

# Missouri Medicaid Community Mental Health Center Health Home SPA Template

*See attached Narrative and chart describing client and information flow*

**LAST UPDATED ON MAY 5, 2011**

Community Mental Health Center Health Home Description	
<p><b>Geographic Area</b> (Describe whether statewide or targeted)</p>	<p>Statewide for Community Mental Health Centers (CMHCs). CMHCs provide services to clients of every county in the state.</p>
<p><b>Population Criteria</b></p>	<p>CMHCs will be the state’s designated provider for individuals of any age with:</p> <ul style="list-style-type: none"> <li>▪ A serious and persistent mental health condition;</li> <li>▪ A mental health condition and one other chronic condition (asthma, cardiovascular disease, diabetes, substance use disorder, developmental disability, overweight (BMI &gt;25);</li> <li>▪ A substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, developmental disability (DD), overweight (BMI &gt;25); or</li> <li>▪ 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).</li> </ul> <p>Individuals eligible for health home services and identified by the state as being an 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.</p> <p>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.</p> <p>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.</p>
<p><b>Provider Infrastructure</b> (Indicate whether designated providers, team of health care professionals or health team)</p>	<p>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.</p> <p>The Missouri CMHC catchment area system divides the state into separate catchment areas. Each catchment area is the specific responsibility of one or more CMHC (three CMHCs are assigned more than one catchment area), assuring statewide and complete coverage of all catchment areas.</p> <p>CMHC health homes will be physician-led with health teams minimally also include a Primary Care Nurse manager, health coach who is either a registered nurse or specialty trained as a health coach and supervised by a registered nurse and clinic support staff. Optional health team members may include a case manager, nutritionist/dietitian, pharmacist, peer recovery specialist, grade school personnel or other representatives 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</p>

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is person-centered, culturally competent and linguistically capable.

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:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinate and provide access to mental health and substance abuse services;
- 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;
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care supports and services;
- 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;
- 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
- 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.

**Health Home Services** – As the state further develops its service delivery models, careful attention is being paid to ensuring that health home services are complementary and not duplicative of existing services (e.g., TCM, MFP and HCBS waiver services).<sup>1</sup>

<b>Comprehensive Care Management</b>	<b>Service Definition</b>	<b>Ways HIT Will Link</b>
	Comprehensive care management services are conducted by licensed nurses or certified health coach supervised by a	MO HealthNet maintains a web-based electronic health record (EHR) accessible to enrolled Medicaid providers,

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	<p>licensed nurse and involve: <i>Identification of high-risk individuals</i> and use of client information to determine level of participation in care management services; <i>assessment</i> of preliminary service needs; <i>treatment plan development</i>, which will include client goals, preferences and optimal clinical outcomes; <i>assignment</i> by the care manager of health team roles and responsibilities; <i>development of treatment guidelines</i> that establish clinical pathways for health teams to follow across risk levels or health conditions; <i>monitoring</i> of individual and population health status and service use to determine adherence to or variance from treatment guidelines and; <i>development and dissemination of reports</i> that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.</p>	<p>including CMHCs, primary care practices and schools. The tool is a HIPAA-client portal that enables providers to:</p> <ul style="list-style-type: none"> <li>▪ Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);</li> <li>▪ View dates and providers of hospital emergency department services;</li> <li>▪ Identify clinical issues that affect an enrollee’s care and receive best practice information;</li> <li>▪ 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;</li> <li>▪ Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;</li> <li>▪ 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</li> <li>▪ Review laboratory data and clinical trait data;</li> <li>▪ Determine medication adherence information and calculate medication possession ratios (MPR); and</li> <li>▪ Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.</li> </ul>
<p><b>Care Coordination</b></p>	<p align="center"><b>Service Definition</b></p> <p>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</p>	<p align="center"><b>Ways HIT Will Link</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>▪ Download paid claims data submitted for an enrollee by any provider over the past three years (e.g., drug claims, diagnosis codes, CPT codes);</li> </ul>

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	<p>clients/family members.</p> <p>Case Managers will be responsible for conducting care coordination activities across the health team. The primary responsibility of the case manager is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.</p>	<ul style="list-style-type: none"> <li>▪ View dates and providers of hospital emergency department services;</li> <li>▪ Identify clinical issues that affect an enrollee’s care and receive best practice information;</li> <li>▪ 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;</li> <li>▪ Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;</li> <li>▪ 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</li> <li>▪ Review laboratory data and clinical trait data;</li> <li>▪ Determine medication adherence information and calculate medication possession ratios (MPR); and</li> <li>▪ Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.</li> </ul>
<b>Health Promotion</b>	<b>Service Definition</b>	<b>Ways HIT Will Link</b>
	<p>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.</p> <p>Health promotion services also assist clients to participate in the implementation of the treatment plan and place a</p>	<p>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:</p> <ul style="list-style-type: none"> <li>▪ Administrative claims data for the past three years;</li> <li>▪ Cardiac and diabetic risk calculators;</li> <li>▪ Chronic health condition information awareness;</li> <li>▪ A drug information library; and</li> <li>▪ The functionality to create a personal health plan and discussion lists to use with healthcare providers.</li> </ul>

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	strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.	
<b>Comprehensive Transitional Care</b> (including appropriate follow-up, from inpatient to other settings)	<b>Service Definition</b>	<b>Ways HIT Will Link</b>
	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.	<p>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.</p> <p>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 health home provider to:</p> <ul style="list-style-type: none"> <li>▪ Use the hospitalization episode to locate and engage persons in need of health home services;</li> <li>▪ Perform the required continuity of care coordination between inpatient and outpatient; and</li> <li>▪ Coordinate with the hospital to discharge and avoid readmission as soon as possible.</li> </ul>
<b>Individual and Family Support Services</b>	<b>Service Definition</b>	<b>Ways HIT Will Link</b>
	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	<p>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:</p> <ul style="list-style-type: none"> <li>▪ Administrative claims data for the past three years;</li> </ul>

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	<p>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.</p>	<ul style="list-style-type: none"> <li>▪ Cardiac and diabetic risk calculators;</li> <li>▪ A drug information library; and</li> <li>▪ The functionality to create a personal health plan and discussion lists to use with healthcare providers.</li> </ul>
<b>Referral to Community and Social Support Services</b>	<b>Service Definition</b>	<b>Ways HIT Will Link</b>
	<p>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.</p>	<p>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 health home providers of impending eligibility lapses (e.g., 60 days in advance).</p>
<b>Provider Standards</b>		
<p><b>Initial Provider Qualifications</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ 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; 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;</li> <li>▪ Meet state requirements for patient empanelment (i.e., each patient receiving CMHC health home services must be assigned to a physician);</li> <li>▪ Meet the state’s minimum access requirements. 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;</li> <li>▪ Actively use MO HealthNet’s comprehensive electronic health record (EHR) to conduct care coordination and prescription monitoring for Medicaid participants;</li> <li>▪ 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;</li> <li>▪ Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns;</li> <li>▪ Conduct wellness interventions as indicated based on clients’ level of risk;</li> <li>▪ Complete status reports to document clients’ housing, legal, employment status education, custody etc.;</li> </ul>		

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- Agree to convene regular, ongoing and documented internal health home team meetings to plan and implement goals and objectives of practice transformation;
- Agree to participate in CMS and state-required evaluation activities;
- 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);
- 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
- 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 health home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the state.

#### Ongoing Provider Qualifications

Each CMHC must also:

- Within three 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;
- Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;
- Demonstrate continuing development of fundamental medical home functionality at 6 months and 12 months through an assessment process to be applied by the state;
- Demonstrate significant improvement on clinical indicators specified by and reported to the state,;
- Provide a Health Home that demonstrates overall cost effectiveness; and
- 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.

#### Assurances

The State assures that hospitals participating in the State plan or 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.	Yes
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.	Yes
The State will report to CMS information	Yes

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submitted by health home providers to inform the evaluation and Report to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.		
Monitoring		
Describe the State’s methodology for tracking avoidable hospital readmissions to include data sources and measure specifications.	Data Sources	Measures Specifications
	Claim data	ACSC readmissions/1000:  (# of readmissions with a primary diagnosis consisting of an AHRQ ICD-9 code <sup>1</sup> for ambulatory care sensitive conditions/member months) x 12,000
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 measures specifications.	Data Sources	Measures Specifications
	Claim data	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 # of Medicaid beneficiaries with SMI or two or more chronic conditions.  Savings calculations will be risk-adjusted, truncate claims of high-cost outliers annually exceeding five standard deviations of the mean, and will net out the value of supplemental payments made to the participating sites during the eight-quarter period.

<sup>1</sup> AHRQ, Center for Delivery, Organization, and Markets (CDOM), Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample (NIS).

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Describe the State's proposal for using health information technology in providing health home services under this program and improving services 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). 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.

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:

- 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 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;
- Electronically request a drug prior authorization or clinical edit override; pre-certifications for radiology, durable medical equipment (DME), optical and inpatient services;
- 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
- Review laboratory data and clinical trait data;
- Determine medication adherence information and calculate medication possession ratios (MPR); and
- Offer counseling opportunities for pharmacists through a point of service medication therapy management (MTM) module.

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:

- Administrative claims data for the past three years;
- Cardiac and diabetic risk calculators;
- Chronic health condition information awareness
- A drug information library; and

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- The functionality to create a personal health plan and discussion lists to use with healthcare providers.

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 health home provider to:

- Use the hospitalization episode to locate and engage persons need of health home services;
- Perform the required continuity of care coordination between inpatient and outpatient; and
- 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, health homes will continue to implement or develop memoranda of understanding (MOU) with local hospitals for notification about hospital admissions.

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).

### 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.

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

## Quality Measures

Comprehensive Care Management	Measures	Data Source	Measure Specification	How HIT will be Utilized
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Clinical Outcomes	All Members: Perceived Efficacy of Treatment	MHSIP Q. 21-35,42,43,47,48	See SAMHSA NOMS measures specifications	See Endnote <sup>ii</sup>
	Members with Diabetes: HbA1c < 7 and HbA1c> 9	CyberAccess Disease Registry	% diabetics under limit; % diabetics over limit	Ibid <sup>iii</sup>
	Members with BMI >25: Absence of Metabolic Syndrome: Only one additional criteria- HbA1c >7 or FBG > 110, BP > 130/85, HDL cholesterol< 40 in men or <50 in women, or Triglycerides > 150	CyberAccess Disease Registry	% overweight w/o metabolic syndrome	Ibid <sup>iv</sup>
	Members with BMI >25: LDL< 100	CyberAccess Disease Registry	Percentage of overweight members whose most recent LDL-C level in the measurement year was <100 mg/dL B	Ibid <sup>v</sup>
Experience of Care	Satisfaction with services	MHSIP (Q. 1-7, 9,12,13)	See SAMHSA NOMS measures specifications	See Endnote <sup>vi</sup>
Quality of Care	All Members: Medical Care items identified on treatment plan for all identified high-risk patients	Audit of a sample of high risk patients	% of members who have a current care plan (i.e., updated at least annually) that has been developed by the care manager with input from the care team during the measurement period	See Endnote <sup>vii</sup>
	All Members: Medication Adherence to Antipsychotics, Antidepressants, and Mood Stabilizers	Pharmacy claims	% members on that class of medication with MPR > 80%	Ibid <sup>viii</sup>
	All Members: Rate of psychotropic prescribing potentially inconsistent	Pharmacy claims	BPMS Prescribing Benchmark Report Specs, number psychotropic	Ibid <sup>ix</sup>

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	with EBP		prescriptions hitting a quality indicator divided by the total of all psychotropic prescriptions in a rolling 90 day period	
	<u>For members with SUD:</u> Utilization of MAT	Claims	% with claim diagnosis of alcohol dependence/abuse prescribed naltrexone or acamprosate	Ibid <sup>x</sup>
	<u>For members with SUD:</u> Utilization of MAT	Claims	% with claim diagnosis of opiate abuse/dependence prescribed buprenorphine or in methadone program	Ibid <sup>xi</sup>
	<u>Members with Asthma:</u> Adherence to COPD Meds	Pharmacy claims	% MPR > 80%	Ibid <sup>xii</sup>
	<u>Members with Asthma:</u> % on inhaled Corticosteroid	Pharmacy claims	% MPR > 80%	Ibid <sup>xiii</sup>
	<u>Members with CVD:</u> Adherence to Meds – CVD and Anti-Hypertensive Meds	Claims and Disease Registry	HEDIS specifications	Ibid <sup>xiv</sup>
	<u>Members with CVD:</u> Use of ARB (angiotensin II receptor blockers) or ACEI (angiotensin converting enzyme inhibitors) medications by persons with a history of CHF (congestive heart failure).	Claims and Disease Registry	HEDIS specifications	Ibid <sup>xv</sup>
	<u>Members with CVD:</u> Use of beta-blocker medications by persons with a history of CHF (congestive heart failure).	Claims and Disease Registry	HEDIS specifications	Ibid <sup>xvi</sup>

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	<u>Members with CVD:</u> Use of statin medications by persons with a history of CAD (coronary artery disease).	Claims and Disease Registry	HEDIS specifications	Ibid <sup>xvii</sup>
<b>Care Coordination</b>	<b>Measures</b>	<b>Data Source</b>	<b>Measure Specification</b>	<b>How HIT will be Utilized</b>
Clinical Outcomes	Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge	Audit for a sample of hospitalized patients	Percentage of hospital-discharged beneficiaries with whom the care manager made telephonic or face-to-face contact within 72 hours of discharge and performed medication reconciliation	See Endnote <sup>xviii</sup>
Experience of Care	Satisfaction with services	MHSIP (Q. 1-7, 9,12,13)	See SAMHSA NOMS measures specifications	See Endnote <sup>xix</sup>
Quality of Care	Use of CyberAccess per member per month (or its successor) for non-MCO enrollees	CyberAccess or its successor	CyberAccess web Hits PMPM	See Endnote <sup>xx</sup>
<b>Health Promotion</b>	<b>Measures</b>	<b>Data Source</b>	<b>Measure Specification</b>	<b>How HIT will be Utilized</b>
Clinical Outcomes	Metabolic screening (BMI, BP, HDL cholesterol, triglycerides, and HbA1c or FBG	CyberAccess Disease Registry	% of members screened in previous 12 months	See Endnote <sup>xxi</sup>
Experience of Care	Satisfaction with services	MHSIP (MHSIP (Q. 1-7, 9,12,13)	See DMH NOMS measures specifications	See Endnote <sup>xxii</sup>
Quality of Care	Patient use of personal EHR (Direct Inform, or its	CyberAccess or its successor	Number Direct Inform web hits PMPM	See Endnote <sup>xxiii</sup>

**Missouri Medicaid Community Mental Health Center Health Home SPA Template**

*See attached Narrative and chart describing client and information flow*

**LAST UPDATED ON MAY 5, 2011**

<b>Community Mental Health Center Health Home Description</b>				
	successor)			
<b>Comprehensive Transitional Care</b> (including appropriate follow-up, from inpatient to other settings)	<b>Measures</b>	<b>Data Source</b>	<b>Measure Specification</b>	<b>How HIT will be Utilized</b>
Clinical Outcomes	<u>All Members</u> : Hospital readmission rate	Claims	% of beneficiaries who are discharged from an inpatient setting and readmitted within 30 days of discharge	See Endnote <sup>xxiv</sup>
	<u>All Members</u> : ED visit following discharge within 7 and 30 days	Claims	Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 72 hours of discharge and performed medication reconciliation	See Endnote <sup>xxv</sup>
Experience of Care	Satisfaction with services	MHSIP (Q. 36,44-46)	See SAMHSA NOMS measures specifications	See Endnote <sup>xxvi</sup>
Quality of Care	Practice team clinical telephonic or face-to-face beneficiary follow-up within 3 days after hospitalization discharge	Audit for a sample of hospitalized patients	% of members who have an ED visit within 7 days of hospital discharge and within 30 days of discharge	See Endnote <sup>xxvii</sup>
<b>Individual and Family Support</b>	<b>Measures</b>	<b>Data Source</b>	<b>Measure Specification</b>	<b>How HIT will be Utilized</b>
Clinical Outcomes	<u>All Members</u> : Portion receiving Individual or family support	Claims	% members that received CMHC community support service at least once in previous 90 days	See Endnote <sup>xxviii</sup>
	<u>Members with DD</u> : DD Community Services	Claims	% members that received DD community support service at least once in	See Endnote <sup>xxix</sup>

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**LAST UPDATED ON MAY 5, 2011**

<b>Community Mental Health Center Health Home Description</b>				
			previous 90 days	
Experience of Care	Satisfaction with services	MHSIP (Q. 1-7, 9,12,13)	See SAMHSA NOMS measures specifications	See Endnote <sup>xxx</sup>
Quality of Care	<u>All Members</u> : Perceived Support	MHSIP (Q. 10, 14-19)	See SAMHSA NOMS measures specifications	See Endnote. <sup>xxxii</sup>
<b>Referral to Community and Social Support Services</b>	<b>Measures</b>	<b>Data Source</b>	<b>Measure Specification</b>	<b>How HIT will be Utilized</b>
Clinical Outcomes	<u>All Members</u> : Access to Services	MHSIP (Q. 8,20, 47-%Homeless)	See SAMHSA NOMS measures specifications	See Endnote. <sup>xxxii</sup>
	<u>Members with DD</u> : DD Community Services	CIMOR – episode of care	% in active service at DD Regional Center or SB 40 Board	See Endnote <sup>xxxiii</sup>
Experience of Care	Satisfaction with services	MHSIP (Q. 1-7, 9,12,13)	See SAMHSA NOMS measures specifications	See Endnote <sup>xxxiv</sup>
Quality of Care	Access to Services	MHSIP(Q. 8,20, 47-%Homeless)	See SAMHSA NOMS measures specifications	See Endnote <sup>xxxv</sup>
<b>Evaluations – Describe how the state will collect information from health home providers for the purpose of determining the effects of this program on reducing:</b>				
<b>Hospital Admissions</b>	<b>Description</b>	<b>Data Source</b>	<b>Frequency of Data Collection</b>	
	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)	Claims	annual	
<b>Emergency Room Visits</b>	<b>Description</b>	<b>Data Source</b>	<b>Frequency of Data Collection</b>	
	Use of HEDIS 2011 codes for ED visits (part of ambulatory care (AMB))	Claims	annual	

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<b>Community Mental Health Center Health Home Description</b>			
	measure)		
<b>Skilled Nursing Facility Admissions</b>	<b>Description</b>	<b>Data Source</b>	<b>Frequency of Data Collection</b>
	Use of HEDIS 2011 codes for discharges for SNF services (part of inpatient utilization - nonacute care (NON) measure)	Claims	annual
<b>Evaluations</b> - Describe how the state will collect information for the purposes of information the evaluations, which will ultimately determine the nature, extent and use of this program as it pertains to the following:			
<b>Hospital Admission Rates</b>	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 a) 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 b) all beneficiaries with SMI or two or more chronic conditions drawn from a list of chronic conditions defined by the State.		
<b>Chronic Disease Management</b>	The State will audit each practice’s implementation of chronic disease management, with a special focus on comprehensive care management. Audits will assess: a) documented self-management support goal setting with all beneficiaries identified by the practice site as high risk, b) Practice team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge, c) documentation that there is a care manager in place and d) that the care manager is operating consistently with the requirements set forth for the practices by the State.		
<b>Coordination of Care for Individuals with Chronic Conditions</b>	The State will assess provision of care coordination services for individuals with the chronic conditions specified within this State Plan Amendment in the following fashion. 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. The measurement methodologies for these four measures are described in the preceding section.		
<b>Assessment of Program Implementation</b>	The State will monitor implementation in two ways. First, a Health Homes Work Group comprised of Department of Social Services and Department 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 will transition to monthly meetings six months into implementation. Second, the two 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.		
<b>Processes and Lessons Learned</b>	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		

## Missouri Medicaid Community Mental Health Center Health Home SPA Template

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**LAST UPDATED ON MAY 5, 2011**

Community Mental Health Center Health Home Description	
	<p>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.</p>
<p><b>Assessment of Quality Improvements and Clinical Outcomes</b></p>	<p>The State will utilize 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.</p>
<p><b>Estimates of Cost Savings</b></p>	<p>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 # of Medicaid beneficiaries with SMI or two or more chronic conditions.</p> <p>Savings calculations will be risk-adjusted, truncate claims of high-cost outliers annually exceeding five standard deviations of the mean, and will net out the value of supplemental payments made to the participating sites during the eight-quarter period.</p>

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It is anticipated that TCM and waiver services may substantially augment health care home services for people with developmental disabilities (DD) and may lead to more successful outcomes when compared to others who may not have these additional supports, but will not duplicate health care home services. In addition, MO HealthNet Managed Care provides episodic telephone care coordination for individuals with chronic conditions (e.g., a member with asthma who accesses the ED will receive a follow-up call from the plan’s care manager who may work with the member to develop an asthma management plan). MO HealthNet Managed Care also conducts referrals to CMHCs for members requiring ongoing and intensive care management and treatment of mental illness. Currently, many individuals with serious and persistent mental health conditions do not routinely or appropriately access primary care services. Implementation of health home services is intended to facilitate increased access to primary care services.

Under the Money Follows the Person program, the Division of DD receives an enhanced federal match (currently 87.22%) for any waiver services, for state plan HCB services, and for targeted case management for 365 days for each individual who transitions from a Medicaid-funded bed in an ICF-MR (primarily the state habilitation centers).

Primarily, MFP is a funding mechanism that enables states to channel more effort towards identification of people in facilities who wish to transition and whose needs can safely be met in the community. There are no aspects of MFP that duplicate in any way the health care home services.

## Missouri Medicaid Community Mental Health Center Health Home SPA Template

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The State envisions the DD system of supports and services will make referrals to and share information with providers of health care homes about individuals DD who also have medical conditions qualifying for health care home services and who elect to receive services from a health care home, but the DD system will not duplicate the health care home service.

The service coordinator has no direct influence over whether an individual is able to access primary care, the scope or quality of the primary care, nor can the service coordinator influence the type of follow up services that a primary care provider may order.

The Missouri Division of DD administers 5 waivers serving approximately 10,000 people annually. HCB providers have no direct influence over the scope or quality of the medical care. Because the state makes health and safety assurances in the waiver, it is not uncommon for the waiver provider or service coordinator to assist individuals with developmental disabilities to access emergency care because of the failure of the primary care system.

None of the services covered any of the 5 waivers is similar in any way to the new service authorized under Sec. 2703. The recently approved Partnership for Hope Waiver, and the reapplications for the comprehensive and Community Support Waivers (currently pending CMS review) include a new service called Professional Assessment and Monitoring however, this service does not duplicate the new state plan health care home option.

<sup>ii</sup> 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 individual's 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 healthcare home performance

<sup>iii</sup> Ibid.

<sup>iv</sup> Ibid.

<sup>v</sup> Ibid.

<sup>vi</sup> 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.

<sup>vii</sup> 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 individual's 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 healthcare home performance

<sup>viii</sup> Ibid.

<sup>ix</sup> Ibid.

<sup>x</sup> Ibid.

<sup>xi</sup> Ibid.

<sup>xii</sup> Ibid.

<sup>xiii</sup> Ibid

<sup>xiv</sup> Ibid

<sup>xv</sup> Ibid

<sup>xvi</sup> Ibid.

<sup>xvii</sup> Ibid.

## Missouri Medicaid Community Mental Health Center Health Home SPA Template

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<sup>xviii</sup> 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 e-mail.

<sup>xix</sup> 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.

<sup>xx</sup> 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

<sup>xxi</sup> The numerator will be aggregated from the CyberAccess metabolic monitoring disease registry. The denominator will be aggregated from the ACI healthcare home number registry. Results will be reported in a spreadsheet and benchmark style by individual health home.

<sup>xxii</sup> 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.

<sup>xxiii</sup> 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

<sup>xxiv</sup> Calculated from administrative claims

<sup>xxv</sup> Ibid.

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<sup>xxviii</sup> Calculated from administrative claims

<sup>xxix</sup> Ibid.

<sup>xxx</sup> 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.

<sup>xxxi</sup> Ibid.

<sup>xxxii</sup> Ibid.

<sup>xxxiii</sup> Ibid.

<sup>xxxiv</sup> Ibid.

<sup>xxxv</sup> Ibid.