Feedback re: Missouri Medicaid Primary Care Health Home SPA Draft
April 04, 2011

1. Geographic Area:
   The description is geared towards the provider, even though it is listed as being available statewide for the individual participants. If no providers choose to participate in an area of the State, does the State intend to offer the health home program only in those areas where providers are located?

2. Population Criteria:
   Health homes provide care across the lifespan of a chronic illness. Health homes cannot be limited by age and must include all categorically needy individuals who meet the State's criteria. How will the State inform/educate Medicaid recipients about the health home program? How will Medicaid recipients select a designated health home provider or opt-out of the program, since comparability must afford choice? Please clarify how preventable poor outcomes would be a chronic condition. The State needs to define the specific chronic conditions targeted. An expansion to other chronic conditions in year 2, would require submittal of a separate SPA with specific details at the time of submission.

3. Provider Infrastructure
   What are the provider type(s) the State will allow to serve as "designated providers" for health homes? Will the health home team include other specialists, e.g. psychiatrists, pulmonologists, ENTs, cardiologists, etc. for other chronic conditions? Also, what about children, how do the pediatricians fit into the team structure? How are optional health team members brought onto the team? Will this occur at the request of the individual or by the care manager? Will the designated provider be responsible for locating the optional team members? Will optional team members be included in the review to determine the selection of primary care medical homes?

4. Health Home Services:
   Explain how the state will leverage existing state plan services with health home services (i.e. TCM, waiver services) to avoid duplication and coordinate services. Describe the delivery system in which the state intends to provide health home services and how the health home program and the State's existing delivery system will work together. (I.e. fee-for-service, managed care, 1915 (c) waiver etc.). Would recommend removal of the term self-direction under health promotion as it could identify other meanings found in waivers. Who teaches the health home recipient about how to use HIT module for health promotion for self utilization? Will the State's data analytics contractor be required to notify the health home the same day the data comes in? What happens if the inpatient stay is initiated on a weekend? Until the data transfer and analytics process is completed, what will be the process to identify the inpatient admission as quickly as possible? If the primary focus of "individual and family supports" will be increasing health literacy, ability to self-manage and participation in the ongoing revision of their treatment plan, what are the differences from "Health promotion"? What is a "direct inform web hit PMPM"? What types of practitioners will be responsible for providing the comprehensive care management services?

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4. Provider Standards:
   Can the State please clarify who will serve as the health home provider? Will health home providers be required to meet any state determined educational and/or certification requirements? If so, please elaborate. If not, how will the state educate providers about the health home program requirements? For initial provider qualifications, how will the State assess “strong, engaged leadership”? How will a health home provider establish up front (and the state determine that it complies) that it is “capable of overall cost effectiveness”? Please clarify the patient panels and the description of access requirements for “third-next-available” appointment. For ongoing provider qualifications, bullet #2 should be health home. What are the standards for the assessment process the State will use to measure providers continuing development? What if the provider does not submit for NCQA recognition or does and fails, will payments be recovered?

5. **Assurances**
   Hospital notification of health home beneficiary seeking services – How will the hospital ED know if a member is a health home beneficiary?

   SAMHSA collaboration – The assurance states that the CMHC model was shared with SAMHSA, but does not indicate that this primary care model was shared.