MEDICAID HEALTH HOMES IN MISSOURI: REVIEW OF PRE-EXISTING STATE INITIATIVES AND STATE PLAN AMENDMENTS FOR THE STATE'S FIRST SECTION 2703 MEDICAID HEALTH HOMES

Brenda C. Spillman, Barbara A. Ormond and Elizabeth Richardson
The Urban Institute

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Missouri has two approved Medicaid Health Home State Plan Amendments (SPAs), the first targeting beneficiaries with serious mental illness (SMI) or behavioral health conditions, and the second targeting beneficiaries with multiple chronic physical conditions. The former was approved on October 20, 2011, while the latter was approved on December 23, 2001; both SPAs went into effect on January 1, 2012. Community mental health centers (CMHCs) are the designated providers for the behavioral health population, while primary care centers--specifically, federally qualified health centers (FQHCs), rural health clinics (RHCs), and hospital-operated primary care clinics--are the designated providers for the population with multiple chronic physical conditions. (Throughout this memorandum, we denote the initiative targeting persons with behavioral health conditions as the CMHC-HH, and the second targeting beneficiaries with multiple chronic conditions as the primary care provider-health home [PCP-HH].)

Missouri's CMHC catchment system divides the state into 25 geographic areas, each of which is served by at least one, but in some case more than one, CMHC. In total, there are 21 full-service CMHCs--which serve all age ranges and provide psychiatric services, counseling, case management, crisis intervention, and housing support, among other services--and nine affiliate sites--which focus primarily on case management and housing support, and are not required to serve all ages.[1] As of January 2012, the state had selected 18 FQHCs operating 67 clinic sites, six public hospitals operating 22 clinic sites, and one Independent RHC to participate.[2] The Health Home program will be statewide, and the Missouri Department of Social Services estimates that about 43,254 Medicaid beneficiaries are eligible. As of April 2012, 37,720 individuals were enrolled; 17,262 in CMHC-HHs, and 20,458 in PCP-HHs.[3]

Implementation Context

The Missouri Medicaid program (known since 2007 as MO HealthNet) operates both a managed care and a fee-for-service (FFS) program. Participation in Medicaid

managed care is largely a function of geography, though certain eligibility groups are also required to enroll, under the state's 1915(b) waiver.[4] Those who are dually eligible for Medicaid and Medicare, those meeting disability standards for Supplemental Security Income, and those receiving adoption subsidy benefits can choose to receive FFS benefits, enroll in managed care, or disenroll at any time, under the waiver.[5] The state contracts with five managed care organizations (MCOs) (Molina Healthcare, HealthCare USA, Harmony Health Plan, Missouri Care Health Plan, and Blue Advantage Plus of Kansas City) who jointly manage care in the Central, Eastern, and Western regions. These regions are roughly located along the I-70 corridor, which runs east to west and includes the state's major urban areas. Counties to the north and south of this corridor are more rural and sparsely populated; these operate on a FFS basis. (See map.)

The Missouri Health Home initiative is taking place within a broader context of state-sponsored care coordination and integration initiatives, many of which predate the passage of the Affordable Care Act. Though Missouri began implementing targeted care coordination and integration programs for its SMI population in 2003,[6] the major push for reform began in 2005. In that year, the state convened the Missouri Medicaid Reform Commission to develop recommendations for restructuring the entire Medicaid program. Among its many recommendations, the final report endorsed the concept of the medical home for Medicaid recipients, citing the need for better continuity and coordination of care. It also developed several recommendations relating to the integration of behavioral and physical health services.[7] These recommendations for the mental health system were developed in consultation with the state Department of Mental Health (DMH),[8] which subsequently would act as the lead agency on the state's mental health reform efforts. In collaboration with MO HealthNet, the Missouri Coalition of Community Mental Health Centers, and the Missouri Primary Care Association (MPCA), DMH led a series of programs--collectively referred to as DMH Net--which were intended to improve the quality of care for persons with SMI, as well as support the clinical integration of primary and behavioral health care. These initiatives would eventually form the basis of the Health Home initiative.[9]

In 2006, the state received a Transformation Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to support its reform efforts.[10] The subsequent Comprehensive Plan for Mental Health, which was published in early 2008, underscored the state's commitment to care integration, and specifically cited the efforts of DMH Net as part of the reform plan.[11] In 2007, DMH secured state funding for a pilot care integration program involving collaborations between FQHCs and CMHCs. In this pilot, FQHCs were required to open primary care clinics on site at the partnering CMHC, while CMHCs provided behavioral health consultants to the FQHC's primary health care teams. Of 13 applicants, seven pilot sites were selected. Each received $100,000 for the first six months of 2008, then $200,000 per year for the next three fiscal years. The six sites that were not selected were awarded one-time planning grants of $30,000, to allow them to lay the groundwork for subsequent funding cycles.[8] Technical assistance for these pilot sites was funded by the Missouri Foundation for Health (MFH), which is a grant-making organization focused on

supporting health improvement programs for underserved and uninsured populations. The 13 collaborative sites vary in structure; one CMHC also has FQHC status, while another merged with an FQHC. Other CMHCs contract with FQHCs to provide services to patients.[12]

More broadly, DMH implemented a range of reforms to both the structures and processes in place within the mental health system. The Community Psychiatric Rehabilitation Program (CPRC) established a team approach to care, and focused attention on meeting a broad array of needs (housing, work, recreation, etc.) to support patients with SMI.[13] A range of health information technology (HIT) tools were developed to support that care (e.g., the Behavioral Pharmacy Management Program, Medication Adherence Report, and CyberAccess, which are discussed in further detail below). In 2007, the Missouri Coalition of CMHCs began training case managers to improve care coordination and develop treatment plans that include physical health interventions.[12] Nurse liaisons were also added to CMHC teams to educate behavioral health staff on physical health issues and review patient charts.[9] CMHCs also introduced a number of prevention and wellness services, such as screening for metabolic and cardiovascular conditions, smoking cessation counseling, and nutrition education. More recently, DMH and MO HealthNet collaborated on a two-year disease management project targeted at the 3,700 highest-cost, nondual Medicaid enrollees with SMI and chronic medical conditions. Under this initiative, DMH agreed to contact identified clients, enroll them in the CPR program, and manage their care. The project, known as DM 3700, began in November 2010.[14]

In addition to these reforms to the mental health system, Missouri also introduced a major primary care case management program, which ran from 2007 to 2010. The Chronic Care Improvement Program (CCIP) was aimed at improving quality of care for MO HealthNet clients with chronic conditions, decreasing their complications, reducing the cost of their care, and connecting them with a "health care home." The program was managed by APS Healthcare, a disease and care management company, and covered all active FFS Medicaid enrollees (roughly 10% of whom are CMHC clients[15]) with a diagnosis of asthma, diabetes, chronic obstructive pulmonary disorder, gastroesophageal reflux disease, cardiovascular disease (CVD), and sickle cell anemia.[3] Under this program, APS conducted outreach and education, telephone support for beneficiaries with questions about medical concerns, and a web-based plan of care that was accessible to any provider with an Internet connection and a password.[16] Providers were paid an incentive to conduct and initial health risk assessment, as well as to develop and use these care plans on a regular basis.[6] As of 2010, CCIP provided additional care management and coordination services to approximately 180,000 patients.[15] Due to budgetary constraints, the program was discontinued in August 2010.

On the private sector side, in 2011 the MFH announced a Request for Applications for a multi-payer patient-centered medical home (PCMH) collaborative project.[17] Though this medical home project is distinct from the Health Homes initiative, the framework for it was developed to resemble Missouri's Health Home SPA, and the two

initiatives will share in learning collaboratives. The project is funded for two years, and at present includes Anthem Blue Cross. Unlike the Health Homes initiative, it is not statewide--it covers the 84 counties served by the MFH.

Beneficiaries who are enrolled in both Medicare and Medicaid are a significant sub-population of Health Home enrollees (12,230 of the current Health Home beneficiaries are dually enrolled, roughly 29% of the overall population). The state is currently finalizing a proposal to the Centers for Medicare and Medicaid Services (CMS) for a demonstration project that targets the dual eligible population through its Health Home initiative. Under the current draft, the state proposes to share with CMS the Medicare savings that Health Homes generate, which the state will in turn share with providers through a pay-for-performance program.[3] As a part of the demonstration, the state is seeking CMS funding to support three additional staff positions: two analysts to work with Medicare data, and a coordinator who will facilitate integration of the two Health Home programs.

Implications for Missouri Section 2703 Medicaid Health Homes Evaluation

These various pre-existing initiatives have several key implications for both the implementation and evaluation of the health homes demonstration. The state has worked with CMHCs for several years to provide care coordination and disease management services to Medicaid enrollees with multiple chronic conditions and SMI. Thus, CMHC providers and state officials have a substantial base of experience in organizing and providing health home-type services. It will be critical to establish how the enhanced federal match will be used by the state, and to what extent the health home demonstration represents a new kind of service rather than an expansion of an existing initiative. In the latter case, the evaluation may find few changes in structure, process, or outcomes. However, the demonstration may serve as a proof of concept for the health home model, as well as provide valuable insight into the issues and challenges surrounding its implementation.

Given that health home-type services have been provided by some providers for a number of years, while others will be relatively new to the program, it will be necessary to clearly identify and describe the structures and processes that are in place at baseline, and to characterize the changes that providers make to these structures and processes as a consequence of becoming health homes. It will also be necessary to adjust the analysis for both the participants' and providers' time in program. Some of these structures and processes are not yet in place, and the state will likely make adjustments to certain aspects of the program based on feedback from providers and periodic internal review. For example, the delineation between the care coordination activities provided through Health Homes and that provided by MCOs is not yet fully detailed, and the payment system may be altered following the 18-month review planned in the SPA. The relationship between the hospitals and Health Homes--a critical piece of the picture given that admissions, readmissions, and emergency room (ER) use are three of the major outcomes being tracked--is still being formalized in many cases. Though much of Missouri's HIT infrastructure was already in place, the

state is still making changes necessary to implement and support Health Home activities. In addition to the information gathered during the site visit, the Urban Institute team will conduct follow-up calls at regular intervals to discuss the progress of these and other implementation activities.

Population Criteria and Provider Infrastructure

Table 1 summarizes the population criteria for both SPA programs and the designated providers and requirements regarding the minimum composition of the Health Home teams. As noted above, the CMHC-HH SPA targets beneficiaries with behavioral health conditions, including both mental illness and substance use, while the PCP-HH SPA targets those with chronic physical conditions. The qualifying chronic physical conditions are the same in the two SPAs: diabetes, asthma, CVD, obesity (defined as having a Body Mass Index [BMI] over 25), developmental disability, and tobacco use. The primary distinction is that substance use and mental illness are not qualifying conditions to receive Health Home services through a primary care center; such beneficiaries would have their Health Home services managed by a CMHC.

The two types of providers on which Missouri is building its Health Home infrastructure have varying experience with Health Home-type services, and have care teams that reflect the different needs of their respective populations. As Table 2 shows, both teams include a Director, Nurse Care Manager, and administrative support staff. The CMHC-HH team adds a primary care physician consultant, while the PCP-HH team adds a behavioral health consultant and a care coordinator, as well as additional clinical staff (i.e., a physician or nurse practitioner, as well as a licensed nurse or medical assistant). Both SPAs indicate that additional team members may be included, depending on beneficiary needs. These members can include the treating physician (if the participant is enrolled in a CMHC-HH), a dietician/nutritionist, and school personnel, among others.

Table 2 is adapted primarily from the current draft of the state's dual eligible proposal to CMS, which outlines the specific roles and responsibilities of each key care team member. Certain CMHC staff roles will continue unchanged (or largely unchanged), though these individuals will play a role in patient care. Behavioral health clinicians and the CPRC teams will remain unchanged, while Community Support Specialists will receive enhanced training to enable them to serve as health coaches who promote lifestyle changes and preventive care, support participants both in managing their health conditions and accessing primary care.

Service Definitions and Provider Standards

Definitions of health home services are identical for the two SPAs, though the providers who have primary responsibility for managing those services differ slightly. (Table 3 provides the full-service definitions.) Nurse Care Managers play a key role in

all of the defined services across both provider categories, with support from the other team members.

The qualifications for Health Home status are also similar between the two SPAs. All Health Home providers must meet initial and ongoing qualifications in addition to those qualifications that are already required for designation as a CMHCs, FQHCs, RHCs, or hospital-operated primary care clinic. The full list of Health Home qualifications is provided in Table 4. In order to meet these qualifications, both types of Health Home will transform their practices over a two-year period by participating in ongoing training sessions or learning collaborative.[18] These learning collaboratives are funded jointly by MFH, the Greater Kansas City Health Care Foundation, and the Missouri Hospital Association.

Training began in August 2011, and will continue throughout 2012. These training modules focus on three components: understanding and implementing the Health Home initiative as mandated under state law; transforming practice in order to improve care quality and efficiency, as well as meet Health Home accreditation standards; and a care team training module focused on understanding the Healthcare Home model, incorporating "whole-person" strategies into service delivery, understanding and assisting in managing chronic diseases, and working with children and adolescents on their basic health literacy.[2]

Use of Health Information Technology

Missouri's Health Home initiative is supported primarily through the existing Medicaid HIT infrastructure, though the state is building on this infrastructure in several ways that relate to broader statewide initiatives as well as Health Homes, specifically, the state's EHR incentive program, meaningful use compliance, and the development of the health information exchange. MO HealthNet maintains a web-based EHR called CyberAccess, which is accessible to all enrolled Medicaid providers, including CMHCs. This system also includes a web portal called Direct Inform, which allows enrollees to look up information on their care utilization, calculate their cardiac and diabetic risk levels, and develop a personal health plan. This feature is intended to facilitate patient self-management and monitoring. In addition, MO HealthNet maintains an initial and concurrent authorization-of-stay tool that requires hospitals to notify MO HealthNet within 24 hours of a new admission of any Medicaid enrollee, as well as to provide information about diagnosis, condition, and treatment.

The state is currently working with its HIT vendor to extend its data transfer capabilities between hospitals and outpatient providers, which would allow Health Home providers to use hospitalization episodes to identify eligible beneficiaries, facilitate the necessary outreach and transfer of care between inpatient and outpatient, and coordinate with the hospital on the discharge process. The state will also encourage Health Home providers to monitor Medicaid eligibility using the Family Support Division (FSD) eligibility website (FSD determines client eligibility for the MO HealthNet program

and database), and will refine the process for notifying Health Home providers of impending eligibility lapses. The state requires all Health Home providers to implement an EHR if they do not already have one, which they will also use for extracting and reporting data.

In addition to these umbrella activities, CMHC-HHs and PCP-HHs will each have provider-specific HIT resources on which to draw. CMHC-HHs will continue to make use of two systems: the Customer Information Management, Outcomes and Reporting (CIMOR) for routine reporting, and ProAct for Care Management Reports. Under the Health Home initiative, the capacity of the CIMOR system will be expanded to enable assignment of enrollees to a CMHC-HH based on enrollee choice and admission for services, and the system will be cross-referenced with the above-mentioned inpatient pre-authorization system to enable concurrent reporting of inpatient authorizations to the appropriate CMHC-HH. The ProAct Care Management Reports include the BPMS, Medication Adherence Report and the Disease Management Report. The BPMS report is used for tracking and reporting on prescribing patterns. The Medication Adherence report alerts to medication adherence concerns. The Disease Management Report provides information on treatment gaps based on diagnosis and EBP. PCP-HHs will have access to the Missouri Quality Improvement Network, which is maintained by the MPCA and will serve as a patient registry as well as a platform for gathering quality measures. The data will be refreshed daily, and will be used to generate reports to support meaningful use requirements, quality improvement, and best practice identification.

Payment Structure and Rates

Both types of health homes will be paid a per member per month (PMPM) capitation rate. The PMPM rate for each enrollee in CMHD-HHs will be $78.74, and the rate for PCP-HHs will be $58.87.

These rates are built up from the assumed staffing ratios for each type of health home personnel. (These are listed above, in the description of the various types of staff that will be involved in the health homes.) In addition to staffing ratios, the input to the PMPM rates included the annual salary (and benefits and overhead) of each type of staffer, which Missouri determined from 2011 surveys of organizations likely to become health homes. For example, if the surveys showed that salary, benefits, and overhead for a given type of staff person came to $60,000 annually, and the assumed staffing ratio was one FTE per 400 patients, then the costs of this type of staff within the total PMPM would be $60,000 divided by 400 divided by 12 months, or $12.50 PMPM.

For both types of health homes, the assumed staffing ratios total to 1-1¼ staff hours (for all types of staff combined) per patient per month. Activities covered by current Medicaid funding streams are not being counted in the planned staffing. PMPM rates reflect only marginal health home-specific staffing requirements.

Missouri plans to adjust the PMPM annually, based on the consumer price index. In addition, the PMPM determination method will be reviewed 18 months after the first PMPM payments "to determine if the PMPM is economically efficient and consistent with quality of care." Consideration will be given at that point to a "tiered rate"--that is, to different PMPM amounts for patients with different characteristics and perhaps to health homes with different characteristics.

Quality Improvement Goals and Measures

Missouri has defined eight overarching quality improvement goals for its Health Homes, each with defined clinical outcome and quality of care measures, summarized in Table 5. The measures are generally similar, with the few differences noted in the table. The only experience of care measure identified is patient satisfaction, which will be obtained from patient surveys, for the goal of empowerment and self-management. Most measures will come from claims, disease registry, medical records, and the web-based health record (CyberAccess).

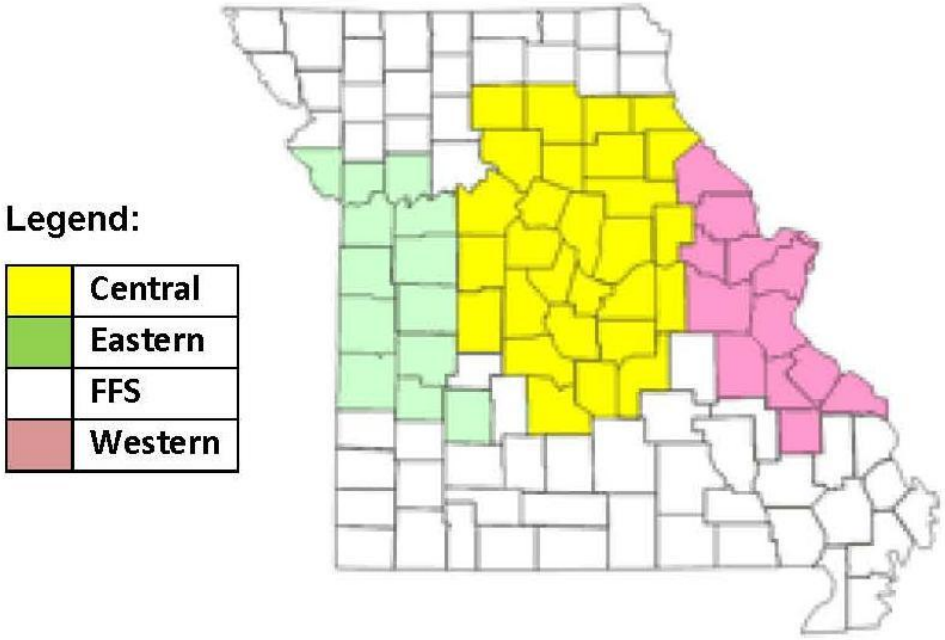
Evaluation Measures and Methods

The evaluation measures and methodology, as described in the SPAs and reproduced in Table 6, are the essentially the same for CMHC-HHs and PCP-MHs, with the exception of estimated cost savings, discussed below. Four of the evaluation areas --chronic disease management, coordination of care, assessment of program implementation, and processes and lessons learned, and assessment of quality improvements and clinical outcomes--pertain to performance and progress toward health homes goals and rely on a combination of processes, including examination of reports on the goals and quality measures in Table 3, audits of practices, and ongoing assessment and oversight of implementation by a Health Homes Work Group and the Steering Committee of the Missouri Medical Home Collaborative. The clinical outcome and quality measures in Table 5 also will be used to assess improvements over time at the health home practice level and for health home practices as a group, with comparisons to regional and national benchmarks where feasible, although it is noted that such benchmarks will not be available specifically for persons with chronic conditions.

The final two measures specify comparison groups in one or both SPAs, but will need clarification in our discussions with the state. For both CMHC-HHs and PCP-HHs, hospital admission rates will be assessed for beneficiaries with the clinical conditions targeted during the learning collaborative year, and for similar beneficiaries, using combined FFS claims and encounter data for participating health home sites and a control group of nonparticipating sites, not otherwise specified. For CMHC-HHs the comparison beneficiaries will have SMI, two or more chronic conditions, or one chronic condition and at risk for developing a second. Selection criteria are the same for PCP-HHs, except that SMI is omitted. Because the description of the timing of the

assessments for the two groups and the nature of the comparison sites is not clear, we will need to explore the design of this assessment further with the state. Finally, for estimates of cost savings, both SPAs provide details of the computation of savings, but only the CMHC-HH SPA specifies an analysis design, a pre/post analysis of both Health Home providers and a group of comparison practices selected to be as similar as possible to participating practices. Comparison practices will be identified by practice type (e.g., FQHC), geographic region, and number of Medicaid beneficiaries with SMI or two or more chronic conditions. The definition of the pre and post-periods is not given and will need to be explored with the state. We will also have to clarify with the state whether a similar pre/post design is intended for the PCP-HH but was inadvertently omitted.

Map of MO HealthNet Managed Care Regions



SOURCE: http://dss.mo.gov/mhk/hregions.htm.

TABLE 1. Target Population and Designated Providers--Missouri		
	SPA 1	**SPA 2**
SPA approval date (Effective date)	10/20/11 (1/1/2012)	12/28/11 (1/1/2012)
Designated provider	CMHCs	PCPs (FQHCs, RHCs, hospital-operated clinics)
Health Home team composition	<u>Required</u>: – Health Home Director – Nurse care manager – Administrative support staff/care coordinator – Primary care physician consultant <u>Optional</u>: – Treating physician or psychiatrist – Mental health case manager – Nutritionist/Dietician – Pharmacist – Peer recovery specialist – School personnel – Others as appropriate	<u>Required:</u> – Health Home Director – Primary care physician or nurse practitioner – Nurse care manager – Administrative support staff/ care coordinator – Licensed nurse or medical assistant – Behavioral health consultant <u>Optional:</u> – Nutritionist – Diabetes educator – School personnel – Others as appropriate
Target population	Beneficiaries must have: – A serious mental health condition (SMI) – SMI or a substance use disorder and another chronic condition, or – SMI or a substance use disorder and tobacco use	Beneficiaries must have: – 2 chronic conditions, or – 1 chronic condition and the risk of developing another
Qualifying chronic conditions	– Asthma – CVD – Developmental disability – BMI over 25 – Substance use disorder (CMHC only) – SMI (CMHC only) – Diabetes* – Tobacco use*	
* Qualifies a person for being at risk of having a second chronic condition.		

TABLE 2. Health Home Staff Roles--Missouri		
Team Member	**Key Roles**	**Staff Ratio**
Health Home Director	– Provides leadership to the implementation and coordination of Health Home activities – Champions practice transformation based on Health Home principles – Develops and maintains relationships with primary and specialty care providers – Monitors performance and leads improvement efforts – Designs and develops prevention and wellness activities	PCPs: 1 full-time equivalent (FTE)/ 2500 enrollees CMHCs: 1 FTE/500 enrollees
Nurse Care Manager	– Develop wellness and prevention initiatives – Facilitate health education groups – Develops the initial treatment plan and health care goals – Consult with Community Support Staff about patient conditions – Liaise with hospital providers on admission/discharge – Provide training on medical issues – Track required assessments and screenings – Assist in implementing core HIT programs and initiatives – Monitor HIT tools and reports for treatment – Medication alerts and hospital admissions/discharges – Monitor and report performance measures and outcomes	1 FTE/250 enrollees
Behavioral Health Consultant (PCPs only)	– Screening/evaluation of individuals for mental health and substance abuse disorders – Brief interventions for individuals with behavioral health problems – Behavioral supports to assist individuals in improving health status and managing chronic illnesses – Meets regularly with the primary care team to plan care and discuss cases, and exchanges appropriate information with team members – Supporting integration with primary care – Conducting treatment interventions and patient education – Providing formal feedback to PCP on behavioral health care issues	1 FTE/750 enrollees
Primary Care Physician Consultant (CMHCs only)	– Participates in treatment planning – Consults with team psychiatrist – Consults regarding specific participant health issues – Assists coordination with external medical providers	1 FTE/500 enrollees
Care Coordinator/ Administrative staff	– Referral tracking – Training and technical assistance – Data management and reporting – Scheduling – Chart audits – Reminding enrollees regarding appointments, filling prescriptions, etc. – Requesting and sending medical records for care coordination	PCPs: 1 FTE/750 enrollees CMHCs: 1 FTE/500 enrollees

TABLE 3. Health Home Service Definitions--Missouri	
Comprehensive care management	– Identification of high-risk individuals and use of client information to determine level of participation in care management services. – Assessment of preliminary service needs. – Treatment plan development, which will include client goals, preferences and optimal clinical outcomes. – Assignment of health team roles and responsibilities. – Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. – Monitoring of individual and population health status and service use to determine adherence to treatment guidelines. – Development and dissemination of progress reports on outcomes for client satisfaction, health status, service delivery and costs.
Care coordination	Care coordination is the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members.
Health promotion	Health promotion minimally consists 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 (e.g., substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity). – Assisting clients in participating in treatment plan implementation, and empowering to understand and self-manage chronic conditions.
Comprehensive transitional care	Care coordination services are 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. A health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to implement the treatment plan, focusing on increasing clients' 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.
Individual and family support services	These services include, but are not limited to advocating for individuals and families, and assisting with obtaining and adhering to prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, and patient ability to self-manage. For individuals with developmental disabilities the health team will refer to and coordinate with the approved developmental disabilities case management entity for services related to habilitation.

TABLE 4. Provider Qualifications by Provider Category--Missouri
Qualifications required for both providers
– Have a substantial percentage of its patients enrolled in Medicaid (at least 25%). – Have strong, engaged, committed leadership (demonstrated through the application process and agreement to participate in learning activities; and that agency leadership have presented the "Paving the Way for Health Care Homes" PowerPoint introduction to Missouri's Health Home Initiative to staff). – Meet state requirements for patient empanelment (i.e., each patient receiving CMHC-HH services must be assigned to a physician). – Provide assurance of enhanced (24/7) patient access to the health team, including the development of telephone or email consultations. – Use MO HealthNet's 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. – Agree to convene internal Health Home team meetings to plan and implement goals and objectives of Health Home practice transformation. – Agree to participate in CMS and state-required evaluation activities. – Agree to develop required reports describing Health Home activities, efforts and progress in implementing Health Home services. – Maintain compliance with all required terms and conditions or face termination as a provider of Health Home services. – Propose a Health Home delivery model that the state determines to have a reasonable likelihood of being cost-effective. – Within 3 months of Health Home service implementation, have developed a contract or memorandum of understanding 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 and identification of Health Home-eligible individuals seeking emergency department services. – Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process. – Demonstrate continuing development of health 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.
Provider qualifications particular to CMHC-HHs
– Routinely use a behavioral pharmacy management system (BPMS) to determine problematic prescribing patterns. – Conduct wellness interventions as indicated based on clients' level of risk. – Complete status reports to document clients' housing, legal, employment status education, custody, etc. – Provide a Health Home that demonstrates overall cost-effectiveness. – Meet National Committee for Quality Assurance (NCQA) Level 1 PCMH requirements OR submit an application for NCQA recognition by month 18 from start of supplemental payments OR meet equivalent recognition standards approved by the state as they are developed.
Provider qualifications particular to PCP-HHs
– Have a formal process for patient input into services provided, quality assurance, access, etc. – Have completed electronic medical record (EMR) implementation and been using the EMR as its primary medical record system. – Attain NCQA 2011 PCMH Level 1 Plus recognition, defined as meeting Level 1 standards, plus the following NCQA 2011 PCMH standards at the specified levels of performance: 3B at 100% and 3C at 75%. Minor deficiencies may be addressed through submission and approval of provider plans of correction. – Meet equivalent recognition standards approved by the state as developed.

TABLE 5. Health Home Goals and Measures--Missouri	
Improve primary health care	Clinical measures: – Ambulatory care-sensitive admissions per 100,000 population under age 75 years. – Preventive/ambulatory care-sensitive ER visits (algorithm, not formally a measure). – Hospital readmissions within 30 days. Quality measures: – Percent of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP. – Adherence to prescribed medication for mental condition. (CMHC only)
Improve behavioral health care/Reduce substance abuse	Clinical measures: – Reduced proportion of adults (18 and older) reporting use of illicit drugs (past year for CMHC, past 30 days for PCP). – Reduced proportion of adults reporting excessive drinking of alcohol (past year for CMHC, past 30 days for PCP). Quality measures (PCP only): – Percent patients 18+ years receiving depression screening. – Percent children screened for mental health issues. – Percent members 18+ years screened for substance abuse.
Improve patient empowerment and self-management	Clinical measures: – Patient use of personal EHR (CyberAccess or its successor, or (PCP only) practice EMR patient portal). Experience of care measures: – Satisfaction with services (CMHC: Mental Health Statistics Improvement Program survey; PCP: CAPHS CG 1.0 Adult and Child Primary Care Surveys).
Improve coordination of care	Clinical measures: – Use of CyberAccess PMPM (or its successor) for nonMCO enrollees. Quality measures: – Percent of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from primary care physician.
Improve preventive care	Clinical measures: – Percent of patients with documented BMI between 18.5-24.9. – Percent of patients aged 18 years and older with a calculated BMI in the past 6 months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. (PCP) – Percent of patients 2-17 years who had documented evidence of BMI percentile, counseling for nutrition and physical activity. (PCP) Quality measures: – Percent members receiving metabolic screening in past 12 months. (CMHC) – Percent of children 2 years of age who had 4 DtaP/DT, 3 IPV, a MMR, 3 H influenza type B, 3 hepatitis B, a chicken pox vaccine (VZV) and 4 pneumococcal conjugate vaccines by their 2nd birthday. (PCP)

TABLE 5 (*continued*)	
Improve diabetes care	Clinical measures: – Percent of patients with diabetes (type 1 or 2) who had HbA1c <8.0% (adults ages 18-75 only for CMHC). – Percent of patients 18-75 years old with diabetes (type 1 or 2) who had BP and LDL below certain levels. (PCP) Quality measures: – Adherence to diabetes medication. (PCP) – Percent of members receiving metabolic screening in past 12 months. (CMHC)
Improve asthma care	Clinical measures: – Percent of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period. Quality measures: – Adherence to prescription medication.
Improve cardiovascular care	Clinical measures: – Percent of patients aged 18 years and older with a diagnosis of hypertension with a blood pressure adequately controlled after 2 office visits. – Percent of patients aged 18+ years diagnosed with coronary artery disease (CAD) with lipid level adequately controlled (LDL<100). Quality measures: – Adherence to CVD and Anti-Hypertensive Meds. – Use of statins by persons with a history of CAD. (CMHC)

TABLE 6. Evaluation Methodology--Missouri	
Hospital admission rates	The state will consolidate data from its FFS Medicaid Management Information System-based claims system and from MCO-generated encounter data for the participating health home sites to assess hospital admission rates, for the participating health home sites and for a control group of nonparticipating 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, 2 or more chronic conditions, or 1 chronic condition and at risk for a second, drawn from a list of chronic conditions defined by the state.
Chronic disease management	The state will audit each practice. 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.
Coordination of care	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 4 measures are described in the preceding section.
Assessment of program implementation	The state will monitor implementation in 2 ways. First, a Health Homes Work Group comprised of Department of Social Services and DMH 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 6 months into implementation. Second, the 2 departments will join private payers and provider representatives on the Steering Committee of the Missouri Medical Home Collaborative to review monthly practice data submissions and analysis by the MFH, as well as the status of practice transformation activities in conjunction with a MFH-funded learning collaborative and possible practice coaching to be provided to at least some of the participating practices.
Processes and lessons learned	The aforementioned work group, as well as the Steering Committee of the Missouri Medical Home Collaborative will approach the health home transformation process for the participating practices as an ongoing quality improvement exercise. Using a combination of evaluation data, information from the learning collaborative Quality Improvement Advisor who will be reviewing regularly submitted practice narrative and data reports, feedback from any practice coaches, and feedback provided to the Health Homes Work Group and the Collaborative Steering Committee by practice representatives, the state will assess what elements of its practice transformation strategy are working--and which are not. Critical attention will be paid to: (a) critical success factors, some of which have already been identified in the literature; and (b) barriers to practice transformation.

TABLE 6 (*continued*)	
Assessment of quality improvements and clinical outcomes	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.
Estimates of cost savings	CMHC only: The state will annually perform an assessment of cost savings using a pre/post-period comparison with a control group of Medicaid primary care practices serving clinically similar populations but not participating as Health Homes. Control group practices will be similar to participating practices to the extent that it is feasible to do so. They will be identified by practice type (e.g., FQHC), geographic region, and number of Medicaid beneficiaries with SMI or 2 or more chronic conditions. Savings calculations will be risk-adjusted, truncated claims of high-cost outliers annually exceeding 3 standard deviations of the mean, and will net out the value of supplemental payments made to the participating sites during the 8-quarter period. PCP: Methods for calculating cost savings for inpatient hospital, ER, and skilled nursing facility use, and how those inputs will be used to calculate savings net of Health Home PMPM are illustrated, but no parallel structure is given for a pre/post comparison of costs for participating Health Home practices with those for similar nonparticipating practices, as was provided in the CMHC SPA.

APPENDIX: Pre-existing Initiatives in Missouri				
	Chronic Care Improvement Program (CCIP)	**Missouri Patient-Centered Medical Home Initiative**	**Missouri Primary/ Behavioral Health Care Integration Initiative**	**DM 3700**
Timeline	– CCIP began enrolling participants in November 2006.[1] – Patient management in CCIP began January 2007.[1] – Program ended in August 2010.[2]	– Applications for participating in the Missouri Medical Home Collaborative were released by MFH in the summer of 2011.[3] – The initiative is currently funded for 2 years. – Practices were notified of selection in fall 2011.	– DMH received funding for a pilot integration grant in 2007. – 7 sites were selected in November 2007. – Funding began in 2008, and lasted for 3 years.	– DMH Net implemented DM 3700 in November 2010. – The project is slated to end in 2012.
Geographic area	CCIP began exclusively serving the I-70 corridor, but was expanded to include Northeast, Southeast, and Southwest regions in Missouri.[4]	84 counties served by MFH.	7 pilot sites throughout the state.	Statewide
Sponsors	DMH Net	MFH, Anthem Blue Cross, United	DMH Net	DMH Net
Scope	– As of 2010, approximately 180,000 were enrolled. – Conditions targeted include asthma, diabetes, CAD, congestive heart failure, chronic obstructive pulmonary disease, gastro esophageal reflux disease (GERD), and sickle cell anemia.[4]	– Includes both licensed physicians and other licensed health care professionals. – At least 66% of selected practices must be MO HealthNet providers.[3]	FQHCs and CMHCs partnered on: – Location of an FQHC primary care clinic at CMHC site. – Integration of a behavioral health provider from the CMHC into the FQHC care team. – Adoption of appropriate best and promising practices. – Full documentation of care in an on-site record. – Incorporation of appropriate care management technologies.	Criteria for inclusion in the project include: – $30,000 or greater in combined Medicaid pharmacy and medical costs between June 2009 and May 2010. – A diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Major Depression-Recurrent. – Not currently a DMH client.
Goals	– Provide MO HealthNet beneficiaries more coordinated, better quality care. – Help beneficiaries make better health-related choices and more effectively manage their own health needs.[1]	– To improve primary care services to enhance quality of care and patient experience.[3] – To reach underserved and high-risk populations in Missouri. – To spur innovation in achieving better health outcomes and lower clinical costs. – To develop and promote a sustainable, effective health home model.	– To improve clinical care. – To improve collaboration between the behavioral and physical health systems. – To improve access to primary care and behavioral health services and supports.	– To provide care coordination and disease management to identified beneficiaries. – To reduce the cost to the state of providing care and treatment and improve outcomes for enrolled clients.

APPENDIX (*continued*)				
	Chronic Care Improvement Program (CCIP)	**Missouri Patient-Centered Medical Home Initiative**	**Missouri Primary/ Behavioral Health Care Integration Initiative**	**DM 3700**
Payment approach	– FFS, with incentive payments. – Physicians received a $50 payment for completing an initial assessment for CCIP participants, and $25 each month a physician logs onto a CCIP patient's web-based care plan.[5]	– Practices receive PMPM payments for their Medical Home activities. – Practices are also eligible for Shared Savings payments of up to 40% of the savings from reductions in costs related to inpatient acute care and emergency department visits. These savings will be calculated relative to historic costs, with risk and outlier adjustments and all costs related to accident and injury excluded. – An additional PMPM payment is available if practices hire or contract out work for a clinical care manager. – Practices who applied and were accepted to the MO HealthNet Health Home initiative will receive supplemental payments through both programs if selected by MFH.[6]	Sites received grant payments of $100,000 for the first 6 months of 2008, then $200,000 per year for the next 3 fiscal years.	FFS, plus an incentive payment of $24 PMPM paid at the end of the year if providers meet cost reduction goals.[7]
Technical assistance	The 2007 legislation also created the HealthNet Oversight committee to oversee implementation of all aspects of the legislation, including those related to health care homes.	Practices participating in the MFH medical home program will participate in the same learning collaboratives as those in the MO HealthNet health home program.[8]	Technical support for the 7 integration pilot sites was funded through a grant from the MFH.	No information found.
HIT use	Providers have access to MO HealthNet infrastructure, including CyberAccess, the Behavioral Pharmacy Management Program, Disease Management Report, and Medication Adherence Reports.	Participating providers are required to maintain a patient registry, either as part of the practice's EMR or as a free-standing web-based registry.[6]	Providers have access to MO HealthNet infrastructure, including CyberAccess, the Behavioral Pharmacy Management Program, Disease Management Report, and Medication Adherence Reports.	Providers have access to MO HealthNet infrastructure, including CyberAccess, the Behavioral Pharmacy Management Program, Disease Management Report, and Medication Adherence Reports.
Evaluation methods	– The 18-member Advisory Committee contracted with Mercer to conduct an analysis of program outcomes. – Key evaluation measures include cost analyses, clinical outcomes comparisons across groups, and examinations of medical and cost outcome.[7]	– Practices must obtain NCQA PCMH recognition at "Level 1 Plus" by the 18th month following receipt of the first Medical Home payment. – CSI Solutions will perform the formal evaluation, which may include surveys and interviews.	Evaluation components included:[9] – Analysis of both behavioral and physical health performance measures (e.g.; diabetes and hypertension control, behavioral health screening performed). – Staff surveys and interviews. – Consumer surveys. – Financial impact analysis.	The state will collect data on:[7] – ER visits, admissions, readmissions. – Episodes of outpatient care. – Aggregate MPR by drug class. – HEDIS indicators (unspecified). – Total health care utilization for: inpatient, outpatient, pharmacy, CPRC; by behavioral vs. physical.

APPENDIX (*continued*)

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This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Final Annual Report - Base Year***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2012/HHOption.shtml.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Final Annual Report - Base Year

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