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State/Territory Name: Wisconsin
State Plan Amendment (SPA) #: 21-0012

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CMS-10434 OMB 0938-1188

Package Information

Package ID	WI2020MS0007O	**Submission Type**	Official
Program Name	SUD Health Home-SUD-focused	**State**	WI
SPA ID	WI-21-0012	**Region**	Chicago, IL
Version Number	2	**Package Status**	Approved
Submitted By	Laura Brauer	**Submission Date**	6/30/2021
Package Disposition		**Approval Date**	9/21/2021 1:22 PM EDT
Priority Code	P2		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th St., Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

September 21, 2021

Jim Jones
Medicaid Director
Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53701

Re: Approval of State Plan Amendment WI-21-0012 SUD Health Home

Dear Mr. Jones,

On June 30, 2021, the Centers for Medicare and Medicaid Services (CMS) received Wisconsin State Plan Amendment (SPA) WI-21-0012 for Substance-used Disorder (SUD) Health Home to add specialized SUD treatment and support services for Medicaid beneficiaries.

We approve Wisconsin State Plan Amendment (SPA) WI-21-0012 with an effective date of July 01, 2021.

For payments made to Health Homes providers under this new Health Homes Program SPA, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 7/1/2021 to 12/31/2023. This includes the initial 8 quarters plus an additional 2 approved quarters for a total of 10 quarters for SUD-focused health home programs.

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 45 for states to report health homes services expenditures for enrollees with SUD. Please note that this is a different line item than other health home programs the state may operate because this is a SUD-focused health home.

If you have any questions regarding this amendment, please contact Mai Le-Yuen at mai.le-yuen@cms.hhs.gov

Sincerely,

James G. Scott

Director

Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2020MS0007O	**SPA ID**	WI-21-0012
Submission Type	Official	**Initial Submission Date**	6/30/2021
Approval Date	9/21/2021	**Effective Date**	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Wisconsin	**Medicaid Agency Name:**	Department of Health Services

Submission Component

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

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

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Effective Date N/A
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SPA ID and Effective Date

SPA ID WI-21-0012

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2021	New
Health Homes Geographic Limitations	7/1/2021	New
Health Homes Population and Enrollment Criteria	7/1/2021	New
Health Homes Providers	7/1/2021	New
Health Homes Service Delivery Systems	7/1/2021	New
Health Homes Payment Methodologies	7/1/2021	New
Health Homes Services	7/1/2021	New
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2021	New

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

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Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The Hub & Spoke (H&S) Integrated Recovery Support Service is a health home that integrates physical and behavioral health services for members with complex substance use disorders. This design is based on the "Hub and Spoke" model implemented in other states in which the lead Hub agency provides specialized SUD treatment and supports, including three forms of Medication Assisted Treatment (MAT) and assessment and assurance that the member's overall behavioral and physical health needs are met. The Spokes collaborate with the Hub to carry out important care management and health promotion services for members with lower intensity needs. At the core of this model, the enrolled member is supported by team-based collaborative care and treatment that supports the person to meet their own identified health care goals across the spectrum of behavioral health and primary health care. The H&S initiative aims to ensure 1) members will have increased access to SUD treatment, better coordination of physical and mental health services, and increased resources for social supports; 2) providers will be incentivized to offer more forms of MAT, thus increasing access for members; and 3) health systems and SUD treatment providers will improve collaboration to address the whole person.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$985492
Second	2022	$4531769

Federal Statute / Regulation Citation

Section 1945 of the Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
WI-21-0012 Additional Enhanced FMAP Request	9/15/2021 8:10 AM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

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Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

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Superseded SPA ID N/A

Name of Health Homes Program

SUD Health Home

☐ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
WI-21-0012 Public Notice 20210601	6/14/2021 12:56 PM EDT	
WI-21-0012 Public Notice 20210614	6/14/2021 12:56 PM EDT	

Submission - Tribal Input

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Name of Health Homes Program:

SUD Health Home

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (•) Yes
- ( ) No

☐ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

☐ All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
5/12/2021	Attendance and consultation at bi-monthly Wisconsin Tribal Health Director meeting.

☐ All Urban Indian Organizations

Date of solicitation/consultation:	Method of solicitation/consultation:
5/12/2021	Attendance and consultation at bi-monthly Wisconsin Tribal Health Director meeting.

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☐ All Indian Tribes

Date of consultation:	Method of consultation:
5/12/2021	Attendance and consultation at bi-monthly Wisconsin Tribal Health Director meeting.

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
Tribal Consultation 20210512	5/18/2021 9:53 AM EDT	PDF

Indicate the key issues raised (optional)

☐ Access

- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

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SAMHSA Consultation

Name of Health Homes Program

SUD Health Home

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
5/13/2021

Health Homes Intro

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Approval Date	9/21/2021	**Effective Date**	7/1/2021
Superseded SPA ID	New		
	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

SUD Health Home

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

The Hub & Spoke (H&S) Integrated Recovery Support Service is a SUD health home that integrates physical and behavioral health services for members with complex substance use disorders. This design is based on the "Hub and Spoke" model implemented in other states in which the lead Hub agency provides specialized SUD treatment and supports, including three forms of Medication Assisted Treatment (MAT) and assessment and assurance that the member's overall behavioral and physical health needs are met. The Spokes collaborate with the Hub to carry out important care management and health promotion services for member with lower-intensity needs. At the core of this model, the enrolled member is supported by team-based collaborative care and treatment that supports the person to meet their own identified health care goals across the spectrum of behavioral health and primary health care. The H&S initiative aims to ensure 1) members will have increased access to SUD treatment, better coordination of physical and mental health services, and increased resources for social supports; 2) providers will be incentivized to offer more forms of MAT, thus increasing access for members; and 3) health systems and SUD treatment providers will improve collaboration to address the whole person.

The H&S health home includes a Hub and its associated Spokes, with a team of health care professionals who deliver the six health home services at various intensities depending on the member's needs. Participation is voluntary and eligible members will opt-in to receive health home services with either the Hub, Spoke, or both depending on treatment need and self-identified goals.

The H&S Integrate Recovery Support Services will be delivered via fee-for-service (FFS) for members in coordination with managed care enrollment. Hubs will bill the State directly for all health home services rendered by the Hub and their associated Spokes. Hub providers will be reimbursed for an initial comprehensive assessment for each new member that enrolls in the health home, and then annually for each enrolled member continuing to receive health home services. Hub providers may bill once per member per month (PMPM) and the monthly reimbursement will depend on the complexity of the member and the intensity of services provided (high, moderate, and low intensity).

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 ten fiscal quarters from the effective date of the SPA. After the first ten 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 10-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

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Superseded SPA ID New

User-Entered

- ○ 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

Describe the area(s):
Brown County
Forest County
Iron County
Milwaukee County
Oneida County
Outagamie County
Price County
Vilas County
Forest County Potawatomi Tribal Nation
Lac du Flambeau Chippewa Tribal Nation
Sokaogon Chippewa Tribal Nation
Oneida Tribal Nation

Health Homes Population and Enrollment Criteria

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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

Specify the conditions included:

- [ ] Mental Health Condition
- [ ] Substance Use Disorder
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] BMI over 25
- [ ] Other (specify):

Specify the criteria for at risk of developing another chronic condition:

Having or being at risk of developing another medical condition, including conditions frequently associated with or with increasing prevalence of Substance Use Disorder:
•Attention deficit hyperactivity disorder (ADHD)
•Anxiety Disorders
•Asthma
•Chronic Pain
•Chronic obstructive pulmonary disease (COPD)
•Diabetes
•Heart Disease
•Hepatitis A, B, and C
•HIV/AIDS
•Hypertension
•Liver/Kidney Disease
•Mood Disorder
•Other Substance Use Disorder
Having or being at risk of developing another medical condition, including conditions frequently associated with or with increasing prevalence of Substance Use Disorder:
•Attention deficit hyperactivity disorder (ADHD)
•Anxiety Disorders
•Asthma
•Chronic Pain
•Chronic obstructive pulmonary disease (COPD)
•Diabetes
•Heart Disease
•Hepatitis A, B, and C
•HIV/AIDS
•Hypertension
•Liver/Kidney Disease
•Mood Disorder
•Other Substance Use Disorder
•Pregnant or within 120 days postpartum
•Post-traumatic stress disorder (PTSD)
•Psychotic Disorder
•Traumatic Brain Injury and Cognitive Disorders

If a member with SUD presents with a risk or condition not listed above, the Hub and Spoke providers have the discretion to clinically assess the member's needs for health home services on a case by case basis.

Resources:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5373082/
https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf
https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4789.pdf
https://www.drugabuse.gov/sites/default/files/soa.pdf

☐ One serious and persistent mental health condition

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)

Describe the process used:

H&S providers and their partners will follow a “no wrong door” approach in providing members access to the program. Members may be referred for services through self-referral, managed care entities, county programs, community partners, primary care providers, hospitals, or others. Hub staff will receive referrals to screen the member to determine eligibility for Medicaid and health home services. If the person is not enrolled in Medicaid, but eligible, H&S staff will assist that person with enrollment.

Medicaid-enrolled individuals with the required diagnosis and treatment needs will be informed of the program and how to participate. If an individual gives consent to participate, the H&S team will work with the member to conduct an initial, comprehensive assessment and will promote engagement with evidence-based approaches, such as Motivational Interviewing and harm reduction. H&S providers should ensure continuity of care by providing consistent contacts throughout the intake, screening, and enrollment, to the greatest extent possible.

Providers must maintain documentation of enrollment verification and consent to participate in the member’s record. The member can choose not to participate at any time by notifying their H&S provider.

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

☐ Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards

☐ Physicians

Describe the Provider Qualifications and Standards

A physician with significant experience treating individuals with substance use disorder and authority to prescribe buprenorphine in an office-based setting

☐ Nurse Practitioners

Describe the Provider Qualifications and Standards

A nurse practitioner with experience treating substance use disorder and have the authority to prescribe buprenorphine in an office-based setting

☐ Nurse Care Coordinators

Describe the Provider Qualifications and Standards

A Registered Nurse (RN) or Advanced Practice Registered Nurse (APRN) with significant experience treating individuals with SUD or other special populations

☐ Nutritionists

☐ Social Workers

Describe the Provider Qualifications and Standards

An individual with a bachelor's degree in a human services related field and experience in the mental health and substance use services systems

☐ Behavioral Health Professionals

Describe the Provider Qualifications and Standards

A psychologist, Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), or Licensed Clinical Social Worker (LCSW) who practices as a substance abuse clinical supervisor or provides substance abuse counseling, treatment, or prevention services within the scope of their licensure; Certified Psychotherapist with Substance Abuse Counselor, Certified Substance Abuse Counselor, or substance abuse counselor in training (SAC-IT) awarded by the Wisconsin Department of Safety and Professional Services

☐ Other (Specify)

Provider Type	Description
Physicians Assistants	A physician assistant with significant experience treating individuals with substance use disorder and authority to prescribe buprenorphine in an office-based setting
Cultural Advisors	A tribal individual with knowledge of cultural traditions, healing methods; provides tribal/community resources for cultural wellness, ceremonies, healers, history, language, etc.

Provider Type	Description
Peer Supports	An individual certified as a recovery coach through CCAR or as a peer specialist through the State with experience in the mental health and substance use services system
Care Coordinator	Individual with at least a high school diploma or equivalent with additional education and/or experience in the medical field, human services, or social services areas. Personal and/or professional knowledge of Medicaid, substance abuse and integrated service delivery systems
Nurses	Registered Nurse (RN), Licensed Practical Nurse (LPN), or Certified Nursing Assistant (CNA) with experience treating individuals with SUD or other special populations

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Both Hubs and Spokes may deliver the six health home services, depending on treatment needs. The Hub site is a regional center of excellence that has a deep knowledge of substance use disorder that can rapidly respond to individuals with high intensity treatment needs. Spoke sites enter into agreements with a Hub to provide care for people with lower intensity treatment needs and to aid in seamless transitions while building provider capacity throughout the region served. Members may receive health home services from either the Hub or Spoke as their treatment needs change during recovery.

Each Hub must utilize DEA-waivered providers to review, approve, or modify comprehensive care plans for members receiving MAT and to provide consultation during member's treatment and recovery. As treatment needs and provider capacity vary throughout the State, Hubs and Spokes may employ a variety of providers, as described above, to deliver the six health home services. Hubs and Spokes must employ individuals with lived experience in substance use recovery.

The Hubs will enter into a contract with the State in order to provide health home services. Hubs will then have agreements with Spoke sites to allow delivery of health home services, consistent with provider qualifications, informed consent, and service coordination requirements. Hubs are ultimately responsible for oversight, communication, and coordination with their Spokes. Hubs will be the billing provider for health home services rendered by both the Hub and their respective Spoke sites.

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 H&S providers must adhere to the state's provider qualifications and standards in order to deliver health home services. These standards include the eleven key components for providers listed above and are outlined in agreements and provider handbooks. Prior to implementation, the State regularly interacts with H&S providers to ensure a seamless transition to implementing the health home benefit. The State will continue to support H&S providers through continuous engagement and outreach, facilitating technical assistance webinars, publishing provider resources, and hosting learning collaboratives among the various providers. These supports may include areas such as engaging members, eligibility and enrollment, claims submission, quality and monitoring, best practices, and innovative care.

Other Health Homes Provider Standards

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

1. The Hub and their Spokes must be enrolled providers approved for Medicaid reimbursement, and currently certified by the Department as appropriate.
2. Hub providers that submit claims must be certified by the Department and in compliance with federal requirements and state licensing or administrative rules.

3. The Hub must obtain written and informed consent from the patient at the time of enrollment into the H&S program.
4. In order to meet urgent needs of individuals with complex SUD, the Hub must provide access to a core set of Medicaid benefits (in addition to the health home services) to engage and stabilize the individual and initiate treatment. These include bio-psychosocial assessments, physical health care assessments needed for initiation of medication assisted treatment (MAT), access to three forms of MAT, and Naloxone.
5. The Hub will ensure that all forms of MAT are available. Memorandums of Understanding (MOUs) with Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) may be utilized to ensure that all forms MAT are available through the Health Home service delivery system.
6. The Hub will conduct initial and ongoing screenings that are trauma informed, culturally sensitive, age appropriate, and address suicide prevention needs. The initial assessment and resulting case plan must be trauma-informed and responsive to race, ethnicity, gender identity, disability, and culture. The Hub will use a department-approved tool, such as the Brief Addiction Monitor (BAM), to collect initial baseline data and monitor progress.
7. Hub sites must coordinate care for the member across a range of settings, including medical, behavioral, dental, pharmaceutical, institutional, and community care settings.
8. Hub staff should direct persons to use providers within their own Managed Care Entity (MCE). Both the Hub and the MCE should identify a sole point of contact to coordinate member care.
9. The Hub will ensure that all communication and information shared with the person receiving services is culturally competent and respectful of the person's language and literacy, as well as their gender identity and preferred pronouns.
10. Hubs and Spokes are required to utilize evidence-based strategies to promote member engagement in treatment, such as Motivational Interviewing.
11. The Hub will track each person's enrollment, treatment, outcomes, member experience, and self-management goals. Hubs will evaluate the effectiveness of the interventions and modify as needed to ensure desired outcomes.
12. The Hub will monitor population health status and service use. The Hub will identify and prioritize population-wide needs and trends, and promote and implement appropriate population-wide treatment guidelines and interventions. Hubs will monitor health disparities and identify best practices for improving health equity and culturally competent care in their context.
13. Hubs will be required to produce an annual report summarizing key metrics as requested by the state.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

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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
- ☐ Other Service Delivery System

Health Homes Payment Methodologies

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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

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

Hub providers may bill one of three tiers of services per member per month (PMPM) depending on the complexity of the member and the intensity of services provided. These tiers include high, moderate, and low intensity. In order to be eligible for high intensity services, members must meet a certain threshold on the state's developed complexity tool. There are no eligibility requirements for moderate or low intensity services in excess of those necessary to be eligible for the health home. Hub and spoke providers must meet minimum direct service hours to be reimbursed for each of the three intensity tiers.
Members receiving high intensity services are reevaluated regularly to determine the appropriateness of this level of service.

- ☐ 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 | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

Package Header

Package ID WI2020MS0007O
SPA ID WI-21-0012
Submission Type Official
Initial Submission Date 6/30/2021
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Superseded SPA ID New
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

Effective Date

6/1/2021

Website where rates are displayed

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

Health Homes Payment Methodologies

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Superseded SPA ID	New		
	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

1. The costs built into the rate for each intensity level are based on the number of expected hours spent administering the six core services per member per month, the distribution of professionals expected to administer those services, the cost of employing these professionals, and the associated administrative overhead costs. The estimated number of hours spent at each intensity level and the distribution of professionals accounting for these hours are based on data provided by the pilot sites, a review of comparable services at the state and national level, and the expertise of state program staff. The cost of employing the professionals is based on salaries provided by the pilot sites, the reimbursement of similar professional for other Wisconsin Medicaid services, and Wisconsin Department of Workforce Development (DWD) data.
2. Hubs and Spokes are teams of providers supported by a PMPM payment. Payment will be made monthly, covering the previous month's service by Hub site providers. Providers will be required to use the following Healthcare Common Procedure Coding System procedure codes when submitting professional claims for reimbursement:H001: Comprehensive Annual AssessmentH006: Monthly Engagement in Services.
3. Hub providers may bill $375.08 for the comprehensive assessment of a member. This assessment may be billed once for each new member that enrolls in the health home and annually for members whose health and support needs dictate the need.

Providers must meet a minimum direct hours requirements to bill each intensity level for a given member. The corresponding intensity levels, direct health home service hours, and PMPM are as follows:

- High intensity = the member must receive at least 20 hours of direct health home services for a Hub to receive its PMPM of $1,086.86
- Moderate intensity = the member must receive at least 10 hours of direct health home services for a Hub to receive its PMPM of $587.74
- Low intensity = the member must receive at least 1 hour of direct health home services for a hub to receive its PMPM of $148.06

These direct hour requirements can only be satisfied by administering the six core health home services to the member while the member is present, either face-to-face, over the phone, or via telehealth. The direct hours do not include the provision of any services that are reimbursed under other Medicaid benefits and only the six Health Home Services are paid or reimbursed under the methodology described in this SPA. Hours spent conducting the initial assessment do not count toward the minimum service requirements.

Health home providers must submit a claim to receive payment.

4. Hub providers are required to submit quarterly reports that include the direct and indirect hours spent with each member. These reports will be reviewed against submitted claims to ensure that the proper intensity level was billed for each member. Hub providers are also required to fill out a complexity scale for each member during their comprehensive assessment. The scales will be reviewed against claims for high intensity members to ensure that only those with high levels of need are receiving high intensity services. Hub providers are expected to update this complexity scale for a member if their condition changes in a way that would qualify them for high intensity services.
5. The PMPM method will be reviewed periodically to determine if the rate is economically efficient and consistent with quality of care. Rates will be updated accordingly.

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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 The State assures to CMS that health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits, other delivery systems including waivers, other Medicaid health homes, and other state plan services. Members cannot be eligible for SUD Health Home services if enrolled in the HIV/AIDS health home, Targeted Case Management, or Prenatal Care Coordination.

☐ 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	
No items available		

Health Homes Services

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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

The H&S providers will complete an initial assessment to develop a plan of care that includes primary care, addiction and behavioral health care, and essential social services to address the needs of the whole person through a team-based care model. The assessment will apply ASAM level of care criteria and when indicated, the provider may promptly engage the individual in treatment. Immediate evidence-based interventions, such as medication assisted treatment (MAT), may begin prior to completion of the full assessment.

The care plan will be developed with the member. The plan will be based on the assessment and tailored to meet the member's needs and goals. The care plan will include well-defined measurable goals, timeframes, the person's preferred natural support network, and the specific, evidence-based services the team will provide or arrange. Health Home staff should motivate and engage the person in planning their treatment.

The Hub will determine the complexity of the person's treatment needs, and delegate care coordination activities to the Hub or the Spoke. Health Homes will identify and connect providers and specialists involved in the person's care to promote integrated healthcare, and identify the roles and communication protocols for all involved providers. Trauma-sensitive and trauma-informed approaches must be used when needed to facilitate the person's engagement.

Periodic reassessment of the person's progress and outcomes will include health status, quality of life, participation in care plan services, satisfaction with services, and availability of community supports. Treatment plan updates may be necessary, including moving from one care setting to another, developing quality improvement activities, and linkages with long term care services and supports. Reassessment will occur annually or more frequently, based upon the intensity of treatment or changes in the person's goals and/or condition. Reassessments will include current information on the person's confidence and readiness for change, adherence to treatment, use of emergency services, and any identified barriers to recovery.

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

The needs identified during the assessment will be incorporated into the care plan and documented in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's comprehensive care plans with the purpose of accessing relevant care plan information for service delivery across providers and health systems.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Contributes to conducting initial assessments and reassessments, the formulation of the comprehensive care plan through engaging with members identifying team roles and responsibilities, and recommending evidence-based interventions.

☐ Nurse Practitioner

Description

Provides necessary clinical oversight and input for initial assessments and reassessments and contributes to the formulation of the comprehensive care plan.

☐ Nurse Care Coordinators

Description

Contributes to the formulation of the comprehensive care plan through identifying appropriate linkages and referrals and coordinating across service and provider settings.

☐ Nurses

☐ Medical Specialists

☐ Physicians

Description

Provides necessary clinical oversight and input for initial assessments and reassessments and contributes to the formulation of the comprehensive care plan.

☐ Physician's Assistants

Description

Provides necessary clinical oversight and input for initial assessments and reassessments and contributes to the formulation of the comprehensive care plan.

- [ ] Pharmacists
- [ ] Social Workers

Description

Contributes to the formulation of the comprehensive care plan through identifying appropriate linkages and referrals and coordinating across service and provider settings.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Care Coordinator	May serve as an initial point of contact for referrals to the program, conducts initial screening and triage, determines eligibility for services, gathers necessary information for the initial assessment, and coordinates follow-up appointments.
Peer Supports	Act as a resource broker for the patient, providing advocacy for patients, assisting with resources, assisting with transportation, support groups and developing a wellness plan.

Care Coordination

Definition

Care coordination involves implementing the individualized comprehensive care plan, in order to engage the member in their home and community, attain member goals, and improve chronic conditions. The care coordinator will facilitate linkages between the member's various care and treatment providers. Components of care coordination include knowledge of and respect for the member's needs and preferences, resource management, advocacy, and communication between providers and family members. Care coordination services will be proactive and based on the member's individualized needs and preferences.

Care coordination involves implementing the individualized comprehensive care plan, in order to engage the member in their home and community, attain member goals, and improve chronic conditions. The care coordinator will facilitate linkages between the member's various care and treatment providers. Components of care coordination include knowledge of and respect for the member's needs and preferences, resource management, advocacy, and communication between providers and family members. Care coordination services will be proactive and based on the member's individualized needs and preferences.

H&S providers serving children and youth will place particular emphasis on coordination with Primary Care Providers, schools, child protective services, juvenile justice, foster parents, or other youth support networks. In collaboration with the youth receiving services, family and natural supports will be included and encouraged to participate in treatment planning and service coordination.

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

Care coordination needs will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans and care coordination needs.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

May serve as the primary care coordinator to follow the member during their treatment and recovery which will include planning linkages between other team members, health care providers, and social services and updating the care plan as appropriate.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

May serve as the primary care coordinator to follow the member during their treatment and recovery which will include planning linkages between other team members, health care providers, and social services and updating the care plan as appropriate.

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers

Description

May serve as the primary care coordinator to follow the member during their treatment and recovery which will include planning linkages between other team members, health care providers, and social services and updating the care plan as appropriate.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Care Coordinators	Provide mobile outreach with a focus on coordinating community-based services with the member whom may also be responsible for other facilitation among team members or health care providers.

Health Promotion

Definition

The H&S team will work with each member to identify health promoting activities, screen for both medical and mental health conditions, and provide linkages for the person to access appropriate physical health care services, such as immunizations or dental care. Health Promotion begins with the initial assessment and continues during the development of a formal comprehensive care plan. The H&S team will talk with the member to assess their readiness for change and provide the member with the appropriate level of encouragement and support to engage in healthy behavior choices and/or lifestyle choices.

The H&S team will also screen for past experience with trauma, as well as for frequently co-occurring health conditions including HIV/AIDS, TB, and infectious hepatitis.

The H&S team will also provide health education to the member and their self-identified support systems regarding chronic conditions, prevention education, and promoting healthy lifestyle choices, such as:
- Smoking prevention and cessation
- Stress reduction
- Nutritional counseling
- Obesity reduction and prevention
- Engaging in regular physical activity
- Disease-specific or chronic care management
- Personal goal-setting for wellness and recovery

H&S providers working with children and youth will emphasize prevention health initiatives, including strategies to build resilience and provide trauma informed care, while actively involving parents/guardians, and other support networks. This will include identifying conditions contributing to risk due to family, physical, or social factors, and working with the youth to address these areas.

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

Health promotion activities will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans and health promotion needs.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

Conducts health screening to inform member needs. Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Conducts health screening to inform member needs. Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.

- [ ] Nurses

Description

Conducts health screening to inform member needs. Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.

- [ ] Medical Specialists

- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers

Description

May provide assistance in conducting health screening to inform member needs and aids the member in identifying and accessing health promotion activities and resources.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Care Coordinators	Provide health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.
Cultural Advisors	Assist the member on learning about Native American culture and how embracing the traditional practices can assist someone through their substance use patterns.
Peer Supports	Provides health promotion education to members and their support system, contributes to the development of member goals related to health promotion, aids the member in identifying and accessing health promotion activities and resources.

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

Definition

Comprehensive transitional care streamlines member movement from one setting to another, between levels of care, and between physical health and behavioral health treatment service providers. Transitions may be from any long-term care facility, institution, or other out-of-home setting back to the community. The H&S team works closely with the member before and during a transition back to the community and shares information with discharging organizations to prevent gaps in care that could result in re-admission or overdose.

H&S providers will develop collaborative relationships with treatment providers, hospital staff, managed care organizations, long-term care agencies, community corrections agents, residential treatment programs, county and tribal agencies, primary care and specialty mental health/substance use disorder treatment providers that provide day treatment, residential treatment, and psycho-social rehabilitation services. Engagement with all stakeholders in a person's transition will emphasize a trauma-sensitive and trauma-informed approach. Additional activities include working with discharge planners to schedule follow-up appointments with primary or specialty care providers within a maximum of seven days of discharge (or fewer if needed for MAT continuity), and working with the people receiving services to help facilitate attendance at scheduled appointments.

Transitional care services will vary by the age of children and youth, and may include transitions to or from residential care facilities or foster care families. Among transitional-age youth, services will address the needs of participants and families as the individuals approach a shift into adult services and programs.

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

Transitional care needs will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans and transitional care needs. In addition, H&S providers will be educated on and encouraged to use the states HIE to receive real time notifications when members seek emergency room services or will be discharged from hospitals to facilitate coordination of care.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

Ensures the member is receiving the appropriate level of care to progress to recovery and stabilization in advance of the transition and may consult on clinical and high risk needs, providing coverage as needed.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Facilitates seamless transition of care and follow-up for members being discharged from various settings such as hospitals, residential treatment facilities, jails, and other agencies. This includes focusing on health promotion and self-management in advance of the transition and supporting members in their transition planning through coordinating the movement between levels of care and linking to resource.

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers

Description

Facilitates seamless transition of care and follow-up for members being discharged from various settings such as hospitals, residential treatment facilities, jails, and other agencies. Ensures the member is receiving the appropriate level of care to progress to recovery and stabilization in advance of the transition. Supports the members in their transition planning through coordinating the movement between levels of care and linking to resource, especially among clinical care providers.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Care Coordinators	Develop relationships and coordinates with discharge planners throughout the region affiliated with hospitals, residential treatment facilities, jails, and other agencies in order to promote seamless discharge planning. Supports members in their transition planning through coordinating the movement between levels of care and linking to resources, especially among community support service providers.
Peer Supports	Act as a resource broker for the patient, providing advocacy for patients, assisting with resources, assisting with transportation, support groups and developing a wellness plan.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support may include any people the member identifies as instrumental in supporting their recovery. Services will include: working with families based upon agreements with the member in treatment; active community outreach to engage and support individuals by meeting members where they are in the community; assisting the member with their medication and treatment adherence; helping the family learn to support treatment monitoring in the home environment; addressing co-dependency challenges; and assisting the member to achieve personal goals and recovery outcomes.

The H&S team will regularly assess the member's readiness to address issues related to family relationships and dynamics. The H&S team will work with the person to improve family relations or to re-engage family members who may have distanced themselves as the person progresses in treatment. Family-based therapy or family team meetings will be available to support those relationships to support the person's long term health and recovery.

Specialized individual support services may include training the person's support network on Naloxone administration and other harm reduction strategies, as well as providing access to Naloxone. Supports will be dynamic and flexible to build rapport and meet the safety needs of the person by including family and person's preferred support network when possible.

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

Individual and family support activities will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to update member's care plans and individual and family support needs to share relevant information across providers and health systems.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

Facilitates individual and family support through engagement with the member's identified support network, including both institutional and natural supports. Provides specialized advocacy on behalf of the member or family with other SUD treatment service providers.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Facilitates individual and family support through engagement with the member's identified support network, including both institutional and natural

supports. Provides specialized advocacy on behalf of the member or family with other health care providers.

- [ ] 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
Cultural Advisors	Provide healing ceremonies, cultural learning and cultural identity work to promote individual and family support.
Care Coordinators	Facilitate individual and family support through engagement with the member's identified support network, including both institutional and natural supports. Provides specialized advocacy on behalf of the member or family with other community-based support service agencies.
Peer Supports	Facilitate individual and family support through engagement with the member's identified support network, including both institutional and natural supports. Will encourage the member to participate in self-help groups and develop a network of healthy relationships with family members or others who are identified by the member, including support to repair family and friend relationships.

Referral to Community and Social Support Services

Definition

Beginning with the initial assessment, the H&S team will assess needs related to financial strain, housing, food assistance, employment, transportation, and other resources. They will refer the member to community-based organizations and other key community stakeholders with the resources and services to support the member's health and well-being.
Referrals will be driven by the assessment process and the person's expressed requests, and noted on the person's care plan. The H&S will designate staff to assist in coordinating and monitoring the following types of services:

- Benefit eligibility (disability, food share, etc.);
- Support to return to meaningful activity/work;
- Subsidized or supportive housing;
- Peer or family support;
- Legal services as appropriate;
- Others as appropriate

To create and recruit a robust network of resources, the H&S will identify and partner with social service providers and community based organizations and will develop cooperative agreements that allow monitoring of the member's participation in the community agency. The H&S will provide training and technical assistance as needed regarding effective interventions for the population. Examples of potential partners include:

- Faith-based organizations;
- Community mental health organizations;
- Social integration opportunities including Recovery Centers;
- Appropriate cultural support centers;
- Mutual help groups (12 Step groups, Smart Recovery, Recovery Support organizations, Peer Run Respite programs, and warm lines)
- Housing assistance providers

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

Referral activities and social support needs based on the initial and ongoing assessments will be documented in the care plan and stored in an electronic format, such as an electronic medical record (EMR) or care management software. H&S providers will have access to the state's Health Information Exchange (HIE) vendor to view member's care plans regarding their social support needs.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

Description

Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery.

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers

Description

Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery. Interacts with various internal and external partners to ensure the member needs are met to support ongoing recovery.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Care Coordinators	Refers and connects the member to other benefits, medical and behavioral services, and educational, community, or social supports as necessary to support ongoing recovery. Interacts with various internal and external partners to ensure the member needs are met to support ongoing recovery.
Peer Supports	Refers, connects, and may accompany the member to applying for other benefits, accessing medical and behavioral services, and accessing educational, community, or social supports as necessary to support ongoing recovery.

Health Homes Services

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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

Members may be referred for health home services through self-referral, managed care entities, county programs, community partners, primary care providers, hospitals, or others. Referred individuals will be screened to determine eligibility for Medicaid and the H&S Integrated Recovery Support Service Health Home. Some members may present to the H&S after an urgent/emergent need, such as discharging from a hospital due to detox, or because they require immediate induction for Medication Assisted Treatment (MAT). Other members may present to H&S providers from referrals that are not considered as urgent or that believe the member will receive more comprehensive care and progress in their recovery through health home services.

Members with immediate needs may receive SUD treatment prior to or in conjunction with being informed about available health home services. Once the member's immediate health care needs are met, and once consent to participate and releases of information are complete, Hub staff complete an initial assessment to inform the comprehensive care plan. During care plan development, staff schedule necessary appointments with the member to ensure access to medications, testing and treatment, peer supports, and other health care services identified. The completed care plan will then be a roadmap to guide providers and members to other treatments and health home services essential to promote member recovery and wellness.

H&S providers will reassess members regularly to update their care plan and to ensure members are receiving and being referred to necessary services and resources. If a member's needs have been addressed and stabilized by the Hub, they may begin to receive services and supports from the lower-intensity Spoke sites. Through ongoing consultation, the Hub and Spoke sites will determine if members continue to receive the appropriate level of care and adjust as needed.

Name	Date Created	
Provider A Workflow	4/26/2021 3:39 PM EDT	
Provider B Workflow	4/26/2021 3:39 PM EDT	
Provider C Workflow	4/26/2021 3:39 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

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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

The state will use paid claims data to compare costs for providing health care services to members enrolled in the H&S program prior to the implementation of the health home and annually thereafter to identify the areas of cost reduction. The state will also assess the costs of providing services to members with SUD and a co-occurring condition who are not enrolled in the health home and compare these costs and outcomes to those of members in the health home. The calculation method will be the same for dual-eligibles. Medicare data is not available to the State and therefore is not considered in cost-savings estimates.

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)

The state will require H&S providers to electronically store care plans in an electronic medical record (EMR) format or via a care coordination software platform in order to securely share information across provider sites. In addition, the state will strongly encourage the use of health information technology (HIT) within the first year of implementation. This will include the use of electronic medical records (EMRs) and the state selected health information exchange (HIE) to interface between Hubs, Spokes, and other relevant providers identified in the care plan and that the member may interact with. Finally, the state will provide the necessary technical assistance to support the implementation and use of HIT among H&S providers.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WI2020MS0007O | WI-21-0012 | SUD Health Home-SUD-focused

Package Header

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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

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