

Records / Submission Packages - Your State

MO - Submission Package - MO2021MS0006O - (MO-21-0033) - Health Homes

Summary   Reviewable Units   News   **Related Actions**

CMS-10434 OMB 0938-1183

Package Information

Package ID	MO2021MS0006O	Submission Type	Official
Program Name	Migrated_HH.Community Mental Health Center – Health Homes	State	MO
SPA ID	MO-21-0033	Region	Kansas City, KS
Version Number	1	Package Status	Pending

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

Package Header

Package ID	MO2021MS00060	SPA ID	MO-21-0033
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

State Information

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

- ☒ State Plan Amendment
- ☒ Medicaid
- ☐ CHIP

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2021M500060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

Package Header

Package ID

MO2021M500060

Submission Type

Official

Approval Date

N/A

Superseded SPA ID

N/A

SPA ID

MO-21-0033

Initial Submission Date

N/A

Effective Date

N/A

SPA ID and Effective Date

SPA ID MO-21-0033

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2021	MO-19-0017
Health Homes Geographic Limitations	10/1/2021	MO-19-0017
Health Homes Population and Enrollment Criteria	10/1/2021	MO-19-0017
Health Homes Providers	10/1/2021	MO-19-0017
Health Homes Service Delivery Systems	10/1/2021	MO-19-0017
Health Homes Payment Methodologies	10/1/2021	MO-19-0017
Health Homes Services	10/1/2021	MO-19-0017
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2021	MO-19-0017

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

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Superseded SPA ID	N/A		

Executive Summary

**Summary Description Including Goals and Objectives** The purpose of this state plan amendment (SPA) is to add Complex Trauma as a qualifying condition and update one of the four core Health Home staff. Missouri would like to expand Health Home enrollment of children and adolescents. Adding Complex Trauma as a qualifying condition will allow an overall focus of how trauma affects both behavioral and physical health conditions. Missouri would like to update the Primary Care Physician Consultant to the Specialized Healthcare Consultant. Updating the Primary Care Physician Consultant to a Specialized Healthcare Consultant will allow Health Homes flexibility in offering additional consultation from a variety of healthcare professionals for special populations. This SPA also updates the Per Member Per Month (PMPM) payment for Community Mental Health Centers (CMCH) Health Homes effective October 1, 2021.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	\$1118000
Second	2023	\$1342000

Federal Statute / Regulation Citation

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

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created
No items available	

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH,Community Mental Health Center - Health Homes

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Governor's Office Review

- ☐ No comment
- ☐ Comments received
- ☐ No response within 45 days
- ☐ Other

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## Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | MO2021M500060 | MO-21-0033 | Migrated\_HHCommunity Mental Health Center - Health Homes

CMS-10434 OMB 0938-1188

The submission includes the following:

- ☐ Administration
- ☐ Eligibility
- ☒ Benefits and Payments
- ☒ Health Homes Program

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

- ☐ Create new Health Homes program
- ☒ Amend existing Health Homes program
- ☐ Terminate existing Health Homes program

Migrated\_HHCommunity Mental Health Center - Health Homes

### Health Homes SPA - Reviewable Units

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

Reviewable Unit Name	Source Type
<input checked="" type="checkbox"/> Health Homes Intro	<input type="radio"/> APPROVED
<input checked="" type="checkbox"/> Health Homes Geographic Limitations	<input type="radio"/> APPROVED
<input checked="" type="checkbox"/> Health Homes Population and Enrollment Criteria	<input type="radio"/> APPROVED
<input checked="" type="checkbox"/> Health Homes Providers	<input type="radio"/> APPROVED
<input checked="" type="checkbox"/> Health Homes Service Delivery Systems	<input type="radio"/> APPROVED
<input checked="" type="checkbox"/> Health Homes Payment Methodologies	<input type="radio"/> APPROVED
<input checked="" type="checkbox"/> Health Homes Services	<input type="radio"/> APPROVED
<input checked="" type="checkbox"/> Health Homes Monitoring, Quality Measurement and Evaluation	<input type="radio"/> APPROVED

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## Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

### Package Header

Package ID MO2021MS00060

SPA ID MO-21-0033

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

#### Name of Health Homes Program

Migrated\_HH.Community Mental Health Center - Health Homes

☐ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

#### Upload copies of public notices and other documents used

Name	Date Created
No items available	

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Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

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Name of Health Homes Program:  
Migrated\_HH.Community Mental Health Center - Health Homes

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

- ☐ Yes
- ☒ No

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Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

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SAMHSA Consultation

Name of Health Homes Program

Migrated\_HH.Community Mental Health Center - Health Homes

Date of consultation

2/28/2011

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

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## Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center – Health Homes

### Package Header

Package ID MO2021MS00060  
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 Approval Date N/A  
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SPA ID MO-21-0033  
 Initial Submission Date N/A  
 Effective Date 10/1/2021

### Program Authority

1945 of the Social Security Act

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

#### Name of Health Homes Program

Migrated\_HH.Community Mental Health Center – Health Homes

### Executive Summary

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

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

### General Assurances

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

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# Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

## Package Header

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Superseded SPA ID	MO-19-0017		
	User-Entered		

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

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## Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

### Package Header

Package ID MO2021MS00060  
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SPA ID MO-21-0033  
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### Categories of Individuals and Populations Provided Health Homes Services

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

☒ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

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## Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0933 | Migrated\_JH.Community Mental Health Center - Health Homes

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SPA ID MO-21-0033  
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 Effective Date 10/1/2021

## Population Criteria

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

☒ Two or more chronic conditions

## Specify the conditions included:

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

Name	Description
Developmental disability	CMHCs will be the state's designated provider for individuals with: <ul style="list-style-type: none"> <li>Developmental disability: this term is used as defined in section 630.005(9) of the Revised Statutes of Missouri.</li> <li>Chronic Obstructive Pulmonary Disorder: changes in the lungs and airways that impede the flow of air, including emphysema and chronic bronchitis.</li> </ul>
Complex Trauma	CMHCs will be the state's designated provider for individuals with: <ul style="list-style-type: none"> <li>Complex Trauma: an infant/child/adolescent's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.</li> </ul>

☒ One chronic condition and the risk of developing another

## Specify the conditions included:

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

Name	Description
Developmental Disability	CMHCs will be state's designated provider for individuals with: <ul style="list-style-type: none"> <li>Developmental disability: this term is used as defined in section 630.005(9) of the Revised Statutes of Missouri.</li> </ul>
Complex Trauma	CMHCs will be state's designated provider for individuals with: <ul style="list-style-type: none"> <li>Complex Trauma: an infant/child/adolescent's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.</li> </ul>

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

## Description of "At Risk" Criteria:

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

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

- Developmental disability: this term is used as defined in section 630.005(9) of the Revised Statutes of Missouri.
- Chronic Obstructive Pulmonary Disorder: changes in the lungs and airways that impede the flow of air, including emphysema and chronic bronchitis.
- Complex Trauma: an infant/child/adolescent's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.

(The description below is a continuation of the "criteria for a serious and persistent mental health condition" that was started in the box below)

10. Anxiety Disorders
    - A. Generalized Anxiety Disorder
    - B. Panic Disorder with Agoraphobia
    - C. Panic Disorder without Agoraphobia
    - D. Agoraphobia without Panic Disorder
    - E. Social Phobia
  11. For children and youth only
    - A. Major depressive disorder, single episode
    - B. Bipolar
    - C. Reactive attachment disorder of infancy or early childhood
  12. For adults aged sixty (60) years and over
    - A. Major depressive disorder, single episode
  13. Adults with a functional assessment score range defined by the department, in combination with one of the following DSM-5 diagnoses, meet the disability and diagnostic requirements:
    - A. Bipolar Disorder, Most Recent Episode Unspecified
    - B. Shared Psychiatric Disorder
    - C. Conversion Disorder
    - D. Dissociative Identity Disorder
    - E. Dysthymic Disorder
    - F. Depersonalization Disorder
    - G. Body Dysmorphic Disorder
    - H. Hypochondriasis
    - I. Somatization Disorder
    - J. Undifferentiated Somatoform Disorder
    - K. Paranoid Personality Disorder
    - L. Cyclothymic Disorder
    - M. Schizoid Personality Disorder
    - N. Schizotypal Personality Disorder
    - O. Obsessive-Compulsive Personality Disorder
    - P. Histrionic Personality Disorder
    - Q. Dependent Personality Disorder
    - R. Antisocial Personality Disorder
    - S. Narcissistic Personality Disorder
    - T. Avoidant Personality Disorder
    - U. Personality Disorder NOS
    - V. Pain Disorder Associated with Psychological Factors
    - W. Pain Disorder Associated with Both Psychological Factors and a General Medical Condition
    - X. Intermittent Explosive Disorder
  14. Individuals younger than 18 with a functional assessment score range defined by the department, in combination with the following DSM-5 psychiatric diagnoses, meet the disability and diagnostic requirements:
    - A. Any diagnosis listed above, or
    - B. Separation Anxiety Disorder
    - C. Oppositional Defiant Disorder
    - D. Attention-Deficit/Hyperactivity Disorder (Predominantly Inattentive Type, Predominantly Hyperactive-Impulsive Type, Combined Type)
  15. Youth or adults, with a functional assessment score range defined by the department, and who have one of the following Not Otherwise Specified (NOS) Disorders, also meet the disability and diagnostic requirements. When an NOS disorder is used as the diagnosis, documentation must specifically include a detailed history/examination for each of the non-NOS criteria and a clear rationale for how those criteria are not met, thus supporting the appropriateness of an NOS diagnosis.
    - A. Mood Disorder NOS
    - B. Anxiety Disorder NOS
    - C. Dissociative Disorder NOS
    - D. Personality Disorder NOS
    - E. Depressive Disorder NOS
    - F. Impulse Control Disorder NOS
    - G. Disruptive Behavior Disorder NOS
    - H. AD/HD NOS
    - I. Bipolar Disorder NOS
- Duration. Rehabilitation services shall be provided to those individuals whose mental illness is of sufficient duration as evidenced by one (1) or more of the following occurrences:
1. Individuals who have undergone psychiatric treatment more intensive than outpatient more than once in a lifetime (crisis services, alternative home care, partial hospital, inpatient);
  2. Individuals who have experienced an episode of continuous residential care other than hospitalization, for a period long enough to disrupt the normal living situation;
  3. Individuals who have exhibited the psychiatric disability for one (1) year or more; or
  4. Individuals whose treatment of psychiatric disorders has been or will be required for longer than six (6) months.
- Whenever discrepancies occur regarding the appropriateness of an ICD-10-CM versus a DSM-5 diagnosis, the DSM-5 diagnosis shall prevail.

☒ One serious and persistent mental health condition

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

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

• Disability. There shall be clear evidence of serious and/or substantial impairment in the ability to function at an age or developmentally-appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning, as indicated by intake evaluation and assessment:

- o Social role functioning/family life—the ability to sustain functionally the role of worker, student, homemaker, family member, or a combination of these; and
- o Daily living skills/self-care skills—the ability to engage in personal care (such as grooming, personal hygiene) and community living (handling individual finances, using community resources, performing household chores), learning ability/self-direction, and activities appropriate to the individual's age, developmental level, and social role functioning;

• Diagnosis. A physician or licensed psychologist shall certify a primary Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis using the current edition of the manual. This diagnosis may coexist with other psychiatric diagnoses.

1. Disorganized  
 2. Atypical  
 3. Paranoid  
 4. Schizophreniform  
 5. Residual  
 6. Schizoaffective  
 7. Undifferentiated

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2. Delusional disorder
3. Bipolar I disorders
  - A. Single manic episode
  - B. Most recent episode manic
  - C. Most recent episode depressed
  - D. Most recent episode mixed
4. Bipolar II disorders
5. Psychotic disorders NOS
6. Major depressive disorder-recurrent
7. Obsessive-Compulsive Disorder
8. Post-Traumatic Stress Disorder
9. Borderline Personality Disorder

(This description is continued above in the box for "Additional description of other chronic conditions")

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**Health Homes Population and Enrollment Criteria**

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

**Package Header**

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**Enrollment of Participants**

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

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

**Describe the process used:**

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

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## Health Homes Providers

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### Types of Health Homes Providers

☒ Designated Providers

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

- ☐ Physicians
- ☐ Clinical Practices or Clinical Group Practices
- ☐ Rural Health Clinics
- ☐ Community Health Centers
- ☒ Community Mental Health Centers

Describe the Provider Qualifications and Standards

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.

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

☐ Teams of Health Care Professionals

☐ Health Teams

### Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

CMHC Healthcare Home staff will include a Health Home Director, Nurse Care Manager, Care Coordinator, and Specialized Healthcare Consultant. Specialized Healthcare Consultant includes one or more of the following: primary care physician consultant, nurse practitioner, dietitian, occupational therapist, or speech language pathologist.

The Health Home Director is responsible for advocating for continued practice transformation designed to integrate physical and behavioral health, prevention, and wellness; managing Health Home enrollments, discharges, and transfers; overseeing the daily operations of the Health Home, including overseeing the completion and submission of required monthly Health Home reports to the state; and, if appropriately credentialed, participating in occupational and health education activities, including, but not limited to, topics on smoking cessation, nutrition, disease prevention, and medication adherence.

The Nurse Care Manager is responsible for overseeing the health trends of the entire population of enrollees (or enrollees on their caseloads); following-up on identified trends impacting the health of the population; participating in health education activities, including topics on smoking cessation, disease prevention, and medication adherence; and completing medication reconciliations for Health Home enrollees post hospital discharge.

The Care Coordinator facilitates the multi-disciplinary teams' reviews of monthly care management and hospital admission reports; completes metabolic screening data entry; assists with appointment scheduling and client tracking; provides technical assistance to the multi-disciplinary teams in utilizing the automated care management reporting systems, if appropriately credentialed; participates in occupational and health education activities, including topics on smoking cessation, disease prevention, and medication adherence; and may, if appropriately credentialed, at the request of the multi-disciplinary team, assist in providing case management services.

The Specialized Healthcare Consultant(s) allow the CMHC Healthcare Home to have flexibility in offering additional consultation from a variety of healthcare professionals for special populations.

In addition, CMHC Healthcare Homes will be physician-led with an individual's multi-disciplinary team. The care team may include the individual's treating psychiatrist (or other qualified prescriber), qualified mental health professional, and a mental health case manager. Additional multi-disciplinary team members may include the individual's treating primary care physician, as well as other representatives as appropriate to meet the individual's needs (e.g. educational, employment, or housing representatives). All members of the individual's team will be responsible for ensuring that care is person-centered, culturally competent, and linguistically capable.

The cost of the Nurse Care Manager, Health Home Director, Care Coordinator, and Specialized Healthcare Consultant will be covered by the per member per month (PMPM) rate described in the payment methodology section below.

### Supports for Health Homes Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care services in various settings, including appropriate follow-up from other settings, such as participation in discharge planning and facilitating transfer from a pediatric inpatient system to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support for 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

10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

**Description**

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

**Other Health Homes Provider Standards**

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

**Initial Provider Qualifications**

1. State Qualifications: In addition to being a state-designated CMHC, each Health Home provider must meet state qualifications, which may be amended from time-to-time as necessary and appropriate, but minimally require that each Health Home:
  - a. Have a substantial percentage of individuals enrolled in Medicaid;
  - b. Have strong, engaged leadership committed to and capable of leading the practice as demonstrated through the application process and agreement to participate in learning activities including in-person sessions and regularly scheduled phone calls as required by the department;
  - c. Meet the department's minimum access requirements. Prior to implementation of Health Home service coverage, provide assurance to the department of enhanced patient access to the care team, including the development of alternatives to face-to-face visits (such as telephone or email), and 24 hours per day 7 days per week crisis services;
  - d. Use the department's identified health information technology tool to conduct care coordination, input metabolic syndrome screening results, track, and measure care of individuals, automate care reminders, produce exception reports for care planning, and monitor prescriptions;
  - e. Use an electronic health management tool to determine problematic prescribing patterns;
  - f. Conduct wellness interventions, as indicated based on the individuals' level of risk;
  - g. Complete status reports to document individuals' housing, legal, employment, education, and custody status;
  - h. Agree to convene regular, ongoing and documented internal Health Home team meetings to plan and implement goals and objectives of ongoing practice transformation;
  - i. Agree to participate in CMS and department-approved evaluation activities;
  - j. Agree to develop required reports describing Health Home activities, efforts and progress in implementing Health Home services;
  - k. Maintain compliance with all of the terms and conditions as a Health Home provider or face termination as a provider of Health Home services; and
  - l. Present a proposed Health Home delivery model that the department determines will 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, and other factors to be determined by the state.
2. Ongoing Provider Qualifications. Each CMHC must also:
  - a. Coordinate care and build relationships with regional hospital(s) or hospital system(s) to develop a structure for transitional care planning, including communication of inpatient admissions of Health Home participants, and maintain a mutual awareness and collaboration to identify individuals seeking emergency department services who might benefit from connection with a Health Home, and encourage hospital staff to notify the area Health Home staff of such opportunities;
  - b. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
  - c. Demonstrate continuing development of fundamental Health Home functionality through an assessment process to be applied by the state;
  - d. Demonstrate significant improvement on clinical indicators specified by and reported to the department;
  - e. Provide a Health Home that demonstrates overall cost effectiveness; and
  - f. Meet accreditation standards approved by the department.

Name

Date Created

No items available

**Health Homes Service Delivery Systems**

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_RH.Community Mental Health Center - Health Homes

**Package Header**

Package ID MO2021MS00060  
 Submission Type Official  
 Approval Date N/A  
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SPA ID MO-21-0033  
 Initial Submission Date N/A  
 Effective Date 10/1/2021

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

- ☒ Fee for Service
- ☐ PCCM
- ☐ Risk Based Managed Care
- ☐ Other Service Delivery System

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## Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH,Community Mental Health Center - Health Homes

### Package Header

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### Payment Methodology

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

☒ Fee for Service

☐ Individual Rates Per Service

☒ Per Member, Per Month Rates

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☒ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

**Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided** All CMHC Health Home providers will receive the same PMPM rate.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

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Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_JHH.Community Mental Health Center - Health Homes

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Agency Rates

Describe the rates used

- ☒ FFS Rates Included In plan
- ☐ Comprehensive methodology Included In plan
- ☐ The agency rates are set as of the following date and are effective for services provided on or after that date

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## Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

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## Rate Development

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

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

## Comprehensive Description Rate Basis/Development

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

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

## Cost Assumptions/Factors Used to Determine Payment:

Missouri will pay CMHC Health Homes the cost of staff primarily responsible for delivery of services not covered by other reimbursement (Health Home Director, Nurse Care Manager(s), Care Coordinator(s), and Specialized Healthcare Consultant(s) whose duties are not otherwise reimbursable by MO HealthNet (MHD). Health Homes receive payments related to Health Home specific training, technical assistance, administration, and data analytics.

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

## Clinical Care Management Standards

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

- The managed care plan will be required to inform the individual's Health Home or MO HealthNet of any inpatient hospital admission or discharge within 24 hours of the occurrence, as determined through its inpatient admission initial authorization and concurrent review processes
- The CMHC Health Home team will provide Health Home services in collaboration with managed care organization network primary care physicians in the same manner as they will collaborate with any other primary care physician who is serving as the PCP of an individual enrolled in the CMHC Health Home.

## Minimum Criteria for Payment:

The criteria required for receiving the PMPM payment is:

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

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

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Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_FH\_Community Mental Health Center - Health Homes

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MO-21-0033

Initial Submission Date

N/A

Effective Date

10/1/2021

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Assurances

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

Describe below how non-duplication of payment will be achieved

Health Home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future Health Home state plan benefits, and other state plan services). In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.
- ☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created
No items available	

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Health Homes Services

MAEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

Package Header

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User-Entered			

Service Definitions

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

Comprehensive Care Management

Definition

Comprehensive care management services include:

- 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;
- c) Treatment plan development, which will include individual goals, preferences and optimal clinical outcomes;
- d) Assignment of care team roles and responsibilities;
- e) Development of treatment guidelines that establish clinical pathways for care teams to follow across risk levels or health conditions;
- f) Determine adherence to or variance from treatment guidelines by monitoring population and individual health status and service delivery practices; and
- g) Development and dissemination of reports which indicate progress toward meeting outcomes for individuals' satisfaction, health status, service delivery, and costs.

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

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

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

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

Scope of service

The service can be provided by the following provider types

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

Provider Type	Description
CMHC	Community Mental Health Center

Care Coordination

Definition

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

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

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

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

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

**Scope of service**

The service can be provided by the following provider types

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

Provider Type	Description
CMHC	Community Mental Health Center

**Health Promotion****Definition**

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

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

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

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

**Scope of service**

The service can be provided by the following provider types

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

Provider Type	Description
CMHC	Community Mental Health Center

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



**Definition**

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

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

MO HealthNet maintains an initial and concurrent authorization of stay tool, which requires hospitals to notify MO HealthNet (via the online authorization tool) within 24 hours of a new admission of any Medicaid enrollee, and provide information about diagnosis, condition, and treatment for authorization of an inpatient stay. These authorizations are sent daily to the Department of Mental Health HIT vendor which then sends an alert to the appropriate treatment team at the Health Home (via the HIT vendor's web-based solution for care management and population health). This information and process allows the Health Home provider to:

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

**Scope of service****The service can be provided by the following provider types**

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

**Provider Type**

CMHC

**Description**

Community Mental Health Center

**Individual and Family Support (which includes authorized representatives)****Definition**

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

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

A module of the MO HealthNet comprehensive, web-based EHR allows enrollees to look up their own healthcare utilization and receive the same content in 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.

**Scope of service****The service can be provided by the following provider types**

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

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## Provider Type

CMHC

## Description

Community Mental Health Center

## Referral to Community and Social Support Services

## Definition

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

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

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

## Scope of service

## The service can be provided by the following provider types

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

## Provider Type

CMHC

## Description

Community Mental Health Center

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Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

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Health Homes Patient Flow

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

1. The CMHC outreach worker, or an individual's case manager, offers the opportunity to enroll in the Health Home, and explains a Nurse Care Manager (NCM) will be assigned to assist in improving health and wellness goals, the availability of these services as a Medicaid benefit, participation is optional, and choosing not to enroll will have no impact on current services.
2. Once an individual enrolls, the CMHC completes a comprehensive health screen. The NCM meets with the individual to review the results of the screen and their treatment history, and to discuss wellness, health, and healthcare goals.
3. A multidisciplinary care team collaborates with the individual to develop a treatment plan, which is reviewed at least quarterly through a functional assessment, and includes wellness, health, healthcare, and self-management goals.
4. The individual's Primary Care Physician (PCP) is notified of enrollment in the Health Home. If the individual does not have a PCP, the CMHC works to connect them with one. Case managers assist individuals to manage chronic health conditions through coordination and collaboration with the PCP.
5. The care team carries out assigned treatment plan responsibilities related to wellness, health status, chronic disease management, housing, employment, and care coordination. Case managers assist individuals to address chronic health conditions through wellness coaching techniques and strategies.
6. The health information technology platform updates care management registries for each enrollee. The registries enable NCMs to identify if individuals receive psychotropic medications outside of best practice guidelines; if the individual fails to fill prescribed medications for chronic health conditions or psychotropic medications; if individuals with hypertension, diabetes, and cardiovascular disease have lab values which exceed desired levels; and track progress in controlling BMI levels, tobacco use, and metabolic screening values.
7. When goals are achieved, the individual may be discharged or transferred to a Primary Care Health Home for continued care management with the option of returning to the CMHC, if needed.

Name	Date Created
Flow Chart for Individuals Engaged thru Outreach 08_2021	8/20/2021 3:04 PM EDT
Flow Chart for Existing CMHC Consumers 08_2021	8/20/2021 3:04 PM EDT

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# Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH.Community Mental Health Center - Health Homes

## Package Header

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 Initial Submission Date N/A  
 Effective Date 10/1/2021

## Monitoring

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

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

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

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

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

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

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

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

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

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

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

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

These authorizations are sent daily to the Department of Mental Health HIT vendor which then sends an alert to the appropriate treatment team at the Health Home (via the HIT vendor's web-based solution for care management and population health). This information and process allows the Health Home provider to:

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

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

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

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

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**Health Homes Monitoring, Quality Measurement and Evaluation**

MEDICAID | Medicaid State Plan | Health Homes | MO2021MS00060 | MO-21-0033 | Migrated\_HH\_Community Mental Health Center - Health Homes

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**Quality Measurement and Evaluation**

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

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PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12) which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop CA-26-05, Baltimore, Maryland 21244-1850.

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