

**Missouri Response to CMS March 10, 2011 Feedback Regarding
Missouri Medicaid Community Mental Health Center Health Home SPA Draft
March 22, 2011**

1. Geographic Area:

Please clarify how the State intends to operate the Community Mental Health Centers (CMHCs) Health Home program on a statewide basis. State's draft indicated that selected CMHCs will be identified by the state. Does the State anticipate having statewide access to Health Home (HH) providers initially or only in limited areas? Please describe the "catchment area structure" of the State. If Medicaid recipients can select a CMHC from which to receive health home services, how will that work with the State's "catchment area" structure?

***Missouri Response:** The Missouri CMHC catchment area system divides the state into 25 separate catchment areas (see map attached). Each catchment area is the specific responsibility of one of 21 full service CMHCs (three CMHCs are assigned more than one catchment area). In addition seven of the catchment areas are served by one or more of nine affiliate CMHCs (see complete list of CMHCs and affiliates attached). Full service CMHCs are responsible for a complete continuum of behavioral health services and supports including psychiatric services, counseling, case management, crisis intervention, and supportive housing across all ages. Affiliate CMHCs focus more intensively on case management and supportive housing and are not required to serve all age ranges. All CMHCs and most (if not all) affiliates will be CMHC health home providers. Persons eligible for CMHC Health home currently in service will be auto assigned to the CMHC or affiliate that served that person the most frequently in the preceding year. All persons auto assigned will be informed of other choices available and may switch if they wish to do so. We will remove the current SPA template language referring to "selected" CMHCs.*

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? Clarify how Medicaid recipients will select a provider as their health home or opt-out of the program, since comparability must afford choice.

***Missouri Response:** We understand that there can be no limitation whatsoever based upon age and will remove all references in the current SPA template to an age limit. Initially at launch health home participants will be selected by analyzing inpatient and outpatient claims for diagnoses consistent with the eligible chronic conditions and analyzing pharmacy claims for medications indicative of the eligible chronic conditions. Persons with a history prior service (utilizing claims) with an eligible health home provider will be auto assigned initially at launch to the health home provider that is seen most frequently in the previous year. Persons eligible for multiple health homes will be subsequently informed of other choices available to them. Persons newly identified for referral to health home services after the initial launch will be offered a choice among the eligible health home available in their area. Upon referral to or at their first visit to their new health home the participant will receive verbal and written explanation of the goals, services, and potential benefits to their health of belonging to a health home. Persons enrolled in a health home will be able to choose not to participate in any particular health home service at the time it is offered.*

3. Provider Infrastructure/Standards:

Health Home providers address specific functions as outlined in the SMDL# 10-024. Can the State please clarify who will serve as the health home provider? What are the qualifications of the provider(s) delivering the health home services? 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? How will the State address provider enrollment? How many health home providers are estimated to be available in the State?

Missouri Response: *The SPA template has been modified to reflect the following CMHC Provider Infrastructure and Provider Standards requirements:*

Provider Infrastructure

CMHCs will serve as designated providers of health home services. CMHCs are certified by the Department of Mental Health and provide services through a statewide catchment area arrangement. Eligible health home clients will have free choice of CMHCs.

CMHC health homes will be physician-led with health teams minimally comprised of 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 community support 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 is person-centered, culturally competent and linguistically capable.

CMHCs will be supported in transforming service delivery by participating in a statewide learning collaborative specifically designed to instruct CMHCs to operate as health homes and provide care using a whole-person approach that integrates primary care, behavioral health, and other needed services and supports. Learning collaborative sessions 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 collaboratives 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.*

Provider Standards

Initial Provider Qualifications

In addition to being a state-designated CMHC each CMHC must:

- *Have a substantial percentage of its patients enrolled in Medicaid, with special consideration given to those with a patient volume of at least 30% 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;*
- *Have strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes;*
- *Have a psychiatrist or primary care physician assigned for the purpose of health home team participation to each patient receiving CMHC health home services;*
- *Actively use MO HealthNet’s comprehensive electronic health record (EHR) to conduct care coordination and prescription monitoring for Medicaid participants;*
- *Utilize an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning;*
- *Track DMH-specified performance indicators and develop care gap to-do lists;*
- *Routinely use a behavioral pharmacy management system to determine problematic prescribing patterns;*
- *Conduct wellness interventions as indicated based on clients’ level of risk;*
- *Complete DMH status reports to document clients’ housing, legal, employment status education, custody etc.;*
- *Agree to participate in a statewide learning collaborative, including in-person sessions and regularly scheduled phone calls;*
- *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;*
- *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;

- *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 health home delivery model that the state determines to have a reasonable likelihood of being cost-effective.*

Ongoing Provider Qualifications

Each CMHC must also:

- *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 six 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.*

Initial enrollment will be based on review and acceptance of the CMHCs initial implementation plan. Initial enrollment will include a minimum of 25 CMHC health home providers (all 21 full-service CMHCs which assure statewide coverage and at least four of the nine additional affiliate CMHCs).

4. Health Home Service Delivery Model:

Please 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.).

Missouri Response: *Missouri health homes will be available to all Medicaid participants including those in fee-for-service, managed care, and other waivers. In the case of health home for persons under Medicaid managed care the health homes will be handled as a separate "wraparound" benefit similar to how current home and community waiver services are handled with respect to managed care. The health home payments will come directly from Missouri Medicaid to the health home providers without passing through the managed care entity and will result in no change in the managed care rates. This will avoid the need for negotiating contract changes and calculating rate adjustments which would result in a substantial delay in launching health homes. This does not represent duplicative payment for manage of care in that the contracted Medicaid managed care companies focus almost entirely on using prior and concurrent authorization of payment for services to manage utilization of services and do not systematically use provider specific performance*

feedback across a wide range of quality of care measures. In short, contracted managed care manages utilization of service focusing on inappropriate overutilization whereas the health homes manage the quality of care by focusing on eliminating gaps in care. With respect to FFS and waivers the health home provider payment rates will be modeled so that they only provide reimbursement for services that are not covered by the current fee-for-service or waiver services.

5. Health Home Services:

Health Home services are comprehensive and timely high quality services provided by designated high quality health home providers or health teams. Can the State please explain how the state will leverage existing state plan services with health home services (i.e., TCM, waiver services)? Which of the health home services will be delivered by which health home provider described in #3 above?

Missouri Response: *For persons receiving TCM or waiver services some of the less directly medically related aspects of their individual and family support and community referral services may at times be performed by their current TCM or waiver service provider. TCM or waiver service providers will be regularly included in the overall healthcare team and involved in development and performance of the person centered plan. The actual costs of the portion of health home services performed by TCM or waiver service providers will not be included in the CMHC health home PMPM payment.*

6. Quality Measures:

Health home providers are required to report to the State on applicable quality measures as a condition for receiving payment. The quality measures should accurately assess the health home services. The State is asked to map their proposed quality measures to their health home service definitions. (Ex: The Care Coordination Measure proposed under in “Quality Measure” section does not measure the Care Coordination definition listed for the service.)

Missouri Response: *We understand that a performance measure can only be used for one of the six health home service categories and cannot apply to any of the other five. We will revise our SPA template to eliminate any performance measure redundancy across the five health home services. We look forward to discussing other specific feedback with your quality measurement specialists.*