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State/Territory Name: Maryland

State Plan Amendment (SPA) #: 25-0012

This file contains the following documents in the order listed:

MD - Submission Package - MD2025MS0002O - (MD-25-0012) - Health Homes

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

December 12, 2025

Perrie T. Briskin
Medicaid Director
Maryland Department of Health
201 West Preston Street., 5th Floor
Baltimore, MD 21201

Re: Approval of State Plan Amendment MD-25-0012 Migrated_HH.MD HHS

Dear Perrie T. Briskin,

On September 30, 2025, the Centers for Medicare and Medicaid Services (CMS) received Maryland State Plan Amendment (SPA) MD-25-0012 for Migrated_HH.MD HHS to update references in the health homes SPA pages from the old operating system (eMedicaid) to the ASO management system.

We approve Maryland State Plan Amendment (SPA) MD-25-0012 with an effective date(s) of July 01, 2025.

If you have any questions regarding this amendment, please contact Nicole Guess at nicole.guess@cms.hhs.gov.

Sincerely,

Wendy E. Hill Petras, Acting Director
Division of Program Operations
Center for Medicaid & CHIP Services

MD - Submission Package - MD2025MS0002O - (MD-25-0012) - Health Homes

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2025MS0002O | MD-25-0012 | Migrated_HH.MD HHS

CMS-10434 OMB 0938-1188

Package Header

Package ID MD2025MS0002O

SPA ID MD-25-0012

Submission Type Official

Initial Submission Date 9/30/2025

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Effective Date N/A

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State Information

State/Territory Name: Maryland

Medicaid Agency Name: Maryland Department of Health, Office of Health Care Financing

Submission Component

State Plan Amendment

Medicaid

CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2025MS0002O | MD-25-0012 | Migrated_HH.MD HHS

Package Header

Package ID MD2025MS0002O
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SPA ID and Effective Date

SPA ID MD-25-0012

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
1945 Health Home Population and Enrollment Criteria	7/1/2025	MD-18-0008
1945 Health Home Providers	7/1/2025	MD-18-0008
1945 Health Home Payment Methodologies	7/1/2025	MD-24-0014
1945 Health Home Services	7/1/2025	MD-18-0008
1945 Health Home Monitoring, Quality Measurement and Evaluation	7/1/2025	MD-24-0014

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2025MS0002O | MD-25-0012 | Migrated_HH.MD HHS

Package Header

Package ID MD2025MS0002O
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Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives Updates references in the health homes SPA pages from the old operating system (eMedicaid) to the ASO management system.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2025	$0
Second	2026	$0

Federal Statute / Regulation Citation

42 CFR §447.201 - State plan requirements

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created

No items available

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MD2025MS0002O | MD-25-0012 | Migrated_HH.MD HHS

Package Header

Package ID	MD2025MS0002O	**SPA ID**	MD-25-0012
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Approval Date	12/12/2025	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

No comment

Comments received

No response within 45 days

Other

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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MD - Submission Package - MD2025MS0002O - (MD-25-0012) - Health Homes

1945 Health Home Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MD2025MS0002O | MD-25-0012 | Migrated_HH.MD HHS

CMS-10434 OMB 0938-1188

Package Header

Package ID	MD2025MS0002O	**SPA ID**	MD-25-0012
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Superseded SPA ID	MD-18-0008		
	System-Derived		

Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home 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

1945 Health Home Population and Enrollment Criteria

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System-Derived

Population Criteria

The state elects to offer Health Home 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):

Name	Description
Opioid Substance Use Disorder	Opioid Substance Use Disorder

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

Eligibility criteria based on opioid substance use disorder:
1. The consumer has been diagnosed with an opioid substance use disorder.
2. The consumer must be engaged in opioid maintenance therapy.
3. The consumer is determined to be at risk for additional chronic conditions due to current tobacco, alcohol, or other non-opioid substance use, or a history of tobacco, alcohol, or other non-opioid substance dependence.

☑ One serious and persistent mental health condition

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

Eligibility criteria based on SPMI or SED:
1. The consumer has been diagnosed with SPMI or SED, meeting all relevant medical necessity criteria to receive psychiatric rehabilitation program (PRP) services or mobile treatment services (MTS).
2. The individual must be engaged in services with a PRP or MTS provider.
1. The consumer is not currently receiving either of the following services, considered duplicative of Health Home services:
a. 1915(i) waiver services
b. Targeted Mental Health Case Management

1945 Health Home Population and Enrollment Criteria

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Enrollment of Participants

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

- (•) Opt-In to a Health Home provider
- ( ) Referral and assignment to a Health Home provider with opt-out
- ( ) Other (describe)

Describe the process used:

Health Homes may enroll an eligible individual to whom they provide PRP, MT, or OTP services, contingent upon participant consent, and in the case of OTP participants, the presence of an identified qualifying risk factor. Health Homes may enroll participants only after they have been enrolled for the provider's applicable PRP, MT, or OTP services, ensuring that all relevant medical necessity criteria has been met to confirm the qualifying diagnosis. Enrollment is complete upon submission of the participant's online intake. Effective January 1, 2025 this process will now be managed in the Behavioral Health Administrative Services (BHASO) system. The BHASO will provide administration of the program at the direction of the State. Consent will authorize sharing of information between identified service providers, the State, applicable Managed Care Organizations (MCOs) and Administrative Service Organizations (ASOs) for the purpose of improved care coordination and program evaluation. The Health Home will notify other treatment providers (e.g., primary care providers) of the participant's goals and the types of Health Home services the participant is receiving and encourage participation in care coordination efforts.

The State uses claims data to identify potentially-eligible consumers who could benefit from Health Home services. This includes individuals with a qualifying diagnosis who experience frequent emergency department usage, hospitalization, or increases in level of care. MCOs and the ASO may assist the State in the identification, outreach, and referral of potential participants among their own consumers. Upon obtaining consumer consent, the State, MCO, or ASO will refer individuals to a Health Home near their residence, at which point the Health Home may outreach to the consumer directly. The State engages additional referral sources to familiarize them with the Health Home's purpose and referral protocols, as well as alert them to opportunities for continued collaboration with Health Home providers. This may include hospitals and emergency departments, public agencies, and school-based health centers.

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1945 Health Home Providers

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System-Derived

Types of Health Home Providers

☑ Designated Providers

Indicate the Health Home 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

Describe the Provider Qualifications and Standards

Health Homes must be licensed by the Department of Health and Mental Hygiene as a Psychiatric Rehabilitation Program (PRP), a Mobile Treatment Services (MTS) provider or an Opioid Treatment Program (OTP). In addition, providers must:

1) Be enrolled as a Maryland Medicaid Provider;
2) Be accredited by, or in the process of gaining accreditation from, an approved accrediting body offering a Health Home accreditation product.
3) For those agencies working with minors, demonstrate a minimum of 3 years of experience serving children and youth.

☐ Federally Qualified Health Centers (FQHC)

☐ Other (Specify)

1945 Health Home Providers

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☐ Teams of Health Care Professionals

☐ Health Teams

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

All Health Homes must maintain staff in the ratios specified below whose time is exclusively dedicated to the planning and delivery of Health Home services.

1) Health Home Director: .5 FTE per 125 Health Home enrollees. Health Homes with less than 125 enrollees may employ 1 FTE individual to serve as both the Nurse Care Manager and Health Home Director, provided that individual is licensed and legally authorized to practice as a registered nurse. Health Homes requiring a Director at a level more than .5 FTE may choose to designate a lead Health Home Director and subsequent additional key management staff to fulfill the Director staffing requirement.

2) Health Home Care Manager: .5 full-time equivalent (FTE) per 125 Health Home enrollees. Among providers with more than 1 FTE Care Manager, the initial 1FTE care manager role must be filled by a nurse, while subsequent staff in this role may be physicians' assistants.

3) Physician or Nurse Practitioner Consultant: 1.5 hours per Health Home enrollee per 12 month period

4) Administrative Support Staff: The State estimates that Administrative Support Staff of approximately .25 FTE per 125 Health Home enrollees will be necessary to effectively implement the Health Home. However, because providers utilize a wide range of care management tools that may lessen the burden of administrative tasks, Health Homes may use their discretion in determining the staffing levels necessary to fulfill the administrative activities of the Health Home.

The staffing ratios specified as "per 125 Health Home enrollees" act as a minimum, requiring providers with less than 125 enrollees to maintain this level regardless of their enrollment. Smaller Health Homes may form a consortium to share Health Home staff and thus costs, although participants will be served at their own provider's location. Creation of such consortiums is contingent upon geographic proximity and State approval of an application addendum detailing the planned collaboration.

Although the aforementioned staffing must be dedicated exclusively to Health Home activities, qualified staff members within the PRP, MT or OTP—such as licensed counselors or nurses—may provide Health Home services as well. It is expected that all staff members, not only those dedicated exclusively to the Health Home, will be fully informed of the goals of the Health Home and collaborate to serve participants.

Supports for Health Home Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Home 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 use disorder 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

To encourage ongoing information-sharing and problem-solving between Health Homes, the Department offers educational opportunities such as webinars and regional meetings. Additionally, regular communication and feedback between the State and individual Health Homes facilitates a collaborative and responsive working relationship. The Maryland Department of Health closely monitors Health Home providers to ensure their services meet Maryland's Health Home standards as well as CMS' Health Home core functional requirements stated above. Oversight activities may include medical chart and care management record review, site audits, and team composition analysis. The State performs outreach to providers and agencies that may collaborate with Health Homes for the benefit of patients, informing them of the Health Home objectives and role in order to foster these linkages.

Other Health Home Provider Standards

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

A Health Home serves as the central point for directing person-centered care with the goal of improving patient outcomes while reducing avoidable health care costs. While providers are afforded a degree of flexibility in the design and implementation of their Health Homes, they must meet certain requirements in addition to those delineated above. These standards are detailed below.

Initial Provider Qualifications
1. Health Home providers must be enrolled in the MD Medicaid program as a PRP,OTP, or Mobile Treatment provider and agree to comply with all Medicaid program requirements.

2. Health Home providers must have, or demonstrate their intention to pursue, accreditation from an approved body offering a Health Home accreditation product.

3. Health Home providers must directly provide, or subcontract for the provision of, Health Home services. The Health Home provider remains responsible for all Health Home program requirements, including services performed by the subcontractor.

4. Health Homes providing PRP or MT services to minors must demonstrate a minimum of 3 years of experience providing services to children and youth.

5. Health Homes must ensure a minimum of one Health Home director and one Care Manager are in place before beginning service provision, and must reach all required staffing levels within 30 days of beginning service provision.

6. Health Homes must provide services to all Health Home enrollees, with each individual's care under the direction of a dedicated care manager accountable for ensuring access to medical and behavioral health care services and community social supports as defined in the participant's care plan.

7. Providers must complete an application to the State demonstrating their ability to perform each of the CMS Health Home core functional components (refer to section Support for Providers). Providers must propose a set of systems and protocols, including:
a. processes used to perform these functions;
b. processes and timeframes used to assure service delivery takes place in the described manner; and
c. descriptions of multifaceted Health Home service interventions that will be provided to promote patient engagement, participation in their plan of care, and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

8. Health Homes must participate in federal and state-required evaluation activities including documentation of Health Home service delivery as well as clients' health outcomes and social indicators in the BHASO system portal.

9. Providers must maintain compliance with all of the terms and conditions as a Health Home provider or will be discontinued as a provider of Health Home services. In the event of any recovery of funds resulting from a provider termination, the FMAP portion of funds recovered will be returned to CMS in accordance with standard protocols.

10. Providers that wish to disenroll as a Health Home must notify the State of their intent with at least 30 days notice prior to discontinuing services. They must inform Health Home participants that they will no longer provide Health Home services, and that these may be obtained elsewhere if the participants wish to transfer their care.

Ongoing Provider Qualifications
Following enrollment, Health Home providers must also:

1. Enroll with Chesapeake Regional Information System for our Patients (CRISP) to receive hospital encounter alerts and access pharmacy data;

2. Convene and document internal Health Home staff meetings every 6 months, at minimum, to plan and implement goals and objectives of practice transformation.

3. Complete a program assessment process every six months confirming that the Health Home meets all staffing and regulatory requirements, and demonstrating a quality improvement plan to address gaps and opportunities for improvement; and

4. Obtain accreditation from an approved accrediting body offering a Health Home accreditation product within 18 months of initiating the accreditation process, or demonstrate significant progress towards this goal.

Name	Date Created
No items available	

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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MD - Submission Package - MD2025MS0002O - (MD-25-0012) - Health Homes

1945 Health Home Payment Methodologies

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CMS-10434 OMB 0938-1188

Package Header

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Payment Methodology

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

- [x] Fee for Service
  - [x] Individual Rates Per Service
  - [x] 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
    - [x] Other

Describe below

Health Homes may receive a one-time reimbursement for the completion of each participants' initial intake and assessment necessary for enrollment into the Health Home. The payment will be the same as the rate paid for monthly services on a per-member basis.
The monthly rate is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland, including the provision of a minimum of two services in the month. The Health Homes are not paying any monies to other providers. There is only one exchange of payment and that is from the State to the Health Home providers.
Health Home providers must document services and outcomes within the participant's file and in the State's Behavioral Health Administrative Services Organization's (BHASO) system. These documents are accessible to the Department and the Department's designees through the BHASO system and are auditable.
Rates are reviewed annually.
Health Home participants may only be enrolled in one Health Home at a time. If a participant is enrolled in a Health Home, Maryland's system automatically blocks the participant from being enrolled in another Health Home.

Health Homes will be paid a monthly rate based on the employment costs of required Health Home staff, using salary and additional employment cost estimates for each of the required positions and their respective ratios. Payment is contingent upon the Health Home meeting the requirements set forth in the Health Home applications, as determined by the State of Maryland. Failure to meet such requirements is ground for payment sanctions or revocation of Health Home status.
The Department does not pay for separate billing for services which are included as part of another service. At the end of each month, Health Homes will ensure that all Health Home services and outcomes have been reported into the BHASO system. The provider will then submit a bill within 30 days for all participants that received the minimum Health Home service requirement in the preceding month.
The provider may begin billing for a Health Home participant when the intake portion of that individual's file has been completed with the necessary demographics, qualifying diagnoses baseline data, and consent form. The initial intake process itself qualifies as a Health Home service. The ongoing criteria for receiving a monthly payment is:
1. The individual is identified in the State's Medicaid Management Information System (MMIS) as Medicaid-eligible and authorized to receive PRP, MT, or OTP services;
2. The individual was enrolled as a Health Home member with the Health Home provider in the month for which the provider is submitting a bill for Health Home services; and
3. The individual has received a minimum of two Health Home services in the previous month, which are documented in the BHASO system.
The agency's fee schedule (rate) was last updated on July 1, 2024 and is effective for services provided on or after that date. Effective July 1, 2024, the Health Home rate will be $145.76.

☐ Per Member, Per Month Rates

☐ 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

There are no variations in payment.

☐ 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)

1945 Health Home Payment Methodologies

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SPA ID MD-25-0012

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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

7/1/2024

Website where rates are displayed

https://health.maryland.gov/mmcp/Pages/Health-Homes.aspx

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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 Behavioral Health rates are typically reviewed and updated for inflation annually. This program was added to that annual review process in FY 2017.
Effective July 1, 2024 the Health Home rate will be increased 3% bringing the rate to $145.76 as a result of Maryland House Bill 350 Fiscal Year 2025 Budget (2024).

1945 Health Home Payment Methodologies

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Assurances

- [x] The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home 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 Recipients of specified waiver services and mental health case management that may be duplicative of Health Home services will not be eligible to enroll in a Health Home. In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

- [x] The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- [x] The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- [x] 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
Standard Funding Questions Template Health Homes (1)	8/25/2023 10:33 AM EDT

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MD - Submission Package - MD2025MS0002O - (MD-25-0012) - Health Homes

1945 Health Home Services

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Service Definitions

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

Comprehensive Care Management

Definition

Health Home staff collaborate to provide comprehensive care management services with active patient and family participation. The Health Home coordinates primary and behavioral health care and social services to address the whole-person needs of patients at the individual and population levels. This includes the following:
a. Initial assessment: The Health Home conducts, or provides a referral to the PCP for, a comprehensive biopsychosocial assessment, if no such assessment has been performed by a licensed physician or nurse practitioner in the preceding 6-month period.
b. Development of Care plan: Using the initial assessment and PCP records as available, the Health Home team works with the participant to develop an ITP including goals and timeframes, community networks and supports, and optimal clinical outcomes.
c. Delineation of roles: The Health Home assigns each team member clear roles and responsibilities. Participant ITPs identify the various providers and specialists within and outside the Health Home involved in the consumer's care.
d. Monitoring and reassessment: The Health Home monitors individual health status and progress towards ITP goals, documenting changes and adjusting care plans as needed, twice annually minimally.
e. Outcomes and Reporting: The Health Home uses the BHASO system portal and other available HIT tools possibly including EHR, to review and report quality metrics, assessment and survey results, and service utilization in order to evaluate client satisfaction, health status, service delivery, and costs.
f. Population-based Care Management: Providers monitor population health status and service use to determine adherence to or variance from treatment guidelines. The Health Home identifies and prioritizes and population-wide needs and trends, then implement appropriate population-wide treatment guidelines and interventions.

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

All Health Homes have access to the BHASO online system portal, allowing providers to report and review participant intake, assessment, assigned staff, ITP, clinical baselines and data relating to chronic conditions, as well as Health Home services provided, such as referrals made and health promotion activities completed. The BHASO system generates reports of the aforementioned data at a participant or provider level. Additional access to hospital encounter and pharmacy data through the Chesapeake Regional Information System for Our Patients (CRISP) Electronic Notification System will enable Health Homes to gain a more comprehensive understanding to their participants' care and health status.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Opioid Treatment Program Clinical Supervisors, Licensed Mental Health Professionals, and PRP Rehabilitation Specialists and PRP Direct Support Staff may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Clinical Supervisors may also play a role in population-based care management tasks.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Coordinators may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Care Coordinators may also play a role in population-based care management tasks.

- [x] Nurses

Description

Nurses may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. Nurse Practitioners may perform the initial biopsychosocial assessment of a new Health Home participant, as well as play in role in population-based care management.

- [ ] Medical Specialists
- [x] Physicians

Description

Physicians may perform the initial biopsychosocial assessment of a new Health Home participant, as well as participate in development and ongoing monitoring and reassessment of the ITP goals. Physicians may also play a role in population-based care management tasks.

- [x] Physician's Assistants

Description

Physicians' Assistants may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

- [ ] Pharmacists
- [x] Social Workers

Description

Social Workers may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment.

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

Provider Type	Description
Health Home Director	The Health Home Director may participate in development of the participant's ITP, as well as ongoing monitoring and reassessment. They may also take part in population-based care management activities.

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Care Coordination

Definition

Care coordination includes implementation of the consumer-centered ITP through appropriate linkages, referrals, coordination and follow-up to needed services and support. Specific activities include: appointment scheduling, referrals and follow-up monitoring, tracking of appropriate screenings and EPDST needs, and communication with other providers and supports. Health Homes serving children place particular emphasis on coordination with school officials, PCPs, and involved agencies such as DSS.
The Health Home provider assigns each enrollee a Care Manager who will be responsible for coordinating the individuals' care and ensuring implementation of the treatment plan in partnership with the individual and family, as appropriate.
At the population level, the Health Home provider develops policies and procedures to facilitate collaboration between primary care, specialist, and behavioral health providers, as well as agencies and community-based organizations; and for children, school-based providers. Such policies will clearly define the roles and responsibilities of each in order to ensure timely communication, use of evidence-based referrals, follow-up consultations, and regular case review meetings with all members of the Health Home team. The Health Home ensures that all regular screenings and immunizations are conducted through coordination with the primary care or other appropriate provider. In addition, members of the Health Home team meets with area providers to enhance collaboration and integration with regard to the population.

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

The BHASO system online portal allows Health Homes to report and review referrals made to outside providers, social and community resources, and individual and family supports. Access to CRISP hospital encounter alerts will facilitate prompt discharge planning and follow-up. Claims data populates fields in the BHASO system, allowing Health Home providers to better track their participant needs, services received, and identify opportunities for improved care coordination.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  Appropriate behavioral health professionals or specialists- including Addictions Counselors, OTP Clinical Supervisors, PRP Rehabilitation Specialists, and PRP Direct Support Staff- may provide care coordination services.

- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

  Description

  Nurse Care Coordinators may provide care coordination services.

- [x] Nurses

  Description

  Nurses may provide care coordination services.

- [ ] Medical Specialists
- [x] Physicians

  Description

  Physicians may provide care coordination services.

- [x] Physician's Assistants

  Description

  Nurse Care Coordinators may provide care coordination services.

- [ ] Pharmacists
- [x] Social Workers

  Description

  Social Workers may provide care coordination services.

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

Provider Type	Description
Administrative Support Staff	Administrative Support Staff may provide care coordination services in the form of appointment scheduling and tracking.

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Health Promotion

Definition

Health Promotion services assist patients and families to participate in the implementation of their care plan and place a strong emphasis on skills development for monitoring and management of chronic and other somatic health conditions. Health promotion services will include health education and coaching specific to an individual's condition(s), development of a self-management goals, medication review and education, and promotion of healthy lifestyle interventions. Such interventions may include, those that encourage substance use and smoking prevention or cessation, improved nutrition, obesity prevention and reduction, and increased physical activity.

Health Homes working with children will emphasize these preventive health initiatives, while actively involving parents and families in the process. This will include identifying conditions for which the child may be at risk due to family, physical, or social factors, and working with the patient and caregivers to address these areas.

At the population level, the Health Home team will use data to: identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions; and modify them accordingly.

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

Health Home providers will use the BHASO system portal to document, review, and report health promotion services delivered to each enrollee. Additionally, periodic updates to clinical outcomes may be reported in tandem with the related health promotion services delivered—for example, while reporting a discussion regarding physical activity in the BHASO system portal, the Health Home would note the participant's weight and BMI.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  As appropriate, the following providers may perform or assist with health promotion services: Addictions Counselors, PRP Rehabilitation Specialists, Licensed Mental Health Professionals, OTP Clinical Supervisors and PRP Direct Support Staff.

- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

  Description

  Nurse Care Coordinators may perform health promotion services.

- [x] Nurses

  Description

  Nurses may perform health promotion services.

- [ ] Medical Specialists
- [x] Physicians

  Description

  Physicians may perform health promotion services.

- [x] Physician's Assistants

  Description

  Physicians' Assistants may perform health promotion services.

- [ ] Pharmacists
- [x] Social Workers

  Description

  As appropriate, Social Workers may perform health promotion services.

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

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

Definition

Health Homes provide services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, interrupt patterns of frequent hospital emergency department use, and ensure timely and proper follow up care. The Health Home increases consumers' and family members' ability to manage care and live safely in the community, shifting the use of reactive care and treatment to proactive health promotion and self-management.

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

To accomplish these functions, providers establish a clear protocol for responding to CRISP alerts or notification from any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Care Managers will follow up with consumers within two business days post-discharge discharge via home visit, phone call, or scheduling an on-site appointment.

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

All Health Homes are required to enroll with CRISP in order to receive alerts of hospital admissions, discharges, or transfer among their Health Home patient panel. Real-time access to this information will allow Health Home providers to provide prompt coordination and follow-up care. This ability will be augmented by real-time access to pharmacy data that may aid in medication reconciliation.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  As appropriate, the following providers may deliver or assist in the delivery of comprehensive transitional care services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, PRP Direct Support Staff.

- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

  Description

  Nurse Care Managers may provide comprehensive transitional care services.

- [x] Nurses

  Description

  Nurses may provide comprehensive transitional care services.

- [ ] Medical Specialists
- [x] Physicians

  Description

  Physicians may provide comprehensive transitional care services.

- [x] Physician's Assistants

  Description

  Physicians' Assistants may provide comprehensive transitional care services.

- [ ] Pharmacists
- [x] Social Workers

  Description

  Social Workers may provide comprehensive transitional care services.

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

Provider Type	Description
Health Home Directors	Health Home Directors may provide comprehensive transitional care services.

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Individual and Family Support (which includes authorized representatives)

Definition

Services include advocating for individuals and families; assisting with medication and treatment adherence; identifying resources for individuals and families to support them in attaining their highest level of health and functioning, including transportation to medically-necessary services; improving health literacy; increasing the ability to self-manage care; facilitating participation in the ongoing revision of care/treatment plan; and providing information as appropriate on advance directives and health care power of attorney. Health Homes connect participants with peer support services, many of which will be offered on-site, as well as referring participants to support groups and self-care programs as appropriate.

At the population level, services include: collecting and analyzing individual and family needs data; developing individual and family support materials and groups regarding the areas listed above; soliciting community organizations to provide group support to the population; and providing training and technical assistance as needed regarding the special needs of and effective interventions for the population.

The Health Home provider will ensure that all communication and information shared with the enrollee, the enrollee's family and caregivers, as appropriate, is language, literacy and culturally appropriate.

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

The BHASO system allows Health Home providers to document, review, and report individual and family support services delivered, including referrals to outside groups or programs. Using real-time pharmacy data, Health Home providers are better able to assist individuals in obtaining and adhering to prescription medications.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  As appropriate, the following providers may deliver or assist in the delivery of individual and family support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

  Description

  Nurse Care Coordinators may provide individual and family support services.

- [x] Nurses

  Description

  Nurses may provide individual and family support services.

- [ ] Medical Specialists
- [x] Physicians

  Description

  Physicians may provide individual and family support services.

- [x] Physician's Assistants

  Description

  Physicians' Assistants may provide individual and family support services.

- [ ] Pharmacists
- [x] Social Workers

  Description

  Social Workers may provide individual and family support services.

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

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Referral to Community and Social Support Services

Definition

The Health Home will identify available community-based resources and actively manage appropriate referrals, access to care, and engagement with other community, social, and school-based supports. Specific services will include: providing assistance for accessing Medical Assistance, disability benefits, subsidized or supported housing, personal needs support, peer or family support, and legal services, as appropriate. The Health Home will assist in coordinating these services and following up with consumers post service engagement.

At the population level, the Health Home team will: develop and monitor cooperative agreements with community and social support agencies that establish collaboration, follow-up, and reporting standards; recruit agencies to enter into those collaborative agreements; and provide training and technical assistance as needed regarding the special needs of and effective interventions for the population.

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

Using the BHASO system online portal, Health Home providers may document, report, and review referrals to community-based resources.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

  Description

  The following providers may provide referrals to community and social support services: OTP Clinical Supervisors, Addictions Counselors, Licensed Mental Health Professionals, PRP Rehabilitation Specialists, and PRP Direct Support Staff.

- [ ] Nurse Practitioner
- [x] Nurse Care Coordinators

  Description

  Nurse Care Coordinators may provide referrals to community and social support services.

- [x] Nurses

  Description

  Nurses may provide referrals to community and social support services.

- [ ] Medical Specialists
- [x] Physicians

  Description

  Physicians may provide referrals to community and social support services.

- [x] Physician's Assistants

  Description

  Physicians' Assistants may provide referrals to community and social support services.

- [ ] Pharmacists
- [x] Social Workers

  Description

  Social Workers may provide referrals to community and social support services.

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

Provider Type	Description
Health Home Director	The Health Home Director may provide referrals to community and social support services.

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Health Home Patient Flow

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

Referral & Enrollment
Potential Health Home participants may be informed of and referred to a Health Home in their region by a variety of sources. Upon engaging with a potential participant, the Health Home enrolls the individual in the appropriate PRP, MT, or OTP services for which they are eligible, and in the case of OTP patients, identify the qualifying risk factors that place them at risk for additional chronic conditions. The Health Home then explains the data-sharing elements of the program and obtain consent from the participant. Finally, the provider creates an entry and intake for the participant in the BHASO system, effectively enrolling them in the Health Home.

Participation
While participating in the Health Home, an individual will receive a minimum of two Health Home services per month, to be documented in the BHASO system portal. A Care Manager will monitor their care and health status, and the Health Home team will assist with the provision of Health Home services as necessary. The Health Home will periodically reassess participants, and in doing so determine whether Health Home services are necessary.

Discharge
Discharge from the Health Home will primarily result from incidents such as relocation, incarceration, or loss of eligibility. In such cases, the Health Home provider will follow discharge protocol appropriate to the circumstances. In such cases where an individual 's PRP, MT, or OTP services cease due to stabilization or reaching age 18, they may remain in the Health Home for six months, during which the Health Home provider will emphasize support their transition to the appropriate level of care. Discharge planning may include the development of a discharge plan with referrals to the appropriate services and providers which will continue the individual's care and support. The Health Home provider will report in the BHASO system the discharge of a participant, as well as note the completion of discharge planning.

Name	Date Created	
Health Home Participant Flow Chart (MACPRO upload)	7/27/2018 1:33 PM EDT	

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1945 Health Home Monitoring, Quality Measurement and Evaluation

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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 Home 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:

Using claims data, the State tracks avoidable hospital readmissions by calculating ambulatory care sensitive conditions (ACSC) readmissions per 1000 enrollees. To calculate this rate: (# of readmissions with a primary diagnosis consisting of an Agency of Healthcare Research and Quality (AHRQ) ICD-9 code for ambulatory care sensitive conditions/member months) x 12,000.
To measure cost savings generated by Chronic Health Homes, the State may compare the costs per member per month for participants by Health Home provider and by condition to costs for comparison groups of OTP, MT, and PRP participants enrolled with non-Health Home providers. The State may also compare overall costs between the groups for emergency room utilization, hospitalizations, nursing facility admissions, and pharmacy utilization. In this assessment, the State may review each Chronic Health Home independently for its overall costs and the allocation of its funds amongst services provided to inform future implementation and process modifications.

Describe how the state will use health information technology in providing Health Home 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).

1.The BHASO system: The BHASO utilizes is a web-based portal accessible to all networks, allowing Health Home providers to record and review of services delivered as well as clinical and social outcomes related to the individuals' chronic conditions. The portal is secure, with Health Homes' access limited to access the records of their own current enrollees. The BHASO reports to the State all data as related to enrollment, compliance, and outcomes at the provider and population levels.

2.Chesapeake Regional Information System for our Patients (CRISP): All Health Home providers must enroll with CRISP's Electronic Notification System to receive hospital encounter alerts. This entails an initial upload of the Health Home's patient panel with all necessary demographic information, followed by monthly panel updates, as well as the set up of a direct message inbox and/or an interface with the provider's EHR to receive alerts.

3.Pharmacy Data: CRISP will additionally provide pharmacy data to Health Homes, including all Schedule II-V through the State's Prescription Drug Monitoring Program (PDMP), as well as any prescription drug within the Surescripts network.

4.Electronic Health Records (EHR) and Clinical Management Systems:Qualification as a Health Home provider is in part dependent upon the ability to report detailed performance metrics, measure improvement in care coordination, and gauge clinical outcomes on a provider level. Providers who do not currently use a robust EHR or clinical management system may determine that such a tool is necessary to meet the reporting and care coordination requirements of the Health Home program, as well as to improve their overall care capabilities.

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Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Home providers report to the state on all applicable quality measures as a condition of receiving payment from the state.
- [x] The state provides assurance that it will identify measureable goals for its Health Home model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.
- [x] The state provides assurance that it will report to CMS information to include applicable mandatory Core Set measures submitted by Health Home providers in accordance with all requirements in 42 CFR §§ 437.10 through 437.15 no later than state reporting on the 2024 Core Sets, which must be submitted and certified by December 31, 2024 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. In subsequent years, states must report annually, by December 31st, on all measures on the applicable mandatory Core Set measures that are identified by the Secretary.
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report.

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