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State/Territory Name: **MICHIGAN**

State Plan Amendment (SPA) #: **20-1500**

This file contains the following documents in the order listed:

MI - Submission Package - MI2020MS0002O - (MI-20-1500) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID MI2020MS0002O

Program Name Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

SPA ID MI-20-1500

Version Number 2

Submitted By Erin Black

Package Disposition

Priority Code P2

Submission Type Official

State MI

Region Chicago, IL

Package Status Approved

Submission Date 7/1/2020

Approval Date 9/9/2020 1:51 PM EDT

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
Division of program Operations
601 East 12th Street; Suite 0300
Kansas City, MO 64106

Center for Medicaid & CHIP Services

September 09, 2020

Robert Gordon
Director, Department of Health and Human Services
Michigan Department of Health and Human Services
400 S Pine
Lansing, MI 48909

Re: Approval of State Plan Amendment MI-20-1500 Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Dear Robert Gordon:

On July 01, 2020, the Centers for Medicare and Medicaid Services (CMS) received Michigan State Plan Amendment (SPA) MI-20-1500 for Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions to add new qualifying diagnoses, operational components, and expand the BHH to more geographic areas. The new qualifying diagnoses represent the highest cost/utilization ICD-10 codes for SMI/SED. In terms of operational components, the new structure will charge a Lead Entity (e.g., a PIHP) with the administrative oversight and payment for health home activities. The Lead Entity will partner with Health Home Partners that meet criteria specified in the SPA, and the payment will flow through the Lead Entity to the Health Home Partners. The staffing model and rates will be optimized to reflect an integrated care team to serve the highest-need SMI/SED beneficiaries. Finally, the BHH will be expanded to all counties within PIHP Regions 1, 2, and 8 to serve an estimated 5,000-6,000 beneficiaries once fully implemented..

We approve Michigan State Plan Amendment (SPA) MI-20-1500 on September 09, 2020 with an effective date(s) of October 01, 2020.

For payments made to Health Homes providers for Health Homes participants who newly qualify based on the Health Homes program's increase in conditions covered under this amendment, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 10/1/2020 to 9/30/2022.

For payments made to Health Homes providers for Health Homes participants who newly qualify based on the Health Homes program's increased geographical coverage under this amendment, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 10/1/2020 to 9/30/2022.

The FMAP rate for payments made to health homes providers will return to the state's published FMAP rate at the end of the enhanced match period. The Form CMS-64 has a designated category of service Line 43 for states to report health homes services expenditures for enrollees with chronic conditions.

Name	Date Created	
No items available		

If you have any questions regarding this amendment, please contact keri rosenbloom at keri.toback@cms.hhs.gov.

Sincerely,

James G. Scott

Director

Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID MI2020MS0002O
SPA ID MI-20-1500
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date 9/9/2020
Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Michigan

Medicaid Agency Name: Michigan Department of Health and Human Services

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID MI2020MS0002O

SPA ID MI-20-1500

Submission Type Official

Initial Submission Date 7/1/2020

Approval Date 9/9/2020

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID MI-20-1500

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2020	MI-16-1500
Health Homes Geographic Limitations	10/1/2020	MI-16-1500
Health Homes Population and Enrollment Criteria	10/1/2020	MI-16-1500
Health Homes Providers	10/1/2020	MI-16-1500
Health Homes Service Delivery Systems	10/1/2020	MI-16-1500
Health Homes Payment Methodologies	10/1/2020	MI-16-1500
Health Homes Services	10/1/2020	MI-16-1500
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2020	MI-16-1500

Submission - Summary

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SPA ID MI-20-1500

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Initial Submission Date 7/1/2020

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Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The SPA will amend the qualifying diagnoses, operational components, and expand the BHH to more geographic areas. The new qualifying diagnoses represent the highest cost/utilization ICD-10 codes for SMI/SED. In terms of operational components, the new structure will charge a Lead Entity (e.g., a PIHP) with the administrative oversight and payment for health home activities. The Lead Entity will partner with Health Home Partners that meet criteria specified in the SPA, and the payment will flow through the Lead Entity to the Health Home Partners. The staffing model and rates will be optimized to reflect an integrated care team to serve the highest-need SMI/SED beneficiaries. Finally, the BHH will be expanded to all counties within PIHP Regions 1, 2, and 8 to serve an estimated 5,000-6,000 beneficiaries once fully implemented.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$18400000
Second	2022	$18400000

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Kate Massey, Director
Medical Services Administration

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Package ID	MI2020MS0002O	**SPA ID**	MI-20-1500
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Approval Date	9/9/2020	**Effective Date**	10/1/2020
Superseded SPA ID	MI-16-1500		
	User-Entered		

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Executive Summary

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

This SPA 20-1500 is amending the existing Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions Health Homes Program (HHP). The SPA is requesting authority to optimize and expand this Health Home in select Michigan counties. The Health Home will provide comprehensive care management and coordination services to Medicaid beneficiaries with a select serious mental illness/serious emotional disturbance (SMI/SED) diagnosis. For enrolled beneficiaries, the Health Home will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the Health Home program: 1) improve care management of beneficiaries with SMI/SED; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

HHPs must meet specific qualification set forth in the SPA, Michigan Department of Health and Human Services (MDHHS) policy, and provide the six federally required core health home services.

MDHHS will provide a monthly case rate to the LE based on the number of beneficiaries with at least one service during that month. HHPs must contract with a LE in order to be a designated HHP and to receive payment. The LE will reimburse the Health Home Partner for delivering health home services. Finally, MDHHS will employ a pay-for- performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

General Assurances

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

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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

Specify the geographic limitations of the program

- ◉ By county
- ○ By region
- ○ By city/municipality
- ○ Other geographic area

Specify which counties:

1. Alcona
2. Alger
3. Alpena
4. Antrim
5. Baraga
6. Benzie
7. Charlevoix
8. Cheboygan
9. Chippewa
10. Crawford
11. Delta
12. Dickinson
13. Emmet
14. Gogebic
15. Grand Traverse
16. Houghton
17. Iosco
18. Iron
19. Kalkaska
20. Keweenaw
21. Leelanau
22. Luce
23. Mackinac
24. Manistee
25. Marquette
26. Menominee
27. Missaukee
28. Montmorency
29. Oakland
30. Ogemaw
31. Ontonagon
32. Oscoda
33. Otsego
34. Presque Isle
35. Roscommon
36. Schoolcraft
37. Wexford

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

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Superseded SPA ID	MI-16-1500		
	User-Entered		

Categories of Individuals and Populations Provided Health Homes Services

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

- [ ] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

Mandatory Medically Needy

- [ ] Medically Needy Pregnant Women
- [ ] Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

- [ ] Medically Needy Children Age 18 through 20
- [ ] Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- [ ] Medically Needy Aged, Blind or Disabled
- [ ] Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

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Population Criteria

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

- [ ] Two or more chronic conditions
- [ ] One chronic condition and the risk of developing another
- [ ] One serious and persistent mental health condition

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

Serious Mental Illness or Serious Emotional Disturbance Diagnosis

a. F41 Other anxiety disorders
b. F32 Major depressive disorder, single episode
c. F43 Reaction to severe stress, and adjustment disorders
d. F33 Major depressive disorder, recurrent
e. F31 Bipolar disorder
f. F06 Other mental disorders due to known physiological condition
g. F25 Schizoaffective disorders
h. F90 Attention-deficit hyperactivity disorders
i. F20 Schizophrenia

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

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

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

Name:

Hybrid Autoenrollment Process

Description:

Potential Behavioral Health Home (BHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The Lead Entity (LE) will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to fully enroll the Medicaid beneficiary into the BHH benefit. The selection of a health home provider is optional, the beneficiary may have other choices of health home providers, and the beneficiary may disenroll from the benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home is voluntary and the potential enrollee must agree to receive Health Homes services and provide consent that is maintained in the enrollee's health record.

Lead Entities will provide information about the BHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. LEs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the BHH.

A. Lead Entity Identification of Potential Enrollees
The LE will be responsible for identifying potential enrollees that have a qualifying BHH diagnosis in the WSA to a perspective HHP and provide information regarding BHH services to the Medicaid beneficiary in coordination with the HHP.

B. Provider-Recommended Identification of Potential Enrollees
Health Home Partners are permitted to recommend potential enrollees for the BHH benefit via the WSA. BHH providers must provide documentation that indicates whether a potential BHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of an individualized care plan. The LE must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

C. Enrollment and Dis-enrollment
Full enrollment into the BHH is contingent on beneficiary completion of the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515), verification of diagnosis eligibility, and the LE electronically enrolling the beneficiary in the WSA. The LE and HHP will work together to identify a recommended HHP setting where the potential health home enrollee will likely be most successful. After receiving the recommendation from the LE and HHP, the beneficiary will have the opportunity to choose their preferred HHP. The variety and number of HHPs may vary by region. Once the Medicaid beneficiary is assigned to a health home, the HHP will work with the beneficiary to complete the enrollment process. The LE must complete and process all required information for beneficiary enrollment through the WSA.

Failure to verify consent or diagnostic eligibility will prevent the Medicaid beneficiary from enrolling into the BHH benefit. Medicaid beneficiaries may opt-out (disenroll) from the BHH at any time with no impact on their eligibility for other Medicaid services.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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SPA ID MI-20-1500

Initial Submission Date 7/1/2020

Effective Date 10/1/2020

Types of Health Homes Providers

☐ Designated Providers

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

☐ Physicians

☐ Clinical Practices or Clinical Group Practices

☐ Rural Health Clinics

☐ Community Health Centers

☐ Community Mental Health Centers

☐ Home Health Agencies

☐ Case Management Agencies

☐ Community/Behavioral Health Agencies

☐ Federally Qualified Health Centers (FQHC)

☐ Other (Specify)

Provider Type	Description
Health Home Partner (HHP)	Provider Qualifications and Standards: The HHP must: • Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. • Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following: o Community Mental Health Services Programs (CMHSPs) o Federally Qualified Health Center/Primary Care Safety Net Clinic o Rural Health Clinic o Tribal Health Center o Clinical Practices or Clinical Group Practices o Community/Behavioral Health Agencies

Provider Type	Description
Lead Entity (LE)	• Be a regional entity as defined in Michigan's Mental Health Code (330.1204b). • Must contract with and pay a negotiated rate to HHPs, • Must maintain a network of providers that support the BHHs to service beneficiaries with a serious mental illness/serious emotional disturbance diagnosis, • Have authority to access Michigan Medicaid claims and encounter data for the BHH target population, • Have authority to access Michigan's Waiver Support Application and CareConnect360, • Provides leadership for implementation and coordination of health home activities, • Serves as a liaison between the health homes site and MDHHS staff/contractors, • Champions practice transformation based on health home principles, • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities, • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitors Health Home performance and leads quality improvement efforts, • Designs and develops prevention and wellness initiatives, and referral tracking, • Must have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including: o Identification of providers who meet the BHH standards, o Provision of infrastructure to support BHHs in care coordination, o Collecting and sharing member-level information regarding health care utilization and medications, o Providing quality outcome protocols to assess BHH effectiveness, and o Developing training and technical assistance activities that will support BHH in effective delivery of health home services.

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

MDHHS will utilize designated providers for health homes. Health Home Partners (HHPs), through the Lead Entity (LE), will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The following represents the care team requirements per 100 enrollees:

- Health Home Director (0.50 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)

- Peer Support Specialist, Community Health Worker, Medical Assistant (3.00-4.00 FTE)
- Medical Consultant (.10 FTE)
- Psychiatric Consultant (.10 FTE)

All providers referenced above must meet the following criteria:

Health Home Director
- Provides leadership for implementation and coordination of health home activities

Behavioral Health Specialist
- An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school

Nurse Care Manager
- Must be a licensed registered nurse

Peer Support Specialist, Community Health Worker, Medical Assistant
- Appropriate certification/training

Medical Consultant
- Primary care physician, physician's assistant, pediatrician, or nurse practitioner

Psychiatric Consultant
- Must be a licensed mental health professional (i.e. psychologist, psychiatrist, psychiatric nurse practitioner)

In addition to the above Required Provider Infrastructure Requirements, eligible BHH providers should coordinate care with the following professions:
- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

Supports for Health Homes Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care 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
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

Participating sites must adhere to the State's provider qualifications and standards in order to maintain active status. These standards include the eleven key components for providers listed above. All Health Homes must participate in State-sponsored activities designed to support approved sites in transforming services delivery. This includes a mandatory Health Home orientation for the designated providers and clinical support staff before the program is officially implemented. The orientation will include all HHPs and include detailed training on program expectations to ensure provider readiness. Ongoing
technical assistance will be made available through additional trainings and webinars after implementation. Individual assistance will be provided on an as needed basis by state or contractual staff. The state also anticipates forming Health Home workgroups and listserv forums for Health Home administrators and staff to communicate amongst each other and share best practices, solutions to potential service barriers or issues, monitoring and performance reporting concerns, and other needs. In addition, the state intends to develop and update a program specific website with provider resources and forms. The state will also serve as a resource, as needed, to connect providers to applicable state and local programs that would aid in the overall needs and goals of the Health Home beneficiary.

Other Health Homes Provider Standards

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

The Michigan BHH Lead Entity (LE) must:
1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
2. Must contract with and pay a negotiated rate to HHPs,
3. Must maintain a network of providers that support the BHHs to service beneficiaries with a serious mental illness/serious emotional disturbance diagnosis,
4. Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,

5. Have authority to access Michigan's Waiver Support Application and CareConnect360,
6. Provides leadership for implementation and coordination of health home activities,
7. Serves as a liaison between the health homes site and MDHHS staff/contractors,
8. Champions practice transformation based on health home principles,
9. Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities,
10. Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management,
11. Monitors Health Home performance and leads quality improvement efforts,
12. Designs and develops prevention and wellness initiatives, and referral tracking,
13. Must have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including:
    a. Identification of providers who meet the BHH standards,
    b. Provision of infrastructure to support BHHs in care coordination,
    c. Collecting and sharing member-level information regarding health care utilization and medications,
    d. Providing quality outcome protocols to assess BHH effectiveness, and
    e. Developing training and technical assistance activities that will support BHH in effective delivery of health home services.

The Lead Entity (LE) and the Health Home Partner (HHP) jointly must:
1. HHPs must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies
2. HHPs must enroll and execute any necessary agreement(s)/contract(s) with the LE; HHPs must also sign the MDHHS-5745 with MDHHS
3. HHPs must adhere to all federal and state laws regarding Section 2703 Health Homes recognition/certification, including the capacity to perform all core services specified by CMS. Providers shall meet the following recognition/certification standards:
    a. Achieve Patient Centered Medical Home (PCMH) from national recognizing body (NCQA, AAAHC, JC, CARF) before the BHH becomes operational. PCMH application can be pending at the time of implementation.
    b. Achieve CMS Stage 2 Meaningful Use (can be in-progress at the time of implementation).
4. Provide 24-hour, seven days a week availability of information and emergency consultation services to beneficiaries
5. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay
6. Ensure person-centered and integrated recovery action planning that coordinates and integrates all clinical and non-clinical health care related needs and services
7. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy
8. Utilize the MDHHS-5515 Consent to Share Behavioral Health and Substance Use Disorder Information
9. Demonstrate the ability to perform each of the following functional requirements. This includes documentation of the processes and methods used to execute these functions.
    a. Coordinate and provide the six core services cited in Section 2703 of the Affordable Care Act
    b. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines
    c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness.
    d. Coordinate and provide access to physical and mental health services.
    e. Coordinate and provide access to chronic disease management, including self- management support to individuals and their families
    f. 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 appropriate
    g. 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 clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level
10. Demonstrate the ability to report required data for both state and federal monitoring of the program

(See attached for further requirements of the LE and HHPs)
Document is titled "2_BHH Provider Requirements and Expectations V1 (3-18-2020)"

Name	Date Created	
2_BHH Provider Requirements and Expectations V1 (3-18-2020)	6/4/2020 3:09 PM EDT	

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

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

- [ ] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- (•) Yes
- ( ) No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

The contract amendment describes these requirements for the LEs:
o Providing a network of BHHs in partnership with community based HHPs identified by the State to assure that all six core health home services are provided to BHH beneficiaries and assigning members to a health

home, including receiving and evaluating referrals from community providers.
o Handling beneficiary requests to opt-out or opt back into the BHH and requests to change HHPs
o Providing beneficiary assignment lists to HHPs and indicating which HHP setting the BHH member is in
o Recruiting and training HHPs, assuring that they meet the HHP and joint Lead Entity and HHP requirements detailed in the State Plan and BHH Handbook
o Providing bidirectional methods for data sharing between the Lead Entity and HHPs, including clinical care alerts and population management tools
o Collecting quality information and reporting on BHH quality measures to the State
o Paying HHPs for BHH services on behalf of the State
o Dedicating no less than .50 FTE to BHH management per 100 consumers, to serve as a State contact and participate in regular meetings with the State and stakeholders
o Meeting all LE and joint LE and HHP Requirements
o Participating in the BHH Learning Collaborative to promote best practices and process improvement in operating the BHHs
o Submitting encounters and documenting BHH service(s) to the State in order to receive the monthly BHH case rate for each enrolled beneficiary with a service in a given month; the case rate will only be made if a HH service was provided by either the LE or an HHP
o Following all federal and State requirements for HHs described in the Michigan Medicaid State Plan and relevant federal statutes.

☐ The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	
No items available		

The State intends to include the Health Home payments in the Health Plan capitation rate

○ Yes
◉ No

Indicate which payment methodology the State will use to pay its plans

☐ Fee for Service (describe in Payment Methodology section)
☐ Alternative Model of Payment (describe in Payment Methodology section)
☐ Other

☐ Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID MI2020MS0002O

SPA ID MI-20-1500

Submission Type Official

Initial Submission Date 7/1/2020

Approval Date 9/9/2020

Effective Date 10/1/2020

Superseded SPA ID MI-16-1500

User-Entered

Payment Methodology

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

- [ ] Fee for Service
  - [ ] Individual Rates Per Service
  - [ ] Per Member, Per Month Rates
  - [ ] Fee for Service Rates based on
    - [ ] Severity of each individual's chronic conditions
    - [ ] Capabilities of the team of health care professionals, designated provider, or health team
    - [ ] Other
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement
    - [ ] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [ ] Other

Describe below

See P4P section of the payment methodology.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

See the payment methodology attached.

- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2020MS0002O	**SPA ID**	MI-20-1500
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	9/9/2020	**Effective Date**	10/1/2020
Superseded SPA ID	MI-16-1500		
	User-Entered		

Agency Rates

Describe the rates used

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2020MS0002O	**SPA ID**	MI-20-1500
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Superseded SPA ID	MI-16-1500		
	User-Entered		

Rate Development

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

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

Comprehensive Description See payment methodology attached.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

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Effective Date 10/1/2020

Superseded SPA ID MI-16-1500

User-Entered

Assurances

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

Describe below how non-duplication of payment will be achieved MDHHS has built into its MMIS, the ability to exclude benefit plans that may duplicate and offer payment for similar services provided under Medicaid. MDHHS will utilize this capability to prevent duplication and payment of services provided under other Medicaid authorities.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
3_MDHHS Behavioral Health Home Payment Methodology V2 (6.9.20)	6/9/2020 5:29 PM EDT	

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2020MS0002O	**SPA ID**	MI-20-1500
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	9/9/2020	**Effective Date**	10/1/2020
Superseded SPA ID	MI-16-1500		
	User-Entered		

Service Definitions

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

Comprehensive Care Management

Definition

Comprehensive care management begins with an assessment that will assist the provider and beneficiary in the development of the beneficiaries' individualized care plan. This care plan will be tailored to meet the beneficiaries' needs and goals. Individualized care plans will be measurable, well-defined, clinically relevant and monitored by members of the care delivery team. Issues identified during the assessment will be incorporated into the care plan which is documented in the EHR. Behavioral and physical health services will be integrated. Family members or other non-compensated support person(s) will be involved, when applicable. Health homes will track participants' treatment, outcomes, and self-management goals utilizing validated measurement tools, as appropriate, throughout their participation in the program. Periodic reassessment of patient will occur, including health status, service utilization, and to ascertain that appropriate community supports have been secured. Adjustments to the treatment plan may be necessary as applicable, including moving from one setting of care to another (e.g., FQHC to CMH, and vice-versa).

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

Health homes are required to have a functioning Electronic Health Record (EHR) to participate. LEs and HHPs will utilize their EHR to facilitate progress made on the overall care plan and adjust the plan accordingly in unison with the needs of the beneficiary. Health Homes will provide reporting via the EHR. Issues identified during the assessment will be incorporated into the care plan which is documented in the EHR.

HHPs must join the LEs centralized, claims-based health information exchange (HIE). This will assist care coordinators with maintaining a comprehensive care plan for each beneficiary enrolled in the health home.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens individuals for mental health and substance use disorders,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for individuals with behavioral health problems,
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on managing a population of patients versus specialty care,
- Works with patients to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Identifies community resources (i.e., support groups, workshops, etc.) for the patient to utilize to maximize wellness, and
- Provides patient education

☐ Nurse Practitioner

Description

Nurse Practitioner: Physician, Nurse Practitioner, Physician's Assistant
Provides medical consultation to assist the care team in the development

of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☐ Nurse Care Coordinators

Description

Nurse Care Manager
(Licensed Registered Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

☐ Nurses

☐ Medical Specialists

☐ Physicians

Description

Physicians, Nurse Practitioner, Physician's Assistant
Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☐ Physician's Assistants

Description

Physicians, Nurse Practitioner, Physician's Assistant
Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Community Health Worker	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Provider Type	Description
Peer Support Specialist	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Medical Assistant	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.

Care Coordination

Definition

Care coordination is the organization of activities between participants responsible for different aspects of a patient's care designed to facilitate delivery of appropriate services across all elements of the broader health care system. It includes management of integrated primary and specialty medical services, behavioral health services, and social, educational, vocational, and community services and supports to attain the goals of holistic, high quality, cost-effective care and improved patient outcomes. Components of care coordination include knowledge of and respect for the patient's needs and preferences, information sharing/communication between providers, patient, and family members, resource management and advocacy.

Key support roles include the Peer Support Specialist, Community Health Worker (CHWs), and Medical Assistants (MAs). Peer Support Specialist services are provided by an individual with a lived experience and journey in receiving public mental health services and supports. The Peer Support Specialist helps to remove barriers and obstacles and links the beneficiary to resources in the recovery community.

Services provided by a Peer Support Specialist support beneficiary with health navigation, accessing resources, and supporting a person-centered recovery journey to achieve community inclusion and participation, independence, recovery, and resiliency.

Peer Support Specialists embody a powerful message of hope, helping beneficiaries achieve a full and meaningful life in the community. The Peer Support Specialist can assist with tasks such as setting recovery goals, developing action plans, and solving problems directly related to recovery.

The Peer Support Specialist shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Support Specialist who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.

Community Health Workers are professionals identified by the American Public Health Association. CHWs are frontline public health workers who have an understanding of the community they serve. The CHW to serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Medical Assistants are multi-skilled health professionals specifically educated to work in ambulatory care settings performing both administrative and

clinical duties. MAs help support care coordination for beneficiaries by scheduling appointments, arranging hospital admissions and laboratory services, instructing patient about medication and special diets, preparing and administering medications, and authorizing prescription refills.

Peer Support Specialists, CHWs, MAs, and other Care Coordinators will, at a minimum, provide:
*Emphasis will be placed on in-person contacts; however telephonic outreach may be used for lower-risk Health Home members who require less frequent face to face contact
*Appointment making assistance, including coordinating transportation
*Development and implementation of care plan
*Medication adherence and monitoring
*Referral tracking
*Use of facility liaisons, as available (i.e., nurse care managers)
*Patient care team huddles
*Use of case conferences, as applicable
*Tracking test results
*Requiring discharge summaries

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

Lead Entities and Health Home Partners will utilize their EHR to record care coordination activities and adjust these activities, as appropriate.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)
- Screens individuals for mental health and substance use disorders,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for individuals with behavioral health problems,
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on managing a population of patients versus specialty care,
- Works with patients to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Identifies community resources (i.e., support groups, workshops, etc.) for the patient to utilize to maximize wellness, and
- Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager
(Licensed Registered Nurse)
- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

☐ Nurses

- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Medical Assistant	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.
Peer Support Specialist	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Provider Type	Description
Community Health Worker	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Health Promotion

Definition

Health Promotion begins with the initial health homes visit or while establishing a formal care plan. The health home will assess the readiness to change and provide the beneficiary with the appropriate level of encouragement and support for the adoption of these healthy behaviors and/or lifestyle changes. Healthy behaviors and/or lifestyle interventions include but are not limited to:
*Development of self-management plans
*Evidenced-based wellness and promotion
*Patient education
*Patient and family activation
*Addressing clinical and social needs
*Patient-centered training (e.g., diabetes education, nutrition education)
*Connection to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiaries' needs and preferences.

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

LEs and HHPs will utilize their EHR to record health promotion activities and adjust these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)
• Screens individuals for mental health and substance use disorders,
• Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
• Conducts brief intervention for individuals with behavioral health problems,
• Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic,
• Supports primary care providers in identifying and behaviorally intervening with patients,
• Focuses on managing a population of patients versus specialty care,
• Works with patients to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
• Develops and maintains relationships with community based mental health and substance abuse providers,
• Identifies community resources (i.e., support groups, workshops, etc.) for the patient to utilize to maximize wellness, and
• Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager
(Licensed Registered Nurse)
• Participates in the selection of strategies to implement evidence-based

wellness and prevention initiatives,
- Participates in initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Peer Support Specialist	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Medical Assistant	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Health Home Partners	Any of the selected provider types above at the HHP.

Provider Type	Description
Lead Entity	• Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.
Community Health Worker	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

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

Definition

Comprehensive transitional care services connect the beneficiary to needed health services available within the community. Health services include care provided outside of the health home. Health homes will be expected to coordinate and track their participants:
*Notification of admissions/discharge
*Receipt of care record, continuity of care document, or discharge summary
*Post-discharge outreach to assure appropriate follow-up services
*Medication reconciliation
*Pharmacy coordination
*Proactive care (versus reactive care)
*Specialized transitions when necessary (e.g., age, corrections)
*Home visits

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

Utilizing the LEs HIE will allow for seamless transitions of care within the region. Moreover, CareConnect360, an MDHHS supported application, is anticipated to support Health Home services by providing access to admission, discharge, and transfer information. CareConnect360 will also provide a resource to health homes providers to track labs, and pharmacy data. In addition, the application will include data on health status and utilization patterns based on claims data. Together, this will allow for seamless transitions of care so that the beneficiary is received and accommodated appropriately at every health service and community setting. Michigan's LEs have access to CareConnect360 and will leverage the application as appropriate.

Scope of service

The service can be provided by the following provider types

	Description
☐ Behavioral Health Professionals or Specialists	Behavioral Health Provider (An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school) • Screens individuals for mental health and substance use disorders, • Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary, • Conducts brief intervention for individuals with behavioral health problems, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Supports primary care providers in identifying and behaviorally

intervening with patients,
- Focuses on managing a population of patients versus specialty care,
- Works with patients to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Identifies community resources (i.e., support groups, workshops, etc.) for the patient to utilize to maximize wellness, and
- Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager
(Licensed Registered Nurse)
- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Community Health Worker	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Provider Type	Description
Peer Support Specialist	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Medical Assistant	Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services reduce barriers to the beneficiaries' care coordination, increase skills and engagement and improve overall health outcomes. Specific activities may include, but are not limited to:
*Use of community supports (e.g., community health workers, peer supports, support groups, self-care programs, as appropriate)
*Facilitation of improved adherence to treatment
*Advocacy for individual and family needs
*Efforts to assess and increase health literacy
*Use of advance directives
*Assistance with maximizing level of functioning in the community

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

The HIE, EHR, and CareConnect360 will assist providers in supporting beneficiaries and their families with helpful information to empower and educate themselves and subsequently maximize self-management of health.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists	**Description** Behavioral Health Provider (An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational

institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)
- Screens individuals for mental health and substance use disorders,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for individuals with behavioral health problems,
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on managing a population of patients versus specialty care,
- Works with patients to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Identifies community resources (i.e., support groups, workshops, etc.) for the patient to utilize to maximize wellness, and
- Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager
(Licensed Registered Nurse)
- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

☐ Nurses

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☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description

Provider Type	Description
Community Health Worker	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Peer Support Specialist	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Medical Assistant	(Must have appropriate certification/training) • Coordinates and provides access to individual and family supports, including referral to community social supports, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic, • Identifies community resources (i.e. social services, workshops, etc.) for patient to utilize to maximize wellness, • Conducts referral tracking, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, and • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.

Referral to Community and Social Support Services

Definition

Referrals to community and social support services provide recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. Specific activities may include, but are not limited to:
*Collaboration/coordination with community-based organizations and other key community stakeholders
*Emphasis on resources closest to the patient's home with least barriers
*Identification of community-based resources
*Availability of resource materials pertinent to patient needs
*Assist in attainment of other resources, including benefit acquisition
*Referral to housing resources as needed
*Referral tracking and follow-up

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

While the community and social services supports network may not have direct access to the enrollee's health record, MDHHS anticipates that the HIE, EHR, and CareConnect360 will afford providers the ability to track, follow-up and evaluate referrals to these services. In addition, HIT will provide beneficiaries and their families with helpful resource materials to empower and educate themselves and subsequently maximize self-management of health.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens individuals for mental health and substance use disorders,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for individuals with behavioral health problems,
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on managing a population of patients versus specialty care,
- Works with patients to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
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- Identifies community resources (i.e., support groups, workshops, etc.) for the patient to utilize to maximize wellness, and
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☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

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- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

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Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2020MS0002O	**SPA ID**	MI-20-1500
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	9/9/2020	**Effective Date**	10/1/2020
Superseded SPA ID	MI-16-1500		
	User-Entered		

Health Homes Patient Flow

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

See attached - BHH Patient Flow V3 (6-10-2020).

Name	Date Created	
5. BHH Patient Flow V4 (7-28-2020)	8/27/2020 1:41 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0002O | MI-20-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

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Superseded SPA ID	MI-16-1500		
	User-Entered		

Monitoring

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

MDHHS will contract with an independent evaluator to execute a cost-efficiency analysis for the BHH program. Broadly, the cost-focused analyses will consider the consequences of improved care coordination and clinical management for beneficiaries enrolled in the program and will also measure total expenditures for individuals enrolled in the program comparing the implementation period with the period immediately prior to program implementation. In addition to the pre-post comparison, the independent evaluator will also compare total expenditures for beneficiaries enrolled in the intervention (program) with expenditures for a concurrent control population identified on the basis of their specific eligible conditions and receipt of care in federally qualified health centers. These dual approaches will provide a robust evaluation of the program. All analyses will be presented in aggregate terms and also as PMPM. Michigan will use the MDHHS Data Warehouse which will include administrative claims data pre- and post-Health Homes implementation; administrative claims data for the intervention and control populations, which will be formally defined in the cost-efficiency evaluation methodology. Adjustments will be made for cost outliers in the analysis.

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

Added to the maintenance of their own electronic health records (EHRs), approved Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home services. The LE will also utilize CareConnect360, which is a care coordination tool that allows providers to access comprehensive retrospective Medicaid claim and encounter data. It supports queries that allow Health Homes to view the following beneficiary information:
*Current and prior health conditions
*Rendering services provider, date of service, and length of stay (if applicable)
*Pharmacy claims data
*Hospitalization and ED utilization, including diagnoses

Health Homes Monitoring, Quality Measurement and Evaluation

Package Header

Package ID	MI2020MS0002O	**SPA ID**	MI-20-1500
Submission Type	Official	**Initial Submission Date**	7/1/2020
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Superseded SPA ID	MI-16-1500		
	User-Entered		

Quality Measurement and Evaluation

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

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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