Table of Contents

State/Territory Name: **Michigan**

State Plan Amendment (SPA) #: **23-1500**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

MI - Submission Package - MI2023MS0002O - (MI-23-1500) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID MI2023MS0002O

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

SPA ID MI-23-1500

Version Number 1

Submitted By Erin Black

Package Disposition

Priority Code P2

Submission Type Official

State MI

Region Chicago, IL

Package Status Approved

Submission Date 3/13/2023

Approval Date 4/3/2023 7:10 PM EDT

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

Center for Medicaid & CHIP Services

April 03, 2023

Farah Hanley
Chief Deputy Director for Health
Medical Services Administration
400 S. Pine Street
7th Floor
Lansing, MI 48933-2250

Re: Approval of State Plan Amendment MI-23-1500 Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Dear Ms. Hanley,

On March 13, 2023, the Centers for Medicare and Medicaid Services (CMS) received Michigan State Plan Amendment (SPA) MI-23-1500 for Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions to expand the Behavioral Health Home to more geographic areas and update staffing requirements to allow flexibility for the required provider infrastructure.

We approve Michigan State Plan Amendment (SPA) MI-23-1500 with an effective date(s) of May 01, 2023.

For payments made to Health Homes providers for Health Homes participants who newly qualify based on the Health Homes program's increased geographical coverage under this amendment, a medical assistance percentage (FMAP) rate of 90 percent applies to such payments for the period 5/1/2023 to 3/31/2025.

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

If you have any questions regarding this amendment, please contact Christine Davidson at christine.davidson@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2023MS0002O | MI-23-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2023MS0002O	**SPA ID**	MI-23-1500
Submission Type	Official	**Initial Submission Date**	3/13/2023
Approval Date	4/3/2023	**Effective Date**	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Michigan	**Medicaid Agency Name:**	Michigan Department of Health and Human Services

Submission Component

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

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2023MS0002O | MI-23-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID MI2023MS0002O
SPA ID MI-23-1500
Submission Type Official
Initial Submission Date 3/13/2023
Approval Date 4/3/2023
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SPA ID and Effective Date

SPA ID MI-23-1500

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Geographic Limitations	5/1/2023	MI-22-1500
Health Homes Providers	5/1/2023	MI-20-1500

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2023MS0002O | MI-23-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID MI2023MS0002O
SPA ID MI-23-1500
Submission Type Official
Initial Submission Date 3/13/2023
Approval Date 4/3/2023
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives This State Plan Amendment (SPA) will expand the BHH to more geographic areas. The SPA will also update staffing requirement to allow flexibility to the required provider infrastructure.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2023	$749600
Second	2024	$1399600

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2023MS0002O | MI-23-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID MI2023MS0002O

SPA ID MI-23-1500

Submission Type Official

Initial Submission Date 3/13/2023

Approval Date 4/3/2023

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

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

Describe Farah Hanley
Chief Deputy Director for Health Behavioral and Physical Health and Aging Services Administration

Health Homes Geographic Limitations

Package Header

Package ID MI2023MS0002O
SPA ID MI-23-1500
Submission Type Official
Initial Submission Date 3/13/2023
Approval Date 4/3/2023
Effective Date 5/1/2023
Superseded SPA ID MI-22-1500
System-Derived

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

Specify the geographic limitations of the program

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

Specify which counties:

1. Alcona
2. Alger
3. Alpena
4. Antrim
5. Arenac
6. Baraga
7. Bay
8. Benzie
9. Charlevoix
10. Cheboygan
11. Chippewa
12. Clare
13. Clinton
14. Crawford
15. Delta
16. Dickinson
17. Eaton
18. Emmet
19. Gladwin
20. Gogebic
21. Grand Traverse
22. Gratiot
23. Hillsdale
24. Houghton
25. Huron
26. Ingham
27. Ionia
28. Iosco
29. Iron
30. Isabella
31. Jackson
32. Kalkaska
33. Keweenaw
34. Leelanau
35. Lenawee
36. Livingston
37. Luce
38. Mackinac
39. Manistee
40. Marquette
41. Mecosta
42. Menominee
43. Midland
44. Missaukee
45. Monroe
46. Montcalm
47. Montmorency
48. Newaygo
49. Oakland
50. Ogemaw
51. Ontonagon
52. Osceola
53. Oscoda

54. Otsego
55. Presque Isle
56. Roscommon
57. Saginaw
58. Schoolcraft
59. Shiawassee
60. Tuscola
61. Washtenaw
62. Wayne
63. Wexford

Health Homes Providers

Package Header

Package ID MI2023MS0002O
SPA ID MI-23-1500
Submission Type Official
Initial Submission Date 3/13/2023
Approval Date 4/3/2023
Effective Date 5/1/2023
Superseded SPA ID MI-20-1500
System-Derived

Types of Health Homes Providers

☑ Designated Providers

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

☐ Physicians
☐ Clinical Practices or Clinical Group Practices
☐ Rural Health Clinics
☐ Community Health Centers
☐ Community Mental Health Centers
☐ Home Health Agencies
☐ Case Management Agencies
☐ Community/Behavioral Health Agencies
☐ Federally Qualified Health Centers (FQHC)
☑ Other (Specify)

Provider Type	Description
Health Home Partner (HHP)	Provider Qualifications and Standards: The HHP must: • Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. • Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following: o Community Mental Health Services Programs (CMHSPs) o Federally Qualified Health Center/Primary Care Safety Net Clinic o Rural Health Clinic o Tribal Health Center o Clinical Practices or Clinical Group Practices o Community/Behavioral Health Agencies
Lead Entity (LE)	• Be a regional entity as defined in Michigan's Mental Health Code (330.1204b). • Must contract with and pay a negotiated rate to HHPs, • Must maintain a network of providers that support the BHHs to service beneficiaries with a serious mental illness/serious emotional

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

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

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

- Health Home Director (0.50 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Community Health Worker, Medical Assistant (3.00-4.00 FTE)
- Medical Consultant (.10 FTE)
- Psychiatric Consultant (.10 FTE)

All providers referenced above must meet the following criteria:

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

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

Nurse Care Manager
- Must be a licensed registered nurse or licensed practical nurse with relevant experience.

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

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

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

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

Supports for Health Homes Providers

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

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

Description

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

Other Health Homes Provider Standards

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

The Michigan BHH Lead Entity (LE) must:
1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
2. Must contract with and pay a negotiated rate to HHPs,
3. Must maintain a network of providers that support the BHHs to service beneficiaries with a serious mental illness/serious emotional disturbance diagnosis,
4. Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,
5. Have authority to access Michigan's Waiver Support Application and CareConnect360,
6. Provides leadership for implementation and coordination of health home activities,
7. Serves as a liaison between the health homes site and MDHHS staff/contractors,
8. Champions practice transformation based on health home principles,
9. Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities,
10. Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management,

11. Monitors Health Home performance and leads quality improvement efforts,
12. Designs and develops prevention and wellness initiatives, and referral tracking,
13. Must have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including:
    a. Identification of providers who meet the BHH standards,
    b. Provision of infrastructure to support BHHs in care coordination,
    c. Collecting and sharing member-level information regarding health care utilization and medications,
    d. Providing quality outcome protocols to assess BHH effectiveness, and
    e. Developing training and technical assistance activities that will support BHH in effective delivery of health home services.

The Lead Entity (LE) and the Health Home Partner (HHP) jointly must:

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

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

Name	Date Created	
2_BHH Provider Requirements and Expectations V1 (3-1-2023)	3/1/2023 9:59 AM EST	

This view was generated on 4/4/2023 6:12 AM EDT