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State/Territory Name: MI

State Plan Amendment (SPA) #: 24-1502

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MI - Submission Package - MI2024MS0005O - (MI-24-1502) - Health Homes

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

Center for Medicaid & CHIP Services

November 18, 2024

Meghan E. Groen
Senior Deputy Director, Behavioral and Physical Health and Aging Services Administration
Michigan Department of Health and Human Services
400 S Pine St.; 7th Floor
Lansing, MI 48933

Re: Approval of State Plan Amendment MI-24-1502 MIGRATED_HH.MI Care Team

Dear Meghan E. Groen,

On September 30, 2024, the Centers for Medicare and Medicaid Services (CMS) received Michigan State Plan Amendment (SPA) MI-24-1502 for MIGRATED_HH.MI Care Team to comply with the final rule that makes Health Home Core Set(s) mandatory starting in 2024.

We approve Michigan State Plan Amendment (SPA) MI-24-1502 with an effective date(s) of October 01, 2024.

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

Sincerely,

James G. Scott
Director, Division of Program Operations
Center for Medicaid & CHIP Services

MI - Submission Package - MI2024MS0005O - (MI-24-1502) - Health Homes

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

CMS-10434 OMB 0938-1188

Package Header

Package ID MI2024MS0005O
SPA ID MI-24-1502
Submission Type Official
Initial Submission Date 9/30/2024
Approval Date 11/18/2024
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Superseded SPA ID N/A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 | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

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SPA ID and Effective Date

SPA ID MI-24-1502

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2024	MI-15-200-X
Health Homes Geographic Limitations	10/1/2024	MI-15-200-X
Health Homes Population and Enrollment Criteria	10/1/2024	MI-15-200-X
Health Homes Providers	10/1/2024	MI-15-200-X
Health Homes Service Delivery Systems	10/1/2024	MI-15-200-X
Health Homes Payment Methodologies	10/1/2024	MI-15-200-X
Health Homes Services	10/1/2024	MI-15-200-X
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2024	MI-15-200-X

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

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Executive Summary

Summary Description Including Goals and Objectives To comply with the final rule that makes Health Home Core Set(s) mandatory starting in 2024.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

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

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act
42 CFR §§ 437.10 and 437.15

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

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Superseded SPA ID	N/A		

Governor's Office Review

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

Describe Meghan Groen, Director
Behavioral and Physical Health and Aging Services Administration

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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MI - Submission Package - MI2024MS0005O - (MI-24-1502) - Health Homes

Health Homes Intro

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Superseded SPA ID	MI-15-200-X System-Derived		

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

MIGRATED_HH.MI Care Team

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

In 2014, upon recommendation from the gubernatorial-created Mental Health and Wellness Commission, the State of Michigan appropriated funding to implement primary care health homes, or Section 2703 of the Affordable Care Act (ACA), in Michigan's Federally Qualified Health Centers (FQHC) and Tribal Health Centers (THC). The Health Home service model is meant to help chronically ill Medicaid and Healthy Michigan Plan beneficiaries manage their conditions through an intimate level of care management and coordination. the MI Care Team utilizes an interdisciplinary team of providers who will operate in a highly behavioral health integrated primary care setting. The care team will help ensure seamless transitions of care and help connect the beneficiary with needed clinical and social services. The program will include all of the health home services mandated by the ACA, including: Care management, care coordination, health promotion, transitional care, patient and family support, and appropriate community referrals.

General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] 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.
- [x] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [x] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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Health Homes Geographic Limitations

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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. Bay
2. Genesee
3. Houghton
4. Huron
5. Iron
6. Kalamazoo
7. Kent
8. Lapeer
9. Lenawee
10. Macomb
11. Marquette
12. Menominee
13. Monroe
14. Montcalm
15. Montmorency
16. Oakland
17. Ontonagon
18. Presque Isle
19. Saginaw
20. Shiawassee
21. Wayne

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Health Homes Population and Enrollment Criteria

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Categories of Individuals and Populations Provided Health Home Services

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

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

Mandatory Medically Needy

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

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

Families and Adults

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

Aged, Blind and Disabled

- [x] Medically Needy Aged, Blind or Disabled
- [x] 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:

- [x] Two or more chronic conditions

Specify the conditions included:

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

Name	Description
Anxiety	Anxiety is a mental health condition that is designated as a chronic condition under the Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA). The MI Care Team service model is intended to help Medicaid beneficiaries better manage chronic conditions through intimate levels of care management and coordination.
COPD	Chronic obstructive pulmonary disease (COPD) is designated as a chronic condition under the Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA). The MI Care Team service model is intended to help Medicaid beneficiaries better manage chronic conditions through intimate levels of care management and coordination.
Depression	Depression is a mental health condition that is designated as a chronic condition under the Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA). The MI Care Team service model is intended to help Medicaid beneficiaries better manage chronic conditions through intimate levels of care management and coordination.
Hypertension	Hypertension is designated as a chronic condition under the Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA). The MI Care Team service model is intended to help Medicaid beneficiaries better manage chronic conditions through

Name	Description
	intimate levels of care management and coordination.

- [ ] One chronic condition and the risk of developing another
- [ ] 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)

Name:

Hybrid Autoenrollment Process

Description:

The State will identify beneficiaries meeting eligibility criteria using claims data, send eligible beneficiaries a notification letter, and inform providers with an existing relationship with these beneficiaries for outreach purposes. The beneficiary letter will provide contact information for eligible locations in their area. For beneficiaries not captured in claims data, providers can recommend enrollment by submitting to the State an attestation form. The State will verify all beneficiary eligibility and process approved enrollments in compliance with approved state plan provisions, which will take two weeks from verification to enrollment.

A beneficiary must provide consent to enroll, which will be retained in their health record. Beneficiaries may disenroll at any time. Beneficiaries who decline enrollment in the benefit at the outset may elect to receive the benefit at any time contingent on eligibility requirements. Beneficiaries who decline or disenroll may do so without jeopardizing their access to other medically necessary services.

Disengaged beneficiaries, and those having moved outside of an eligible geographic area or died will be recommended for disenrollment. Except for moving and death, disengaged beneficiaries will be disenrolled after the provider has made three unsuccessful contact attempts within a quarter (providers will not be reimbursed for unsuccessful contacts). After the final attempt, providers will recommend disenrollment to the State with appropriate rationale. The State will verify and process disenrollments. Providers and the State must maintain a list of disenrolled beneficiaries and providers must try to re-establish contact with these beneficiaries at least bi-annually, as applicable.

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Health Homes Providers

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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)

Describe the Provider Qualifications and Standards

Federally Qualified Health Centers (FQHC): FQHCs must be enrolled as a Medicaid provider. They must meet all federal requirements to ensure their designation as an FQHC (Section 330 Health Center grantee or FQHC look-alike) is in good standing. FQHCs must also meet all state requirements for participation, along with all standard provider policies for participation with Medicaid. FQHCs must apply for participation and all designated providers within the FQHC must participate in an initial health home training. The medical staff of the FQHC will act as the designated provider and will be responsible for the overall provision of health home services.

☑ Other (Specify)

Provider Type	Description
Tribal Health Center (THC)	Tribal Health Center (THC): THCs must be enrolled as a Medicaid provider. They must meet all federal requirements of the Indian Health Service. THCs must also meet all state requirements for participation, along with all standard provider policies for participation with Medicaid. THCs must apply for participation and all designated providers within the THC must participate in an initial

Provider Type	Description
	health home training. The medical staff of the THC will act as the designated provider and will be responsible for the overall provision of health home services.

Health Homes Providers

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- [ ] Teams of Health Care Professionals
- [ ] Health Teams

Health Homes Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

In order to serve as a Health Homes provider, each FQHC and THC must provide each Health Homes beneficiary with access to an interdisciplinary care team capable of meeting the beneficiary's mental and physical health needs. The beneficiary's specific needs will dictate the size and scope of provider involvement. At a minimum, each FQHC and THC must provide the following on-site care team members who are qualified to perform functions including but not limited to the following:

Primary care Provider (i.e., primary care physician, physician assistant, or nurse practitioner):
•Lead the care team in providing medical care services;
•Lead in selecting strategies to implement evidence based wellness and prevention initiatives;
•Lead care plan development, including development of specific goals for all enrollees;
•Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge;
•Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs;
•Lead in monitoring assessments and screenings to assure findings are integrated in the care plan;
•Use the EHR and other HIT to link services, facilitate communication among team members, and provide feedback;
•Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

Behavioral Health Consultant (e.g., LMSW):
•Screen/evaluate individuals for mental health and substance abuse disorders;
•Refer to licensed mental health provider and/or SUD therapist as necessary;
•Provide brief intervention for individuals with behavioral health problems;
•Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the clinic;
•Support primary care providers in identifying and providing behavioral interventions;
•Focus on managing a population of patients versus providing specialty care;
•Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions;
•Develop and maintain relationships with community based mental health and substance abuse providers;
•Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness;
•Provide patient education.

Nurse Care Manager (i.e., RN):
•Participate in selecting strategies to implement evidence based wellness and prevention initiatives;
•Participate in initial care plan development including specific goals for all enrollees;
•Communicate with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding patient care and records including admission/discharge;
•Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs;
•Monitor assessments and screenings to assure findings are integrated in the care plan;
•Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback;
•Monitor and report performance measures and outcomes;
•Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the clinic.

Community Health Worker:
•Coordinate and provide access to individual and family supports, including referral to community social supports;
•Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the clinic;
•Identify community resources (i.e. social services, workshops, etc.) for patient to use to maximize wellness;
•Referral tracking;
•Coordinate and provide access to chronic disease management including self-management support;
•Implement wellness and prevention initiatives;
•Facilitate health education groups;
•Provide education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Health Homes Coordinator (i.e., Administrative Staff):
•Provide leadership to implement and coordinate health home activities;
•Serve as the liaison between the MPCA and MDCH Health Home staff;
•Champion practice transformation based on Health Home principles;
•Develop and maintain working relationships with primary and specialty care providers including CMHSPs and inpatient facilities;
•Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management;
•Monitor Health Home performance and lead improvement efforts;
•Lead in monitoring and reporting performance measures and outcomes;
•Design and develop prevention and wellness initiatives;

•Referral tracking;
•Provide training and technical assistance;
•Perform data management and reporting.

(Access to) a Psychologist and/or Psychiatrist:
•The care team must have access to a doctoral-level psychologist and/or psychiatrist for consultation purposes;
•Communicate treatment methods, advice and/or recommendations to the Behavioral Health Provider for inclusion.

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 service delivery. This includes a mandatory Health Homes orientation for the designated providers and clinical support staff before the program is officially implemented. The orientation will occur regionally or on-site 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 Homes workgroups and listserv forums for Health Homes 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 Homes beneficiary.

Other Health Homes Provider Standards

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

Under Michigan's approach to Medicaid Health Home implementation in Federally Qualified Health Centers (FQHC) and Tribal Health Centers (THC) the objective is to provide efficient care, increase access, create a continuum of care, reduce costs, avoid preventable emergency room visits, and improve patient outcomes. To achieve these objectives health home providers will be required to meet the following standards.

1. Enrollment/Recognition/Certification
a. Health home providers must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies
b. Be a Section 330 Health Center program grantee of any type, Federally-Qualified Health Center Look-Alike, Tribal 638 facility, or Urban Indian organization
c. Health home providers must adhere to all federal and state laws in regard to Health Homes recognition/certification, including the capacity to perform all core services specified by CMS. Providers shall meet the following recognition/certification standards:
i. Achieve Patient Centered Medical Home (PCMH) from national recognizing body (NCQA, AAAHC, JC) before health homes becomes operational. PCMH application can be pending

2. A personal care team will be assigned to each patient
a. Ensure each patient has an ongoing relationship with a personal member of their care team who is trained to provide first contact and support continuous and comprehensive care, where both the patient and the care team recognize each other as partners in care. Behavioral health is embedded into primary care, with real-time consult available to primary care provider
b. Care teams are staffed according to model selected

3. Whole Person Orientation
a. Provide or take responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care
b. Meaningful use of technology for patient communication
c. Develop a person centered care plan for each individual that coordinates and integrates all clinical and non-clinical health care related needs and services

4. Coordinated/Integrated Care
a. Dedicate a care coordinator responsible for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes and communication with external specialists
b. Communicate with patient, and authorized family and caregivers in a culturally and linguistically appropriate manner
c. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services and health promotion
d. Directly provide or have an Memorandum of Agreement (MOA) in place to coordinate or provide:
i. Mental health/behavioral health and substance use disorder services
ii. Oral health services

iii. Chronic disease management
iv. Coordinated access to long term care supports and services
v. Recovery services and social health services (available in the community)
vi. Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco treatment/cessation, and health coaching)
e. Conduct outreach to local health systems and establish bi-directional referral processes whereby the health system communicates directly with the Health Homes and the Health Homes communicates directly with the health system to maximize appropriate care transitions
f. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
g. Review and reconciliation of medications
h. Assessment of social, educational, housing, transportation, and vocational needs that may contribute to disease and/or present as barriers to self-management (Social workers, CHW)
i. Maintain a reliable system and written standards/protocols for tracking patient referrals; Health Homes providers will utilize CareConnect 360 or another medium to assist with tracking and follow-up efforts

5. Emphasis on Quality and Safety
a. Health homes providers must adhere to all applicable privacy, consent, and data security statutes
b. Demonstrate use of clinical decision support within the practice workflow specific to the conditions identified in the health homes project
c. Demonstrate use of a population management tool such as a patient registry and the ability to evaluate results and implement interventions that improve outcomes
d. Each Health Home shall implement formal screening tools such as SBIRT, PHQ9, GAD, diabetes and asthma risk tests to assess treatment needs
e. 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

6. Enhanced Access
a. Provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations
b. Monitor access outcomes such as the average 3rd next available appointment and same day scheduling availability
c. Use of email, text messaging, patient portals and other technology as available to the practice to communicate with patients is encouraged
d. Implement policies and procedures to operation with open access scheduling and available same day appointments

7. Health Information Technology
a. Must have an Electronic Health Record (EHR) in place with capability of behavioral health information integration.
b. Provider must have achieved Meaningful Use stage 1 as defined by the Centers for Medicare and Medicaid Services.
c. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members as well as between the health team and individual and family caregivers, and provide feedback to practices; as feasible and appropriate.
d. Health Home providers must have the capacity to electronically report to the state or its contracted affiliates information about the provision of core services and outcome measures.

8. Health Homes Team
a. Support Health Homes team participation in all related activities and trainings including travel costs associated with Health Homes activities.
b. Work collaboratively with MDHHS and contractors to adapt and adopt program processes for Health Home care team use in the participating sites(s).
c. Actively engage in Health Home process and outcome achievement activities including ongoing coaching, data feedback and customized improvement plans to meet initiative goals.
d. Commit a management staff member (such as the Health Home Coordinator) and a clinician champion serving on the care team(s) at the participating site(s) to contribute actively to and support the project.
e. Commit a staff member to serve as the liaison to the beneficiary's assigned managed care health plan.
f. Submit evidence of active care plan development or active care plan maintenance/management in to the state's Medicaid Management Information System known as the Community Health Automated Medicaid Processing System (CHAMPS).

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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MI - Submission Package - MI2024MS0005O - (MI-24-1502) - Health Homes

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

CMS-10434 OMB 0938-1188

Package Header

Package ID	MI2024MS0005O	**SPA ID**	MI-24-1502
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Superseded SPA ID	MI-15-200-X System-Derived		

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

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

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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MI - Submission Package - MI2024MS0005O - (MI-24-1502) - Health Homes

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

CMS-10434 OMB 0938-1188

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Payment Methodology

The State's Health Homes 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

The rates for Health Homes services are effective for services provided on or after July 1, 2016, and can be found at http://www.michigan.gov/medicaidproviders. Payment for Health Homes services are contingent on the approved Health Homes providers meeting the requirements set forth in their Health Homes applications, as determined by MDHHS. Failure to meet these requirements may result in loss of Health Homes status and termination of payments. The monthly payment for Health Homes is in addition to the existing fee for services, encounter or daily rate payments for direct services. The Michigan Medicaid fee schedule may be found at www.michigan.gov/medicaidproviders. There are two rates associated with the Health Home program. There is an "Assessment and Health Action Plan" rate to be paid in the first month of a beneficiary's participation and an "Ongoing Care Coordination" rate to be paid in subsequent months. Both rates reflect personnel costs of the required team of health care professionals providing Health Home services. The Health Home rates also reflect related indirect and overhead costs for these positions. The indirect/overhead costs associated with the health care professionals includes administrative assistance, office space of the health

care professional staff, including costs of rent and utilities, equipment and services used (e.g., copiers, phone systems, and IT support), and costs associated with liability insurance, staff training, and with any audit that may occur. MDHHS' payment methodology is designed to only reimburse for the costs associated with the aforementioned Health Homes' staff for the delivery of services that are not covered by any other currently available Medicaid reimbursement mechanism. MDHHS will annually evaluate the Health Home payment rates to determine whether the rates require adjustment or re-base due to staffing costs of the team of health care professionals, changes in related indirect and overhead costs, or other factors determined by MDHHS.

The "Assessment and Health Action Plan" rate is developed based on the estimated time that would be spent by each member of the Home Health care team to assess the individual and develop a care plan. The hourly rates for each position, fully loaded to include indirect and overhead costs, are then utilized to determine the total rate. This in-person assessment is required for the provider to enroll the individual into the Health Home.

The "Ongoing Care Coordination" rate is based on the number of full time equivalent (FTE) employees needed at each level on the care team to maintain monthly care coordination with the enrolled individuals. The ratios of FTEs per enrollee and the salaries for each position were then utilized to compute a monthly payment needed for each position on the care team. The monthly payments for each position were then added together to arrive at the total monthly rate. All "Ongoing Care Coordination" payments made to the Health Home provider are contingent on the provider making an established contact with the beneficiary during the payment month. Health home services contacts, as described in the core service definitions, may or may not require face-to-face interaction with a beneficiary.

MDHHS will require providers to submit a qualifying reporting code on a monthyly basis to document services and will require providers to document services in the patient's chart or electronic health record. If a core health homes service is not rendered, that month's payment will be subject to recoupment. Four months after the month a monthly payment is made, MDHHS will conduct an automatic recoupment process that will look for an approved claim that documents that the health home provided at least one of the five core health homes services (excluding the Health IT requirement) during the month in review.

☐ 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

See attached plan.

☐ 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

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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

Health Homes Payment Methodologies

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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 See the attached plan.

Health Homes Payment Methodologies

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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

Health home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future health home state plan benefits, and other state plan services). 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, including the assurance that each beneficiary will only be enrolled in one health home at a time.

Health Home care coordination is done at the primary care practice level, thus creating an intimate level of care coordination and management. The more intensive aspects of Health Home care coordination include a lower employee to beneficiary ratio for Community Health Workers (CHWs) as compared to the Michigan Medicaid managed care plan contract for care coordination and social support services. In addition, Health Home providers will be required to use the IMPACT and Nuka care coordination models and require team huddles at the primary care practice level, which provides an intensive level of behavioral health integration.

As provided in their contracts, managed care plans and their care coordinators/managers will communicate with Health Home providers to ensure that both entities promote coordination of services and avoid duplication of services.

☑ 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	
MI Care Team Payment Methodology	9/23/2024 1:36 PM EDT	

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Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

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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

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

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

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

The establishment of a centralized, claims-based health information exchange (HIE) will assist care coordinators with maintaining a comprehensive care plan for each beneficiary enrolled in the health home.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists	**Description** Behavioral Health Provider (Must be a licensed master's level social worker in Michigan.) • Screen/evaluate individuals for mental health and substance abuse disorders. • Refer to licensed mental health provider and/or SUD therapist as necessary. • Provide brief intervention for individuals with behavioral health problems. • Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic. • Support primary care providers in identifying and providing behavioral interventions. • Focus on managing a population of patients versus providing specialty care. • Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions. • Develop and maintain relationships with community based mental health and substance abuse providers. • Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness. • Provide patient education.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager
(Must be a licensed registered nurse in Michigan.)
- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☑ Nurses

Description

Nurse
(Must be a licensed registered nurse in Michigan.)
- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☐ Medical Specialists

☑ Physicians

Description

Physicians, Physicians Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☑ Physician's Assistants

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)

- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☐ Pharmacists

☑ Social Workers

Description

Social Worker
(Must be a licensed master's level social worker in Michigan.)
- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

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Care Coordination

Definition

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

A key support role includes the Community Health Worker (CHW). CHWs are professionals identified by the American Public Health Association. CHWs are frontline public health workers who have an understanding of the community they serve. The CHW serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

CHWs and other Care Coordinators will, at a minimum, provide:

- Emphasis will be placed on in-person contacts; however telephonic outreach may be used for lower-risk Health Home members who require less frequent face to face contact (lower-risk is defined at the Health Homes level by clinicians on the Health Homes care team in consideration of management of chronic conditions)
- Appointment making assistance, including coordinating transportation
- Development and implementation of care plan
- Medication adherence and monitoring
- Referral tracking
- Use of facility liaisons, as available (i.e., nurse care managers)
- Patient care team huddles
- Use of case conferences, as applicable
- Tracking test results
- Requiring discharge summaries

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

Health Home Providers will utilize their EHR to record care coordination and health promotion activities and make adjustments to these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(Must be a licensed master's level social worker in Michigan.)

- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager
(Must be a licensed registered nurse in Michigan.)

- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☑ Nurses

Description

Nurse
(Must be a licensed registered nurse in Michigan.)
- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☐ Medical Specialists

☑ Physicians

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☑ Physician's Assistants

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.

- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☐ Pharmacists

☑ Social Workers

Description

Social Worker
(Must be a licensed master's level social worker in Michigan.)
- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Community Health Workers	Community Health Worker (Must be at least 18 years of age; Must possess a high school diploma or equivalent; Must be supervised by licensed professional members of the care team; MDHHS strongly encourages the completion of the CHW Certificate Program) • Coordinate and provide access to individual and family supports, including referral to community social supports. • Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic. • Identify community resources (i.e. social services, workshops, etc.) for patient to use to maximize wellness. • Referral tracking. • Coordinate and provide access to chronic disease management including self-management support. • Implement wellness and prevention initiatives. • Facilitate health education groups. • Provide education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

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Health Promotion

Definition

Health Promotion begins with the initial health homes visit or while establishing a formal care plan. The health home will assess the readiness to change and provide the beneficiary with the appropriate level of encouragement and support for the adoption of these healthy behaviors and/or lifestyle changes. Healthy behaviors and/or lifestyle interventions include but are not limited to:

- Development of self-management plans
- Evidenced-based wellness and promotion
- Patient education
- Patient and family activation
- Addressing clinical and social needs
- Patient-centered training (e.g., diabetes education, nutrition education)
- Connection to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiaries' needs and preferences.

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

Health Home Providers will utilize their EHR to record care coordination and health promotion activities and make adjustments to these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☑ Nurse Care Coordinators

Description

Nurse Care Manager
(Must be a licensed registered nurse in Michigan.)

- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

- ☑ Nurses

Description

Nurse
(Must be a licensed registered nurse in Michigan.)

- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in

the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☐ Medical Specialists

☑ Physicians

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☑ Physician's Assistants

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☐ Pharmacists

☑ Social Workers

Description

Social Worker
(Must be a licensed master's level social worker in Michigan.)
- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.

- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Community Health Workers	Community Health Worker (Must be at least 18 years of age; Must possess a high school diploma or equivalent; Must be supervised by licensed professional members of the care team; MDHHS strongly encourages the completion of the CHW Certificate Program) • Coordinate and provide access to individual and family supports, including referral to community social supports. • Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic. • Identify community resources (i.e. social services, workshops, etc.) for patient to use to maximize wellness. • Referral tracking. • Coordinate and provide access to chronic disease management including self-management support. • Implement wellness and prevention initiatives. • Facilitate health education groups. • Provide education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2024MS0005O | MI-24-1502 | MIGRATED_HH.MI Care Team

Package Header

Package ID	MI2024MS0005O	**SPA ID**	MI-24-1502
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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care services connect the beneficiary to needed health services available within the community. Health services include care provided outside of the health home. Health homes will be expected to coordinate and track their participants:

- Notification of admissions/discharge
- Receipt of care record, continuity of care document, or discharge summary
- Post-discharge outreach to assure appropriate follow-up services
- Medication reconciliation
- Pharmacy coordination
- Proactive care (versus reactive care)
- Specialized transitions when necessary (e.g., age, corrections)
- Home visits

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

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

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(Must be a licensed master's level social worker in Michigan.)

- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager
(Must be a licensed registered nurse in Michigan.)

- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in

the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☑ Nurses

Description

Nurse
(Must be a licensed registered nurse in Michigan.)
- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☐ Medical Specialists

☑ Physicians

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☑ Physician's Assistants

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide

feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

- [ ] Pharmacists
- [x] Social Workers

Description

Social Worker
(Must be a licensed master's level social worker in Michigan.)
- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.

Provide patient education.

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

Health Homes Services

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	System-Derived		

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services reduce barriers to the beneficiaries' care coordination, increase skills and engagement and improve overall health outcomes. Specific activities may include, but are not limited to:

- Use of community supports (e.g., community health workers, peer supports, support groups, self-care programs, as appropriate)
- Facilitation of improved adherence to treatment
- Advocacy for individual and family needs
- Efforts to assess and increase health literacy
- Use of advance directives
- Assistance with maximizing level of functioning in the community
- Assistance with the development of social networks

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

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

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(Must be a licensed master's level social worker in Michigan.)

- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager
(Must be a licensed registered nurse in Michigan.)

- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.

- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☑ Physician's Assistants

Description

Physicians, Physician Assistant, and Nurse Practitioners
(Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan.)
- Lead the care team in providing medical care services.
- Lead in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Lead care plan development, including development of specific goals for all enrollees.
- Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge.
- Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Lead in monitoring assessments and screenings to assure findings are integrated in the care plan.
- Use the EHR and other Health Information Technology (HIT) to link services, facilitate communication among team members, and provide feedback.
- Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

☐ Pharmacists

☑ Social Workers

Description

Social Worker
(Must be a licensed master's level social worker in Michigan.)
- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.

- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Community Health Workers	Community Health Worker (Must be at least 18 years of age; Must possess a high school diploma or equivalent; Must be supervised by licensed professional members of the care team; MDHHS strongly encourages the completion of the CHW Certificate Program) • Coordinate and provide access to individual and family supports, including referral to community social supports. • Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic. • Identify community resources (i.e. social services, workshops, etc.) for patient to use to maximize wellness. • Referral tracking. • Coordinate and provide access to chronic disease management including self-management support. • Implement wellness and prevention initiatives. • Facilitate health education groups. • Provide education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Health Homes Services

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Referral to Community and Social Support Services

Definition

Referrals to community and social support services provide recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. Specific activities may include, but are not limited to:

- Collaboration/coordination with community-based organizations and other key community stakeholders
- Emphasis on resources closest to the patient's home with least barriers
- Identification of community-based resources
- Availability of resource materials pertinent to patient needs
- Assist in attainment of other resources, including benefit acquisition
- Referral to housing resources as needed
- Referral tracking and follow-up

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

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

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(Must be a licensed master's level social worker in Michigan.)

- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

Nurse Care Manager
(Must be a licensed registered nurse in Michigan.)

- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate

communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

- [x] Nurses

Description

Nurse
(Must be a licensed registered nurse in Michigan.)
- Participate in selecting strategies to implement evidence-based wellness and prevention initiatives.
- Participate in initial care plan development including specific goals for all enrollees.
- Communicate with medical providers, subspecialty providers including mental health and SUD service providers, long term care and hospitals regarding patient care and records including admission/discharge/transfer.
- Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs.
- Monitor assessments and screenings to assure findings are integrated in the care plan.
- Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback.
- Monitor and report performance measures and outcomes.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.

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

Description

Social Worker
(Must be a licensed master's level social worker in Michigan.)
- Screen/evaluate individuals for mental health and substance abuse disorders.
- Refer to licensed mental health provider and/or SUD therapist as necessary.
- Provide brief intervention for individuals with behavioral health problems.
- Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic.
- Support primary care providers in identifying and providing behavioral interventions.
- Focus on managing a population of patients versus providing specialty care.
- Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions.
- Develop and maintain relationships with community based mental health and substance abuse providers.
- Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness.
- Provide patient education.

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

Provider Type	Description
Community Health Workers	Community Health Worker (Must be at least 18 years of age; Must possess a high school diploma or equivalent; Must be supervised by licensed professional members of the care team; MDHHS strongly encourages the completion of the CHW Certificate Program) • Coordinate and provide access to individual and family supports, including referral to community social supports.

Provider Type	Description
	• Meet regularly with the care team to plan care and discuss cases and exchange information with team members as part of the daily routine of the clinic. • Identify community resources (i.e. social services, workshops, etc.) for patient to use to maximize wellness. • Referral tracking. • Coordinate and provide access to chronic disease management including self-management support. • Implement wellness and prevention initiatives. • Facilitate health education groups. • Provide education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

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

Eligible Health Homes patients will present at a qualified Health Homes clinic for enrollment into the program. At this time, the patient must complete consent and enrollment forms to formally begin participation in the program. If the patient is completely new to the qualified Health Homes provider, then a full new patient orientation of the practice and the Health Homes program will be provided. On a patient's first Health Home visit, the enrollment will entail an introduction to the core Health Homes team and a care plan will be developed that attends to the patient's particular needs. In addition, necessary arrangements will be provided for needed services outside of the four walls of the Health Homes provider. Follow-up appointments and community supports will be determined by the care team and implicated providers will be called upon as needed and as directed through the usage of care team huddles. It should be noted that while every patient will interface with the care team, the extent to which a given care team member's services are required will be dependent upon the conditions or preference of the patient.

Name	Date Created	
MI Care Team Patient Flow	9/23/2024 1:37 PM EDT	

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Health Homes 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 Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates:

MDHHS will contract with an academic research institution to execute a cost-savings analysis for the primary care Health Homes program. Broadly, the cost-focused analyses will consider the consequences of improved care coordination and clinical management for beneficiaries enrolled in the program, and will also measure total expenditures for individuals enrolled in the program comparing the implementation period with the period immediately prior to program implementation. In addition to the pre-post comparison, the contractor will also compare total expenditures for beneficiaries enrolled in the intervention (program) with expenditures for a concurrent control population identified on the basis of their specific eligible conditions and receipt of care in federally qualified health centers. These dual approaches will provide a robust evaluation of the program. All analyses will be presented in aggregate terms and also as PMPM. Data source is MDHHS Data Warehouse.

Measure Specifications: Administrative Claims Data pre- and post-Health Homes implementation; administrative claims data for the intervention and control populations, which will be formally defined in the contractor's methodology.

Adjustments will be made for cost outliers in the analysis.

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

All Health Homes providers must have Electronic Health Record (EHR) capabilities with meaningful use attainment. These systems will be used to link care in all settings of care to ensure seamless coordination and delivery of services. CareConnect 360 will also be utilized for care transition and planning purposes. In addition, telemedicine will be utilized for the provision of medical services as appropriate, particularly in rural or other areas that may lack density of psychiatrists/psychologists or other needed specialty providers.

Added to the maintenance of their own EHRs, approved Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home services. Health Homes will utilize CareConnect360, which is a care coordination tool that allows providers to access comprehensive retrospective Medicaid claim and encounter data. It supports queries that allow Health Homes to view the following beneficiary information:

- Current and prior health conditions
- Rendering services provider, date of service, and length of stay (if applicable)
- Pharmacy claims data
- Hospitalization and ED utilization, including diagnoses

Health Homes Monitoring, Quality Measurement and Evaluation

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Package Header

Package ID	MI2024MS0005O	**SPA ID**	MI-24-1502
Submission Type	Official	**Initial Submission Date**	9/30/2024
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Quality Measurement and Evaluation

- [x] 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.
- [x] 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.
- [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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