifying conditions. Upon enrollment, individuals assigned to a Health Home will be informed by the state via U.S. mail and other methods as necessary of all available Health Homes throughout the state. The notice will describe individuals' choice in selecting a Health Home as well as provide a brief description of Health Home services, and describe the process for individuals to opt-out of receiving treatment services from the assigned Health Home provider. Individuals who have been auto-assigned to a Health Home provider will have the choice to opt out of receiving treatment services from the assigned Health Home provider and select another service provider from the available Health Homes throughout the state at any time. Individuals who have been auto-assigned to a Health Home provider may also opt out of the Health Home program altogether at any time without jeopardizing their existing services. Other individuals with qualifying chronic conditions who are not currently receiving services at the Health Home may request to be part of the Health Home. Potentially eligible individuals receiving services in the hospital ED or as an inpatient will be notified about eligible Health Homes and referred based on their choice of provider. Eligibility for Health Home services will be identifiable through the state's comprehensive Medicaid electronic health record. Health Home providers to which patients have been auto-assigned will receive communication from the state regarding a patient's enrollment in Health Home services. The Health Home will notify other treatment providers (e.g., primary care and specialists such as OB/GYN) about the goals and types of Health Home services as well as encourage participation in care coordination efforts.

iii. Provider Infrastructure

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

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

CMHC Health Homes will be physician-led with health teams minimally comprised of a

Health Home Director, a Health Home Primary Care Physician Consultant, a Nurse Care Manager(s),and a Health Home Administrative support staff. Optional health team members may also include an individual's treating primary care physician, treating psychiatrist, and mental health case manager, as well as a nutritionist /dietitian, pharmacist, peer recovery specialist, grade school personnel or other representative as appropriate to meet clients' needs (e.g., educational, employment or housing representative). All members of the team will be responsible for ensuring that care is person-centered, culturally competent and linguistically capable. All mandatory Health Home team members' time will be covered by the PMPM rate described in the Payment Methodology section below.

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

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

☐ Team of Health Care Professionals as described in § 1945(h)(6)
☐ Health Team as described in § 1945(h)(7), via reference to § 3502

iv. Service Definitions

A. Comprehensive Care Management

1. **Service Definition:** Comprehensive care management services are conducted by the Nurse Care Manager, Primary Care Physician Consultant, the Health Home Administrative Support staff and Health Home Director with the participation of other team members and involve:
   a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;
   b. assessment of preliminary service needs; treatment plan development, which will include client goals, preferences and optimal clinical outcomes;
   c. assignment of health team roles and responsibilities;
   d. development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
   e. monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
   f. development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

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

B. Care Coordination

1. **Service Definition:** Care Coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals,

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

2. **Ways Health IT Will Link:** MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:
   a. Download paid claims data submitted for an enrollee by any provider over the past 3 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;
   f. pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
   g. Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice;
   h. Review laboratory data and clinical trait data;
   i. Determine medication adherence information and calculate medication possession ratios (MPR); and
   j. Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

C. Health Promotion

1. **Service Definition:** Health promotion services shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health- promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist clients to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. The Health Home Director, Primary Care Physician Consultant, and Nurse Care Manager will each participate in providing Health Promotion activities.

2. **Ways Health IT Will Link:** A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same

content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Utilization data available through the module includes:

a. Administrative claims data for the past 3 years;
b. Cardiac and diabetic risk calculators;
c. Chronic health condition information awareness;
d. A drug information library; and
e. The functionality to create a personal health plan and discussion lists to use with healthcare providers.

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

1. **Service Definition:** In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management. The Health Home Director, Primary Care Physician Consultant, and Nurse Case Manager will all participate in providing Comprehensive Transitional Care activities, including, whenever possible, participating in discharge planning.

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

E. Individual and Family Support Services (including authorized representatives)

1. **Service Definition:** Individual and family support services activities include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health

literacy, ability to self manage their care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for services more directly related to Habilitation and coordinate with the approved DD case management entity for services more directly related a particular healthcare condition. Nurse Care Managers will provide this service.

2. **Ways Health IT Will Link:** A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Utilization data available through the module includes:
   a. Administrative claims data for the past 3 years;
   b. Cardiac and diabetic risk calculators;
   c. Chronic health condition information awareness;
   d. A drug information library; and
   e. The functionality to create a personal health plan and discussion lists to use with healthcare providers.

F. Referral to Community and Social Support Services

1. **Service Definition:** Referral to community and social support services, including long term services and supports, involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples. For individuals with DD, the health team will refer to and coordinate with the approved DD case management entity for this service. The Nurse Care Manager and Administrative support staff will provide this service.

2. **Ways Health IT Will Link:** Health Home providers will monitor continuing Medicaid eligibility using the DFS eligibility website and data base. MO HealthNet and the Department of Mental Health will also develop a process to notify health home providers of impending eligibility lapses (e.g., 60 days in advance).

v. Provider Standards

A. Initial Provider Qualifications

1. **State Qualifications:** In addition to being a state-designated CMHC, each Health Home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each Health Home:
   a. Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a considerable volume of needy individuals, defined as receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), furnished uncompensated care by the provider, or furnished services at either no cost or reduced based on a sliding scale. Patient percentage requirements will be determined by the state;
   b. Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated through the application process and agreement to participate in learning activities including in-person sessions and regularly scheduled phone calls; and that agency leadership have presented the state approved "Paving the

Way for Health Care Homes" PowerPoint introduction to Missouri's Health Home Initiative to all agency staff and board of directors;

c. Meet state requirements for patient empanelment (i.e., each patient receiving CMHC health home services must be assigned to a physician);
d. Meet the state's minimum access requirements as follows: Prior to implementation of health home service coverage, provide assurance of enhanced patient access to the health team, including the development of alternatives to face-to-face visits, such as telephone or email, 24 hours per day 7 days per week;
e. Actively use MO HealthNet's comprehensive electronic health record (EHR) to conduct care coordination and prescription monitoring for Medicaid participants;
f. Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;
g. Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns;
h. Conduct wellness interventions as indicated based on clients' level of risk;
i. Complete status reports to document clients' housing, legal, employment status education, custody etc.;
j. Agree to convene regular, ongoing and documented internal Health Home team meetings to plan and implement goals and objectives of practice transformation;
k. Agree to participate in CMS and state-required evaluation activities;
l. Agree to develop required reports describing CMHC Health Home activities, efforts and progress in implementing Health Home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of Primary Care Nurse Manager's time and activities);
m. Maintain compliance with all of the terms and conditions as a CMHC Health Home provider or face termination as a provider of CMHC Health Home services; and
n. Present a proposed Health Home delivery model that the state determines to have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the Health Home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

2. **Ongoing Provider Qualifications** Each CMHC must also:
   a. Within 3 months of Health Home service implementation, have developed a contract or MOU with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a Health Home site, and in addition motivate hospital staff to notify the CMHC Primary Care Nurse Manager or staff of such opportunities. The state will assist in obtaining hospital/Health Home MOU if needed;
   b. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
   c. Demonstrate continuing development of fundamental health home functionality at 6 months and 12 months through an assessment process to be applied by the state;
   d. Demonstrate significant improvement on clinical indicators specified by and reported to the state;
   e. Provide a Health Home that demonstrates overall cost effectiveness; and
   f. Meet NCQA level 1 PCMH requirements as determined by a DMH review or submit an application for NCQA recognition by month 18 from the date at which

supplemental payments commence OR meet equivalent recognition standards approved by the state as such standards are developed.

vi. Assurances

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

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

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

vii. Monitoring

A. **Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications:** Using claims data, the state will track avoidable hospital readmissions by calculating ACSC readmissions/1000: (# of readmissions with a primary diagnosis consisting of an AHRQ ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.

B. **Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications:** The State will annually perform an assessment of cost savings using a pre/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. It will also be broken out for each CMHC Health Care Home. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditure. Savings calculations will be trended for inflation, and will truncate the claims of high-cost outliers annually exceeding three standard deviations of the mean. Savings calculation will include the cost of PMPM payments received by Health Home Providers. The assessment will also include the performance measures enumerated in the Quality Measures section.

C. **Describe the State's proposal for using health information technology in providing Health Home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider):** To facilitate the exchange of health information in support of care for patients receiving or in need of health home services, the state will utilize several methods of health information technology (HIT).

The following is a summary of HIT currently available for Health Home providers to conduct comprehensive care management, care coordination, health promotion, individual and family support and referral to community and social support services. Also included is a description of the state's process to improve health information exchange (HIE) for comprehensive transitional care services.

As Missouri implements its Health Home models, the State will also be working toward the development of a single data portal to facilitate information exchange, measures documentation and calculation and state reporting to CMS. The state will also continue to refine a process for HIE between CMHCs and primary care practices and has contacted SAMSHA to learn more about opportunities available under the national technical assistance center on integrated care.

1. ***HIT for Comprehensive Care Management and Care Coordination*** – MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-compliant portal that enables providers to:

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

2. ***HIT for Health Promotion and Individual and Family Support Services*** – A module of the MO HealthNet comprehensive, web based EHR allows enrollees to access their own healthcare utilization information and receive the same content in laypersons' terms. The information facilitates self-management and monitoring necessary for an enrollee to attain the highest levels of health and functioning. Health Home providers will provide instruction to individuals on the use of the module. Utilization data available through the module includes:

(a) Administrative claims data for the past 3 years;
(b) Cardiac and diabetic risk calculators;
(c) Chronic health condition information awareness
(d) A drug information library; and
(e) The functionality to create a personal health plan and discussion lists to use with healthcare providers.

3. ***HIT for Comprehensive Transitional Care*** – MO HealthNet maintains an initial and concurrent authorization of stay tool which requires hospitals to notify MO HealthNet (via accessing the online authorization tool) within 24 hours of the next usual workday regarding a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay. MO HealthNet and

the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will be transferred to the states data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a Health Home. The contractor would then immediately notify the Health Home provider of the admission, which would enable the Health Home provider to:

(a) Use the hospitalization episode to locate and engage persons need of health home services;
(b) Perform the required continuity of care coordination between inpatient and outpatient; and
(c) Coordinate with the hospital to discharge and avoidable admission as soon as possible. The daily data transfer will be in place within six months of implementation of the SPA. In the interim, Health Homes will continue to implement or develop memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.

4. ***Referral to Community and Social Support Services*** – Health Home providers will be encouraged to monitor continuing Medicaid eligibility using the FSD eligibility website and data base. MO HealthNet and the Department of Mental Health will also refine process to notify Health Home providers of impending eligibility lapses (e.g., 60 days in advance).

5. ***Specific HIT Strategies for CMHCs Customer Information Management, Outcomes and Reporting (CIMOR)*** - CMHCs will continue to utilize CIMOR for routine functions (e.g., contract management, billing, benefit eligibility, etc.); however CIMOR's capacity will continue to be expanded in support of CMHC comprehensive care management and care coordination functions. CIMOR will enable assignment of enrollees to a CMHC Health Home based on enrollee choice and admission for services. CMHC Health Home providers utilize CIMOR to report Department of Mental Health required outcome measures. In addition, the CMHC Health Home enrollment data in CIMOR will be cross referenced with MO Health Net inpatient pre-authorization data to enable the automated real-time reporting of inpatient authorizations to the appropriate CMHC.

6. ***Behavioral Pharmacy Management System (BPMS)*** – CMHCs utilize BPMS to receive aggregate and individual identification and reporting of potentially problematic prescribing patterns.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

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

viii. Quality Measures: Goal Based Quality Measures

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

A. Goal 1: Improve Health Outcomes for Persons with Mental Illness

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1)Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive condition- age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 75 yrs	Claims	Numerator = Total # of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years / Denominator = Total mid-year population under age 75	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Health Homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care.
(2)Emergency Department Visits: preventative / ambulatory care-sensitive ER visits (algorithm, not formally a measure)	Claims	Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measures, which is too lengthy to place in the SPA. The algorithm is a nationally recognized method of calculating preventable ED visits.	Hospital ER visits will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Health Homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(3)Hospital Readmission: Hospital readmissions within 30 days	Claims	Percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology.	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Health Homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) All Members: Medication Adherence to Antipsychotics, Antidepressants and Mood Stabilizers	Pharmacy Claims	Numerator = Number of members on that class of medication in the past 90 days with medication possession ratios (MPR) > 80% / Denominator = Number of all members on that class of medication in the past 90 days	The medication adherence HEDIS indicators & meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in administrative claims combined with clinical information & disease Registry to assess & monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>90%

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(2) Care Coordination: % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performed medication reconciliation with input from PCP.	Claims & Monthly Health Home Report	Number of patients contacted (by phone or face-to-face) within 72 hours of discharge / Number of all patients discharged	The numerator will be aggregated from the monthly health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80%

B. Goal 2: Reduce Substance Abuse

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
1. Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months.	Annual status report	Numerator = Number of adults who report using illicit drugs in the previous 12 months / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual Health Home	5%
2. Reduce the proportion of adults (18 and older) who drank excessively in the previous 12 months.	Annual status report	Numerator = Number of adults who report drinking excessively in the previous 12 months / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual Health Home.	9%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

C. Goal 3: Increase patient empowerment and self-management

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Patient Use of personal HER (Direct Inform, or its successor)	Cyber Access or its success-sor	Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period / Denominator = Number of patients actively enrolled in the health home at any point during the 90 days x 90	This is a standard management report available within the CyberAccess tool. Results will be reported by individual Health Home on the spreadsheet and benchmark style and disseminated all Health Homes.	Greater than 0.25

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Satisfaction with services	Mental Health Statistic Improvement Program (MHSIP) survey	SAMHSA National outcome Measures (NOMS) specifications Numerator = number of MHSIP survey responses with an average score < 2.5 (1= strongly agree, 5 = strongly disagree) across all **general satisfaction** questions / Denominator = number of MHSIP survey responses	Results of the MHSIP survey will be aggregated by Health Home and across the entire statewide initiative. Final report will benchmark individual Health Home performance compared to other Health Homes and the statewide average and identify individual items for performance improvement.	Greater than 90%

3. Quality of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

D. Goal 4: Improve coordination of care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Care Coordination - % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 2 days of discharge and performance medication reconciliation with input from PCP.	Claims and Monthly Health Home Report	Numerator = Number of patients contacted (phone or face-to-face) within 72 hours of discharge / Denominator = Number of all patients discharged x 100	The numerator will be aggregated from the monthly Health Home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Use of CyberAccess per member per month (or its successor) for non-MCO enrollees	Cyber-Access or successor	CyberAccess web hits PMPM Numerator = the number of times cyber access was open a healthcare home number for the 90 day reporting period. Denominator = Number of patients actively enrolled in the health home at any point during the 90 days x 90	This is a standard management report available within the Cyber Access tool. Results will be reported by individual Health Home on the spreadsheet and benchmark style and disseminated all health Homes.	One cyber access utilization PMPM

E. Goal 5: Improve preventive care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5 – 24.9	Disease Registry	Numerator = Number of patients with BMI of 18.5 - 24.9 / Denominator = Number of all patients with a documented BMI x 100	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	80%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Metabolic Screening - % of members screened in previous 12 months. Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG)	Disease Registry	Number of current enrollees with a documented metabolic screening in the last 12 months / Total enrollees.	The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80% completion

F. Goal 6: Improve Diabetes Care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Adult Diabetes - % of patients 18 – 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	Claims and Disease Registry	Numerator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in health home registry and having a documented Hba1c in the previous 12 months	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in administrative claims combined with clinical information & Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Health Home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>70%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Preventive - % of members screened in previous 12 months – Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG)	Disease Registry	Numerator = Number of current enrollees with a documented metabolic screening in the last 12 months / Denominator = Total enrollees x 100	The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI Health Home number registry. Results will be reported in a spreadsheet and benchmark style by individual Health Home.	80% completion

G. Goal 7: Improve asthma care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Pediatric Asthma - % of patients 5–17 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.	Claims	Numerator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in health home registry	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Health Home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>70%

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(2) Adult Asthma - % of patients 18-50 years old who were identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.	Claims	Numerator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in health home registry	(same)	>70%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Asthma: Adherence to prescription medications for asthma and/or COPD**.**	Claims	Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for asthma/COPD in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>90%

H. Goal 8: Improve Cardiovascular (CV) Care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period	Claims and Disease Registry	Numerator = for a given 90 day period number of patients between the age of 18 t0 85 years old identified as having hypertension in health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90 / Denominator = for a given 90 day period number of patients between the age of 18 to 75 years old identified as having hypertension in health home registry who had two documented episodes of care in the previous 12 months	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines.	>90%

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(2) CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).	Claims and Disease Registry	Numerator = for a given 90 day period number of patients between the age of 18 years or older identified as having cardiovascular disease in health home registry months where the most recent documented LDL level in the previous 12 months is < 100 / Denominator = for a given 90 day period number of patients between the age of 18 years and older identified as having cardiovascular disease in health home registry	Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>70%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Members with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds	Claims and Disease Registry	Numerator = number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on that class of medication in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Health Home performance	>90%

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(2) Members with CVD: Use of statin medications by persons with a history of CAD (coronary artery disease).	Claims and Disease Registry	Numerator = for a given 90 day period number of patients identified as having coronary artery disease in health home registry and a prescription for a Statin / Denominator = for a given 90 day period number of patients coronary artery disease in health home registry	Same	>70%

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Quality Measures: Service Based Measures **N/A**

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

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

i. Hospital admissions

1. Description: Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures).
2. Data Source: Claims
3. Frequency of Data Collection: Annual

ii. Emergency room visits

1. Description: Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure).
2. Data Source: Claims
3. Frequency of Data Collection: Annual

iii. Skilled Nursing Facility admissions

1. Description: Use of HEDIS 2011 codes for discharges for skilled nursing facility services (part of inpatient utilization – non-acute care (NON) measure).
2. Data Source: Claims
3. Frequency of Data Collection: Annual

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

i. Hospital admission rates: The State will consolidate data from its fee-for-service MMIS-based claims system and from MCO-generated encounter data for the participating Health Home sites to assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency), for the participating Health Home sites and for a control group of non-participating sites. The analysis will consider:

1. The experience of beneficiaries with the clinical conditions of focus during the learning collaborative year (expected to grow from year 1 to year 2), and
2. All beneficiaries with SMI or 2 or more chronic conditions drawn from a list of chronic conditions defined by the State.

ii. Chronic disease management: The State will audit each practice's implementation of chronic disease management, with a special focus on comprehensive care management. Audits will assess:

1. Documented self-management support goal setting with all beneficiaries identified by the practice site as high risk;
2. Practice team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge;
3. Documentation that there is a care manager in place; and
4. That the care manager is operating consistently with the requirements set forth for the practices by the State.

iii. Coordination of care for individuals with chronic conditions: The State will assess provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment as follows:

1. The State will measure:
   a. Care manager contact during hospitalization,
   b. Practice team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge,

c. Active care management of High Risk patients, and
d. Behavioral activation of High Risk patients.

2. Measurement methodologies for these 4 measures are described in the preceding section.

iv. Assessment of program implementation: The State will monitor implementation in 2 ways.

i. First, a Health Homes Work Group comprised of Dept. of Social Services and Dept. of Mental Health personnel and provider representatives will meet regularly to track implementation against a) a work plan and b) against performance indicators to assess implementation status. The meetings will initially occur on a biweekly basis, and then transition to monthly meetings 6 months into implementation.

ii. Second, the 2 Departments will join private payers and provider representatives on the Steering Committee of the Missouri Medical Home Collaborative to review monthly practice data submissions and analysis by the Missouri Foundation for Health, as well as the status of practice transformation activities in conjunction with a Missouri Foundation for Health-funded learning collaborative and possible practice coaching to be provided to at least some of the participating practices.

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

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

vii. Estimates of cost savings: The Missouri DMH and its statewide CMHC providers have been engaged in care coordination and disease management for general medical conditions in persons with severe mental illness (SMI) since 2004. As a result, Missouri is able to model anticipated savings in the §2703 Health Homes for Chronic Conditions when provided by CMHCs based on actual historic savings in previous projects.

1. **Analysis #1 – Cost Savings for New Patients Just Entering CMHC Services:** Total Medicaid costs were examined pre- and post-enrollment in CMHC management services. The persons selected were 636 patients who were newly enrolled in Missouri Medicaid's CMHC program. Patients were included if they had 9 months of Medicaid claims in each of the 2 preceding years, a diagnosis of severe mental illness, a history of psychiatric hospitalization or multiple ER visits, and functional limitations as a result of their mental illness. The exact enrollment date for CMHC services varied from client to client, which minimized the impact of bias due to changes in the healthcare delivery system at specific points in time or over the study period. Average total monthly Medicaid costs were calculated for the month of CMHC enrollment, the 24 months prior to enrollment, and the 24 months after enrollment for each client. Linear regression trend lines were then calculated on those pre-CMHC service and post-CMHC service cost data.

2. **Analysis #2 – Cost Savings of persons already receiving CMHC services and then had a health home model implemented that is similar to the proposed §2703 Health Home model.** In this project, Missouri Medicaid contracted with APS to implement a health home model (Chronic *Care Improvement Program "CCIP"*) for more than 86,000 patients statewide in both primary care and CMHC-based health homes, including dual eligibles. There were 6,500 clients in CMHCs that were eligible for APS CCIP. Due to funding limitations, less than 20% of CMHC patients at the time were actually enrolled in the APS program. CMHCs provided approximately 8% of the overall health homes in this project. The cost of the CMHC services was included in the pre/post period costs. The CMHC cohort sub-analysis presented below uses the same methodology applied by Mercer in its independent evaluation of the overall APS CCIP program.

INTERVENTION SAVINGS OFF TREND

CCIP Clients in CMHC Health Homes Base Period PMPM (FY2006)	$1,556
Expected Trend	16.67%
Expected Trend PMPM with No Intervention	$1,815.81
Actual Trend PMPM in Performance Period (FY2007)	$1,504.34
Gross PMPM Cost Savings	$311.47
Number of Lives	6,757
Gross Program Savings	$25,254,928
Vendor Fees	$1,301,563
Net Program Savings	$23,953,365
NET PMPM Program Savings	$295.41
Net Program Savings/(Cost) as % of Expected PMPM	16.3%

The State will annually perform an assessment of cost savings using a pre/post-period comparison with a control group of Medicaid primary care practices serving clinically similar populations but not participating as Health Homes. Control group practices will be similar to participating practices to the extent that it is feasible to do so. They will be identified by practice type (e.g., FQHC), geographic region, and number of Medicaid beneficiaries with serious mental illness or 2 or more chronic conditions. Savings calculations will be risk-adjusted, truncated claims of high-cost outliers annually exceeding 3 standard deviations of the mean, and will net out the value of supplemental payments made to the

participating sites during the 8-quarter period.

It is important to note that the cohorts used in both the preceding analyses included dual eligibles in the intervention groups, however the analyses did not include the Medicare costs. If the analyses had included Medicare costs, it is believed that there would have been additional proportional savings in these costs as well. Missouri did not explicitly flag which patients were dual eligibles or attempt to model how their inclusion impacted the overall savings. However, approximately 50% of the clients and service will be dual eligible at any given time in Missouri's CMHC programs. Taken together for our proposed § 2703 CMHC Health Home, the State conservatively estimates including the cost of the Health Home intervention:

- Year 1 will yield 5% Savings over year 0 total costs trended forward
- Year 2 will yield 10% Savings over year 0 total costs trended forward
- Year 3 will yield 15% Savings over year 0 total costs trended forward

SFY2010 Total Medicaid Healthcare Costs for CMHC SMI Patients are:

Adults:	$1,616 PMPM
Children:	$1,070 PMPM
Age Weighted Average:	$1,471 PMPM

Estimated savings off-trend including the cost of the Health Home intervention:

- Year 1: $ 74 PMPM
- Year 2: $147 PMPM
- Year 3: $221 PMPM

4.19 – B: Payment Methodology View

Attachment 4.19-B

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month
Provider Type: CMHC Health Home Provider

Overview of Payment Structure: Missouri has developed the following payment structure for designated CMHC Health Homes. All payments are contingent on the Health Home meeting the requirements set forth in their Health Home applications, as determined by the State of Missouri. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology for Health Homes is in addition to the existing fee-for-service or Managed Care plan payments for direct services, and is structured as follows:

Clinical Care Management	Missouri will pay for reimbursement of the cost of staff

per-member-per-month (PMPM) payment	primarily responsible for delivery of services not covered by other reimbursement (Primary Care Nurses, Physician Consultants, and Administrative Support staff) whose duties are not otherwise reimbursable by MO HealthNet.

Managed Care: All Health Home payments including those for MO HealthNet ("MHN") participants enrolled in managed care plans will be made directly from MHN to the Health Home provider. As a result of the additional value that managed care plans will receive from MHN direct paid Health Home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the CMS reimbursed HH services. This Health Home delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care. Additionally:

- The managed care plan will be informed of its members that are in Health Home services and a managed care plan contact person will be provided for each Health Home provider to allow for coordination of care.

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

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

Clinical Care Management per member per month (PMPM) payment

This reimbursement model is designed to only fund Health Home functionalities that are not covered by any of the currently available Medicaid funding mechanisms. Nurse Care Manager and Primary Care Physician Consultant duties often do not involve face-to-face interaction with Health Home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Missouri's Health Home model includes significant support for the leadership and administrative functions that are required to transform a traditional CMHC service delivery system to the new data-driven, population focused, person centered Health Home requirements.
The criteria required for receiving a monthly PMPM payment is:

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

Team Member	FTE/Cost	PMPM	Team Member Role
Nurse Care Manager	1 FTE/250 enrollees $105,000 / year	PMPM $35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Health Home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases, treatments & medications h. Track required assessments and screenings i. Assist in implementing DMH Net health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes
Primary Care Physician Consultant	1 hr/enrollee/yr $150/hr	PMPM $12.50	a. Participates in treatment planning b. Consults with team psychiatrist c. Consults regarding specific consumer health issues d. Assists coordination with external medical providers

Team Member	FTE/Cost	PMPM	Team Member Role
Health Home Director	1 FTE/500 enrollees $115,000 / year	PMPM $19.17	a. Provides leadership to the implementation and coordination of Healthcare Home activities b. Champions practice transformation based on Healthcare Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Healthcare Home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives
Administrative Support	1 FTE support staff/500 enrollees Non-PMPM paid staff training time Contracted services	PMPM $12.07	a. Referral tracking b. Training and technical assistance c. Data management and reporting d. Scheduling for Health Home Team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending Medical Records for care coordination
TOTAL PMPM		**$78.74**	

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

Appendix R:

The Primary Care State Plan Amendment
(effective January 1, 2012)

MEDICAID MODEL DATA LAB

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

TN#: MO 2-11-0015 | Supersedes TN#: MO -2-00-0000 | Effective Date: January 1, 2012 | Approved Date:

Transmittal Numbers (TN) and Effective Date

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

Supersedes Transmittal Number (TN)
00-0000

Transmittal Number (TN)
11-0015

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

Effective Date January 1, 2012

3.1 - A: Categorically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

☑ Health Home Services

How are Health Home Services Provided to the Medically Needy? Not provided to Medically Needy

i. Geographic Limitations

Health Homes will be provided as follows: Statewide
If Targeted Geographic Basis: N/A

ii. Population Criteria

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

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

from the list of conditions below:

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

Description of Other Chronic Conditions Covered.
Developmental Disabilities.

Description of "At Risk" Criteria

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

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

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

iii. Provider Infrastructure

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

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

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

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

Learning activities will support providers of primary care health home services in addressing the following components:

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

☐ Team of Health Care Professionals as described in § 1945(h)(6)
☐ Health Team as described in § 1945(h)(7), via reference to § 3502

iv. Service Definitions

A. Comprehensive Care Management

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

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

   a. Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
   b. View dates and providers of hospital emergency department services;
   c. Identify clinical issues that affect an enrollee's care and receive best practice information;
   d. Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;

e. Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
f. Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice; and
g. Review laboratory data and clinical trait data;
h. Determine medication adherence information and calculate medication possession ratios (MPR); and
i. Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

A. Care Coordination

1. Service Definition:

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

2. Ways Health IT Will Link:

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

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

C. Health Promotion

1. **Service Definition:**

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

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

1. **Ways Health IT Will Link:**

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

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

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

1. **Service Definition:**

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

2. **Ways Health IT Will Link:**

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

MO HealthNet and the Department of Mental Health are working with the vendor to develop capacity for a daily data transfer listing all new hospital admissions discharges. This information will

be transferred to the state's data analytics contractor which will match it to a list of all persons assigned and/or enrolled in a healthcare home. The contractor would then immediately notify the healthcare home provider of the admission, which would enable the primary care health home provider to:

a. Use the hospitalization episode to locate and engage persons in need of primary care health home services;
b. Perform the required continuity of care coordination between inpatient and outpatient; and
c. Coordinate with the hospital to discharge and avoid readmission as soon as possible.

E. Individual and Family Support Services (including authorized representatives)

1. Service Definition:

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

1. Ways Health IT Will Link:

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

a. Administrative claims data for the past three years;
b. Cardiac and diabetic risk calculators;
c. A drug information library; and
d. The functionality to create a personal health plan and discussion lists to use with healthcare providers.

F. Referral to Community and Social Support Services

1. Service Definition:

Referral to community and social support services involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples. For individuals with DD the health team will refer to and coordinate with the approved DD case management entity for this service. The Nurse Care Manager and appropriate primary care health home Administrative Support staff will provide referrals to community and social support services.

2. Ways Health IT Will Link:

Primary care health home providers will be encouraged to monitor continuing Medicaid eligibility

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

v. Provider Standards

A. Initial Provider Qualifications

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

k. Agree to participate in CMS and state-required evaluation activities;
l. Agree to develop required reports describing primary care health home activities, efforts and progress in implementing primary care health home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of primary care health home service staff time and activities);
m. Maintain compliance with all of the terms and conditions as a primary care health home provider or face termination as a provider of primary care health home services; and
n. Present a proposed healthcare home delivery model that the state determines to have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the primary care health home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

B. Ongoing Provider Certification Requirements

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

vi. Assurances

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

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

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

vii. Monitoring

A. **Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications:** Using claims data, the state will track avoidable hospital readmissions by calculating ACSC readmissions/1000: (# of readmissions with a primary diagnosis consisting of an AHRQ ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.

B. **Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications:** The State will annually perform an assessment of cost savings using a pre-/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. It will also be broken out for each primary care health home. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditures. Savings calculations will be trended for inflation, and will truncate the claims of high-cost outliers annually exceeding three standard deviations of the mean. Savings calculations will include the cost of PMPM payments received by primary care health home providers. The assessment will also include the performance measures enumerated in the Quality Measures section.

C. Describe the State's proposal for using health information technology in providing Health Home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider):
To facilitate the exchange of health information in support of care for patients receiving or in need of primary care health home services, the state will utilize several methods of health information technology (HIT). Following is a summary of HIT currently available for primary care health home providers to conduct comprehensive care management, care coordination, health promotion and individual and family support services. Also included is a description of the state's process to improve health information exchange (HIE) for comprehensive transitional care services. As Missouri implements its primary care health home models, the state will also be working toward the development of a single data portal through to facilitate information exchange, measures documentation and calculation and state reporting to CMS. The state will also continue to refine a process for HIE between CMHCs and primary care practices.

1. <u>HIT for Comprehensive Care Management and Care Coordination</u> – MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers, including CMHCs, primary care practices, and schools. The tool is a HIPAA-client portal that enables providers to:
    a. Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);
    b. View dates and providers of hospital emergency department services;
    c. Identify clinical issues that affect an enrollee's care and receive best practice information;

d. Prospectively examine how specific preferred drug list (PDL) and clinical edit criteria would affect a prescription for an individual enrollee and determine if a prescription meets requirement for Medicaid payment;
e. Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
f. Identify approved or denied drug prior authorizations or clinical edit overrides or medical pre-certifications previously issues and transmit a prescription electronically to the enrollee's pharmacy of choice; and
g. Review laboratory data and clinical trait data;
h. Determine medication adherence information and calculate medication possession ratios (MPR); and
i. Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

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

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

memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.

4. Referral to Community and Social Support Services – Primary care health home providers will be encouraged to monitor continuing Medicaid eligibility using the FSD eligibility website and data base. MO HealthNet and the Department of Mental Health will also refine process to notify primary care health home providers of impending eligibility lapses (e.g., 60 days in advance).

5. Data Warehouse and Reporting System – The Missouri Primary Care Association launched the Missouri Quality Improvement Network (MOQuIN) in early 2011, and is in the final stages completing a data warehouse for the purpose of functioning as a patient registry for the FQHCs and generating quality measures to support clinical quality improvement. Patient demographics and clinically authenticated patient care data from the FQHC EMRs are included in the data set to support the required measures. The data will be refreshed daily. MPCA will host a web-based reporting platform for users. Each health center's data will be available to the health center for individual report generation at all levels, health center, site, provider, and patient, to assist with care management. MPCA will generate aggregate reports to support quality improvement, best practice identification, and benchmarking. The data warehouse is expected to be functional for reporting purposes by October 2011.

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

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

viii. Quality Measures: Goal Based Quality Measures

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

A. Goal 1: Improve Health Outcomes for Persons with Chronic Conditions

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1)Ambulatory Care-Sensitive Condition Admission: Ambulatory care-sensitive condition-age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces need for admission to hospital, per 100,000 population under age 75 yrs	Claims	Numerator = Total # of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years / Denominator = Total mid-year population under age 75	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care.
(2)Emergency Department Visits: preventative / ambulatory care-sensitive ER visits (algorithm, not formally a measure)	Claims	Missouri will utilize the NYU Emergency Department Classification algorithm [V2.0] for this measures, which is too lengthy to place in the SPA. The algorithm is a nationally recognized method of calculating preventable ED visits.	Hospital ER visits will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(3)Hospital Readmission : Hospital readmissions within 30 days	Claims	Percentage of patients readmitted for all-cause conditions within 30 days of hospital discharge using the CMS Hospital Compare methodology.	Hospital discharge events will be identified by data analysis of administrative claims. Results of the audited sample will be aggregated in a spreadsheet benchmarking the individual Primary care health homes against each other and disseminated by email.	NCQA's most recently published 50th percentile regional rate for Medicaid managed care

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Care Coordination : % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.	Claims & EMR	Numerator: Number of patients contacted (by phone or face-to-face) within 72 hours of discharge / Denominator: Number of all patients discharged	The numerator will be aggregated from the monthly primary care health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home.	80%

B. Goal 2: Improve Behavioral Healthcare

(1) Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Reduce the proportion of adults (18 and older) reporting use of any illicit drug during the past 30 days**.**	EMR	Numerator = Over the prior 12 months the Number of adults who report using illicit drugs in the previous 30 days / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual Primary care health home	<7.1% (HP2020 goal)
(2) Reduce the proportion of adults (18 and older) who drank excessively in the previous 30 days	EMR	Numerator = Over the prior 12 months the Number of adults who report drinking excessively in the previous 30 days / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	>25.3% (HP2020 goal)

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
% of patients 18 years of age and older receiving depression screening through the use of a standardized screening instruments within the measurement period	EMR	Numerator = Number of adults screened for Depression in the previous 12 months / Denominator = Total number of adults in the past 12 months x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	90%
Percentage of children screened through EPSDT for mental health issues.	EMR or MHN on-line tool	Numerator = Number of children 0 – 18 y.o. with EPSTD MH items completed in prior 12 months Denominator= total number of unique children enrolled in Health Home in prior 12 months	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	>85%
% of members aged 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented, as necessary	EMR	Numerator = Number of adults screened for drinking excessively in the previous 12 months / Denominator = Number of all adult in the past 12 mo. x 100	Results will be reported in a spreadsheet and benchmark style by individual primary care health home.	90%

C. Goal 3: Increase patient empowerment and self-management

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Patient Use of personal EHR (Direct Inform, or its successor) or practice EMR patient portal	CyberAccess or its success-sor or practice EMR patient portal	Numerator = Number of times Direct Inform was used (patients online EHR record was opened) in a 90 day period / Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90	This is a standard management report available within the CyberAccess tool or via EMR reporting. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all Primary care health homes.	Greater than 0.25

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Satisfaction with services	CAPHS CG 1.0 Adult and Child Primary Care Surveys Adult Questions #6, 17, 19, and 20. Child Questions #6, 17, 19, and 22.	Numerator = number questions with response of 3-usually or 4-always Denominator = total number of questions with any answer	Results of the CAPHS survey will be aggregated by Primary care health home and across the entire statewide initiative. Final report will benchmark individual Primary care health home performance compared to other Primary care health homes and the statewide average and identify individual items for performance improvement.	>80%

3. Quality of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

D. Goal 4: Improve coordination of care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Care Coordination - % of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performance medication reconciliation with input from PCP.	Claims and EMR	Numerator = Number of patients contacted (phone or face-to-face) within 72 hours of discharge / Denominator = Number of all patients discharged x 100	The numerator will be aggregated from the monthly Primary care health home report. The denominator will be aggregated from claims. Results will be reported in a spreadsheet and benchmark style by individual Primary care health home.	80%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Use of CyberAccess per member per month (or its successor) enrollees	Cyber-Access or successor	PMPM Numerator = the number of times cyber access was open a healthcare home number for the 90 day reporting period. Denominator = Number of patients actively enrolled in the primary care health home at any point during the 90 days x 90	This is a standard management report available within the Cyber Access tool. Results will be reported by individual Primary care health home on the spreadsheet and benchmark style and disseminated all primary care health homes.	One cyber access utilization PMPM

E. Goal 5: Improve preventive care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Body Mass Index (BMI) Control - % of patients with documented BMI between 18.5 – 24.9	EMR	Numerator = Number of patients with BMI of 18.5 - 24.9 / Denominator = Number of all patients with a documented BMI x 100	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	80%

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Adult Weight Screening and Follow-Up- Percentage of patients aged 18 years or older with a calculated BMI in the past three months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.	EMR	Numerator= Patients in the denominator with a calculated BMI in the past 3 months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented./ Denominator= All active patients aged 18 years or older.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	37 %

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Weight Assessment and Counseling for Children and Adolescents- The percentage of patients 2-17 years of age who had an outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period.	EMR	Numerator= Patients in the denominator with BMI % documentation, counseling for nutrition and counseling for physical activity during the 90 day reporting period/ Denominator= All active patients 2-17 years of age.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	15% (HP 2020- NWS-6.3) The percentage was derived from the HP 2020 goal of: Increase the proportion of physician visits made by all child or adult patients that include counseling about nutrition or diet.

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
% of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday.	EMR	Numerator = number of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday. Denominator total= number of children 2 years of age	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and EMR to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>80% completion (HP 2020)

F. Goal 6: Improve Diabetes Care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Adult Diabetes - % of patients 18 – 75 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	EMR	Numerator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients between the age of 18 to 75 years old identified as having diabetes in primary care health home registry and having a documented Hba1c in the previous 12 months	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>60% (NCQA 2009 DRP)

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
% of patients 18–75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.	EMR	Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent BP in the previous 12 months was <140/90 mmHg. Denominator = total number of patients in the previous 12 months 18–75 years of age with diabetes (type 1 or type 2)	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>65% (NCQA 2009 DRP)
% of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.	EMR	Numerator = number of patients 18–75 years of age with diabetes (type 1 or type 2) whose most recent LDL-C in the previous 12 months was <100mg/dL. Denominator = total number of patients in the previous 12 months 18–75 years of age with diabetes (type 1 or type 2)	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>36% (NCQA 2009 DRP)

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Child Diabetes - % of patients under 18 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%	EMR	Numerator = For a given 90-day period, number of patients under the age of 18 years old identified as having diabetes in primary care health home registry and a documented Hba1c in the previous 12 months for whom the most recent documented Hba1c level is .8% / Denominator = For a given 90-day period, number of patients under the age of 18 years old identified as having diabetes in primary care health home registry and having a documented Hba1c in the previous 12 months	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will use data analytics of the diagnostic & service utilization information in practice EMRs to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>60%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Diabetes: Adherence to prescription medications for Diabetes.	Claims	Numerator = number of members on medication for Diabetes in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for Diabetes in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>90%

G. Goal 7: Improve asthma care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Pediatric Asthma - % of patients 5–17 years old who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.	Claims	Numerator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 5 to 17 years old identified as having asthma in primary care health home registry	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>70%

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(2) Adult Asthma - % of patients 18-50 years old who were identified as having persistent asthma & were appropriately prescribed medication (controller medication) during the measurement period.	Claims	Numerator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in primary care health home registry and a prescription for a controller medication / Denominator = for a given 90 day period number of patients between the age of 18 to 50 years old identified as having asthma in primary care health home registry	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the Primary care health home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>70%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with Asthma: Adherence to prescription medications for asthma and/or COPD**.**	Claims	Numerator = number of members on medication for asthma/COPD in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on medication for asthma/COPD in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>90%

H. Goal 8: Improve Cardiovascular (CV) Care

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(1) Hypertension - % of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen will for at least 2 office visits, w/ blood pressure adequately controlled (BP < 140/90) during the measurement period	EMR	Numerator = for a given 90 day period number of patients between the age of 18 t0 85 years old identified as having hypertension in primary care health home registry and who had two documented episodes of care in the previous 12 months where the most recent documented blood pressure in the previous 12 months is < 140/90 / Denominator = for a given 90 day period number of patients between the age of 18 to 75 years old identified as having hypertension in primary care health home registry who had two documented episodes of care in the previous 12 months	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and Disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines.	>50% (HP 2020)

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
(2) CAD - % of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).	Claims and Disease Registry	Numerator = for a given 90 day period number of patients between the age of 18 years or older identified as having cardiovascular disease in primary care health home registry months where the most recent documented LDL level in the previous 12 months is < 100 / Denominator = for a given 90 day period number of patients between the age of 18 years and older identified as having cardiovascular disease in primary care health home registry	Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance	>70%

2. Experience of Care

Measure	N/A	Measure Specification	N/A
Data Source	N/A	How Health IT will be Utilized	N/A

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will be Utilized	Benchmark Goal
Members with CVD: Adherence to Meds – CVD and Anti-Hypertensive Meds	Claims and Disease Registry	Numerator = number of members on that class of medication in the past 90 days with medication possession ratio (MPR) > 80% / Denominator = number of all members on that class of medication in the past 90 days	The medication adherence HEDIS indicators and meaningful use measures were developed from treatment guidelines. We will utilize data analytics of the diagnostic and service utilization information in administrative claims combined with clinical information and disease Registry to assess and monitor the extent to which a specific individuals' healthcare is consistent with treatment guidelines. Persons whose care deviates from that recommended by the treatment guidelines are identified as high risk individuals. Monitoring reports will be provided to the healthcare home both in the form of action required "to-do" lists of specific individuals needing specific evidence-based treatments and aggregate reports of the overall Primary care health home performance.	>90%

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Quality Measures: Service Based Measures: N/A

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

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

i. Hospital admissions

1. Description: Use of HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures)
2. Data Source: Claims
3. Frequency of Data Collection: Annual

ii. Emergency room visits

1. Description: Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB) measure)
2. Data Source: Claims
3. Frequency of Data Collection: Annual

iii. Skilled Nursing Facility admissions

1. Description: Use of HEDIS 2011 codes for discharges for SNF services (part of inpatient utilization – non-acute care (NON) measure)
2. Data Source: Claims
3. Frequency of Data Collection: Annual

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

i. Hospital admission rates: The State will consolidate data from its fee-for-service MMIS-based claims system and from MCO-generated encounter data for the participating Primary care health home sites to assess hospital admission rates, by service (medical, surgical, maternity, mental health and chemical dependency), for the participating Primary care health home sites and for a control group of non-participating sites. The analysis will consider:

1. The experience of beneficiaries with the clinical conditions of focus during the learning collaborative year (expected to grow from year 1 to year 2), and
2. All beneficiaries with 2 or more chronic conditions, or 1 chronic condition and at risk for a second, drawn from a list of chronic conditions defined by the State.

ii. Chronic disease management: The State will audit each practice's implementation of chronic disease management, with a special focus on comprehensive care management. Audits will assess:

1. Documented self-management support goal setting with all beneficiaries identified by the practice site as high risk;
2. Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge;
3. Documentation that there is a care manager in place; and
4. That the care manager is operating consistently with the requirements set forth for the practices by the State.

iii. Coordination of care for individuals with chronic conditions: The State will assess provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment as follows:

1. The State will measure:
   a. Care manager contact during hospitalization,

b. Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge,
c. Active care management of High Risk patients, and
d. Behavioral activation of High Risk patients.

2. Measurement methodologies for these 4 measures are described in the preceding section.

iv. Assessment of program implementation: The State will monitor implementation in 2 ways.

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

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

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

vii. *Estimates of cost savings*

I. INPATIENT UTILIZATION IMPACT**:**

A. Assumed reduction in hospital inpatient utilization is **15.4125%** for Medicaid patients

in primary care health homes (PCHHs).

B. Estimated average inpatient days per MHD patient admission. =**3 days**.

C. Average estimated Medicaid inpatient cost per day, including Medicaid share of hospital provider tax assessment, =**$ 1,672.62**

D. Assumed number of MHD Health Home assigned patients =**25,372**

E. Assume that an MHD participant would have **at least 1 hospital I/P admission annually** if not assigned to a Health Home

F I. $ 1,672.62 times 3 days average per admission = $ 5,017.86 average cost of Medicaid inpatient admission

II. 25,372 estimated MHD Primary Care Health Home patients, times $ 5,017.86 average Medicaid I/P admit cost, =$ 127,313,144 estimated MHD cost of hospital I/P admissions for Health Home patients prior to PCHH services

III. $ 127,313,144 estimated cost of hospitalization for MHD HH patients, times 15.4125% average I/P cost reduction, =**$ 19,622,138 estimated Medicaid I/P hospital cost savings.**

G. Assume that achieving gross Medicaid inpatient hospital cost savings for health home patients requires additional or "replacement" costs for increased utilization of other services such as physicians and pharmacy. Prior actuarial review found replacement cost factor of 6% to achieve hospital I/P cost reductions

H. $19,622,138 estimated gross Medicaid I/P hospital cost savings, net of 6% replacement cost factor = **$18,444,810 estimated net Medicaid I/P cost savings.**

II. <u>EMERGENCY ROOM UTILIZATION IMPACT</u>:

A. Assumed reduction in hospital emergency room utilization is **23.4857%** for Medicaid patients in primary care health homes (PCHHs).

B. Assume that an MHD ER visit is at least as costly as the average hospital outpatient visit.

C. Assume that an MHD participant would have **at least 1 ER visit annually** if not assigned to a Health Home.

D. For the months of June thru August 2011, the following MHD O/P hospital amounts were shown on the monthly FSD / MHD managerial reports:

June 2011: $ 45,239,283 hospital outpatient payments for 104,082 recipients, = $ 434.65 average O/P visit cost.

July 2011: $ 52,051,110 hospital outpatient payments for 114,477 recipients, = $ 454.69 average O/P visit cost.

August 2011: $ 57,679,060 hospital outpatient payments for 122,824 recipients, = $ 469.61 average O/P visit cost.

Average MHD hospital O/P cost per visit = **$ 452.98** for June - August 2011

E. Effective October 1, 2011, radiology services will be paid on a fee schedule instead of the hospital outpatient percentage methodology. Estimated impact on total outpatient costs = $50,000,000 reduction on an annual SFY basis. Based on hospital O/P payments above, estimated O/P payments for an entire SFY without the radiology fee

schedule conversion = $206,625,937. Percentage reduction in future total O/P costs would = 24.20%. Average MHD hospital O/P cost per visit reflecting future reduction in hospital outpatient radiology costs = **$343.37.**

F. Assumed number of MHD Health Home assigned patients =**25,372**

G. I. $ 343.37 average cost per MHD hospital ER / OP visit, multiplied by 25,372 estimated MHD HH patients,=

$ 8,711,919 estimated MHD cost of ER visits for Health Home patients prior to PCHH services

II. $ 8,711,919 estimated cost of ER for MHD HH patients, times 23.4857% average I/P cost reduction, =
$ 2,046,055 estimated Medicaid ER cost savings.

III. MHD HEALTH HOME COST IMPACT, NET OF HEALTH HOME PMPM PAYMENTS

A. Estimated I/P hospital cost savings for MHD Health Home patients = $ 18,444,810

B. Estimated ER cost savings for MHD Health Home patients =$ 2,046,055

C. Assume number of MHD Health Home assigned patients =25,372

D. I. Tentative Primary Care Health Home PMPM = $58.87

II. Tentative Primary Care Health Home PMPY = $706.44

III. Annual Primary Care PMPM cost = $(17,923,796)

E. **Primary Care Health Home estimated annual savings net of PMPM costs =$2,567,070**

F. Total estimated pre-PCHH costs = $ 136,025,063

G. **PCHH savings as a percentage of pre-PCHH costs = 1.89%**

IV. NOTE ON MEDICAID INPATIENT COST PER DAY

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

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions

Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy

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

i. Geographic Limitations: N/A

ii. Population Criteria: N/A
iii. Provider Infrastructure: N/A
iv. Service Definitions: N/A
v. Provider Standards: N/A
vi. Assurances: N/A
vii. Monitoring: N/A

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures: N/A

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Quality Measures: Service Based Measures: N/A

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

x. Evaluations: N/A

4.19 – B: Payment Methodology View
Attachment 4.19-B

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Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type: FQHC, RHC,
Primary Care Clinics Operated by Hospital
Primary care health home Providers

Overview of Payment Structure: Missouri has developed the following payment structure for designated primary care health homes. All payments are contingent on the primary care health home meeting the requirements set forth in their primary care health home applications, as determined by the State of Missouri. Failure to meet such requirements is grounds for revocation of primary care health home status and termination of payments. The payment methodology for primary care health homes is in addition to the existing fee-for-service or Managed Care plan payments for direct services, and is structured as follows:

Clinical Care Management per-member-per-month (PMPM) payment	Missouri will pay for reimbursement of the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Nurse Care Managers, Behavioral Health Consultant, Care Coordination and Administrative Support staff) whose duties are not otherwise reimbursable by MO HealthNet.

Managed Care: All primary care health home payments including those for MO HealthNet ("MHN") participants enrolled in managed care plans will be made directly from MHN to the primary care health home provider. As a result of the additional value that managed care plans will receive from MHN direct paid Primary care health home services, the managed care plan is not required to provide care coordination or case management services that would duplicate the CMS reimbursed HH services. This primary care health home delivery design and payment methodology will not result in any duplication of payment between Primary care health homes and managed care.

Additionally:

- The managed care plan will be informed of its members that are in primary care health home services and a managed care plan contact person will be provided for each primary care health home provider to allow for coordination of care.

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

- The Primary Care Primary care health home team will provide primary care health home services in collaboration with MCO network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the Primary Care Primary care health home.

Clinical Care Management per member per month (PMPM) payment

This reimbursement model is designed to only fund primary care health home functionalities that are not covered by any of the currently available Medicaid funding mechanisms. . Nurse Care Manager, Behavioral Health Consultant, and Care Coordinator duties do not always involve face-to-face interaction with primary care health home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Missouri's primary care health home model includes significant support for the leadership and administrative functions that are required to transform a traditional primary service delivery system to the new data-driven, population focused, person centered Primary care health home requirements.

The criteria required for receiving a monthly PMPM payment is:

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

Team Member	FTE/Cost	PMPM	Team Member Role
Nurse Care Manager	1 FTE/250 enrollees $105,000 / year	PMPM $35.00	a. Develop wellness & prevention initiatives b. Facilitate health education groups c. Participate in the initial treatment plan development for all of their Primary care health home enrollees d. Assist in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consult with Community Support Staff about identified health conditions f. Assist in contacting medical providers & hospitals for admission/discharge g. Provide training on medical diseases, treatments & medications h. Track required assessments and screenings i. Assist in implementing MHD health technology programs & initiatives (i.e., CyberAccess, metabolic screening) j. Monitor HIT tools & reports for treatment k. Medication alerts & hospital admissions/discharges l. Monitor & report performance measures & outcomes

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

Team Member	FTE/Cost	PMPM	Team Member Role
Primary care health home Director Administrative support	1 FTE/2500 enrollees $90,000/year Non-PMPM paid staff training time Contracted services	PMPM $8.87	a. Provides leadership to the implementation and coordination of Healthcare Home activities b. Champions practice transformation based on Healthcare Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors Healthcare Home performance and leads improvement efforts e. Designs and develops prevention and wellness initiatives Referral tracking f. Training and technical assistance g. Data management and reporting h. Non-PMPM paid staff training time
Care Coordination	1 FTE/750 enrollees $65,000/year	PMPM $7.22	a. Referral tracking b. Training and technical assistance c. Data management and reporting (can be separated into second part time function) d. Scheduling for Primary care health home Team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending Medical Records for care coordination
TOTAL PMPM		**$58.87**	

Payment Type: Alternate Payment Methodology: ***N/A***

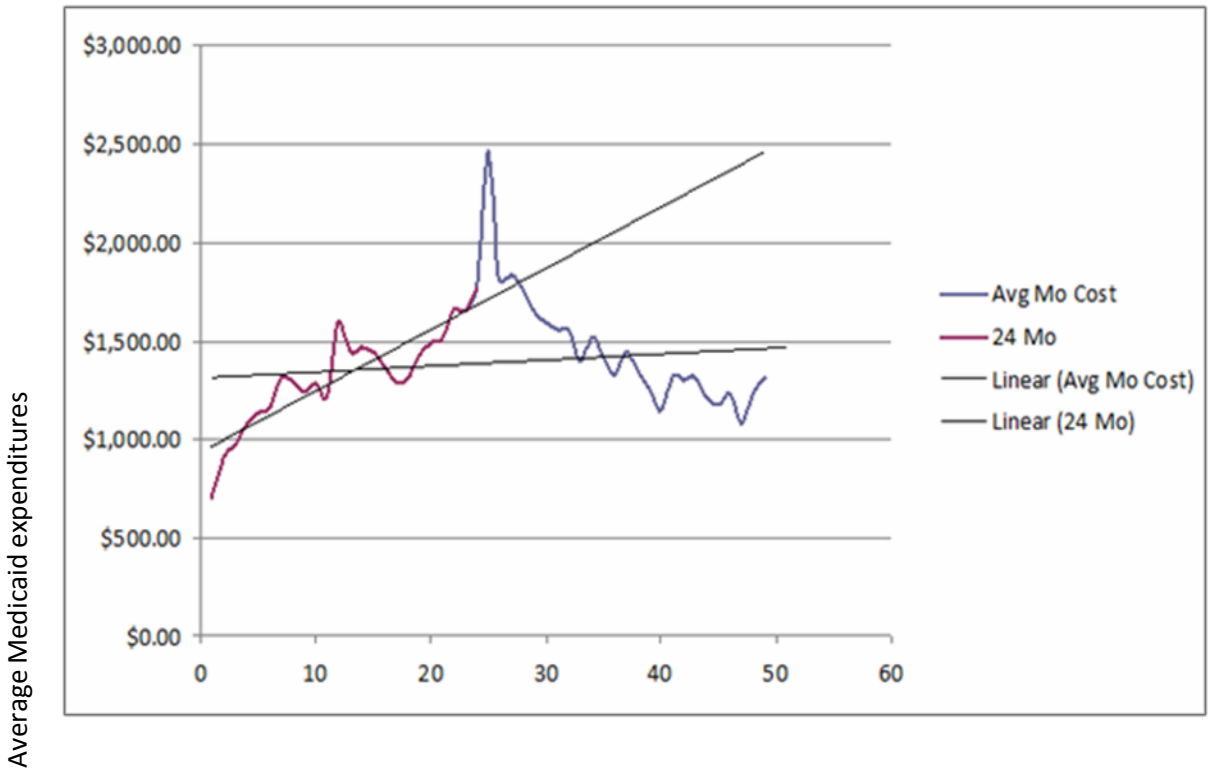
Provider Type: N/A

Description: N/A

Appendix S

Total HealthCare Utilization Per User Per Month

Pre and Post Community Mental Health Case Management



Appendix T

Letters of Support

MEMO

January 25, 2012

TO: Hospital CEO

FROM: Herb B. Kuhn
President and CEO
Missouri Hospital Association

U/R//S

Ian McCaslin, M.D. Director
MO HealthNet Division

U/R//S

SUBJECT: Medicaid Healthcare Home Initiative

We are pleased to announce that Missouri is the first state in the country to implement the Medicaid Healthcare Home Initiative. The purpose of the healthcare home is to assist Medicaid participants in managing their chronic physical and behavioral health conditions. The initiative is expected to improve health outcomes and reduce healthcare costs through care coordination across all health issues.

This is a major priority of the Missouri MO HealthNet Division and the Missouri Department of Mental Health. The MHA Board of Trustees supports the development of new and innovative ideas aimed at reducing costs and improving efficiency of the care we deliver. The Medicaid Healthcare Home Initiative is a good example of an excellent idea moving forward.

This letter is asking for your support in making the Medicaid Healthcare Home Initiative a success. Mo HealthNet has designated an initial set of 25 primary care health homes and 27 community mental health centers. They may be contacting your hospitals to establish collaborative relationships necessary to ensure appropriate coordination of care for individuals who choose to enroll in the Healthcare Homes. Coordination is required in the areas of hospital admissions and discharges, emergency room visits and
re-hospitalizations, and referral for health home enrollment.

Thank you for your consideration in forging positive partnerships with the Medicaid Healthcare Homes and achieving improved outcomes with reduced costs for Missourians with chronic health care needs.

hbk:rim/cml attachment

MPCA
Missouri Primary Care Association
3325 Emerald Lane ❖ Jefferson City, MO 65109-6879
(573) 636-4222 ❖ Fax (573) 636-4585

May 31, 2012

Samar Muzaffar, MD
Medical Director
MO HealthNet Division
PO Box 6500
Jefferson City, MO 65102-6500

Dear Dr. Muzaffar,

We are writing to express our strong support of the MO HealthNet application for the Centers for Medicare and Medicaid Services' (CMS) *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees Demonstration* project. We are proud that Missouri was the first state in the nation to have a State Plan Amendment approved under Section 2703 of the ACA to create the two-prong Health Home Initiative and would encourage CMS to further recognize the state's efforts to improve the quality of care for individuals who are dually eligible for Medicare and Medicaid by supporting the state's alignment application.

We have been extremely appreciative of Missouri's state leadership and commitment to the dually eligible population in the existing Health Home programs and believe that this demonstration program will build on the strong foundation the state has already created for this population. By sharing any Medicare savings generated by Missouri's investment in the Health Home program, CMS will give the state more ability to incentivize the practices that improve the quality of care for individuals dually eligible for Medicare and Medicaid while reducing costs.

We support the state's application without hesitation and urge CMS to provide Missouri with the opportunity to grow its existing Health Home program, improve the quality and experience of care for dual-eligibles while enhancing the value for all. We greatly appreciate your attention to this important matter.

u/ r//s

Sincerely,
Joseph Pierle, MPA
CEO