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State/Territory Name: Michigan

State Plan Amendment (SPA)#: 25-1500

This file contains the following documents in the order listed:

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- 3) Approved SPA Pages

MI - Submission Package - MI2025MS0002O - (MI-25-1500) - Health Homes

Summary Reviewable Units Versions Correspondence Log Analyst Notes **Approval Letter** RAI Transaction Logs News Related Actions

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



Center for Medicaid & CHIP Services

February 05, 2026

Meghan E. Groen
Chief Deputy Director, Health Services
Michigan Department of Health and Human Services
400 S. Pine Street, 7th Floor
Lansing, MI 48933

Re: Approval of State Plan Amendment MI-25-1500

Dear Director Groen,

On September 03, 2025, the Centers for Medicare and Medicaid Services (CMS) received Michigan State Plan Amendment (SPA) MI-25-1500 for Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions. This SPA proposes to expand the Behavioral Health Home program in three counties in Prepaid Inpatient Health Plan (PIHP) region 10 and to add staff to the Health Home staffing structure.

We approve Michigan State Plan Amendment (SPA) MI-25-1500 with an effective date(s) of October 01, 2025.

For payments made to 1945 Health Home providers for 1945 Health Home participants who newly qualify based on the 1945 Health Home program's increased geographical coverage under this amendment, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 10/1/2025 to 9/30/2027.

The FMAP rate for payments made to 1945 health home providers will return to the state's published FMAP rate at the end of the enhanced match period. The Form CMS-64 has a designated category of service Line 43 for states to report 1945 health home services expenditures for enrollees with chronic conditions.

If you have any questions regarding this amendment, please contact Christine Davidson at 312-886-3642 or christine.davidson@cms.hhs.gov.

Sincerely,

Wendy E. Hill Petras

Acting Director, Division of Program
Operations

Center for Medicaid & CHIP Services

MI - Submission Package - MI2025MS0002O - (MI-25-1500) - Health Homes

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

CMS-10434 OMB 0938-1188

Package Header

Package ID	MI2025MS0002O	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	02/05/2026	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 | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS00020	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	02/05/2026	Effective Date	N/A
Superseded SPA ID	N/A		

SPA ID and Effective Date

SPA ID MI-25-1500

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
1945 Health Home Intro	10/1/2025	MI-24-1500
1945 Health Home Geographic Limitations	10/1/2025	MI-24-1500
1945 Health Home Providers	10/1/2025	MI-24-1500
1945 Health Home Payment Methodologies	10/1/2025	MI-24-1500
1945 Health Home Services	10/1/2025	MI-24-1500

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS00020	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	02/05/2026	Effective Date	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicare and Medicaid Services to revise the current Behavioral Health Home (BHH) State Plan Amendment (SPA). This revision aims to expand the BHH in three counties within Prepaid Inpatient Health Plan (PIHP) region 10. In addition to this expansion, MDHHS is seeking to add the following staff to the health home staffing structure: SOAR Navigator, Housing Specialist, and Parent Support Partner. This update will also involve revising health services to better reflect current roles and responsibilities.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2026	\$3500000
Second	2027	\$3500000

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created
No items available	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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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 E. Groen
Chief Deputy Director
Health Services

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 - MI2025MS0002O - (MI-25-1500) - Health Homes

Summary Reviewable Units Versions Correspondence Log Analyst Notes Approval Letter RAI Transaction Logs News **Related Actions**

1945 Health Home Intro

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

CMS-10434 OMB 0938-1188

Package Header

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Superseded SPA ID	MI-24-1500		
	System-Derived		

Program Authority

1945 of the Social Security Act

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

Name of 1945 Health Home Program

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

Executive Summary

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

The BHH currently provides comprehensive care management and coordination services to Medicaid beneficiaries with select SMI/SED diagnoses in Michigan's Prepaid Inpatient Health Plan (PIHP) Regions 1, 2, 3, 4, 5, 6, 7, 8 and 9. The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicare and Medicaid Services to revise the current Behavioral Health Home (BHH) State Plan Amendment (SPA). This revision aims to expand the BHH in three counties within Prepaid Inpatient Health Plan (PIHP) region 10. In addition to this expansion, MDHHS is seeking to add the following staff to the health home staffing structure: SOAR Navigator, Housing Specialist, and Parent Support Partner. This update will also involve revising health services to better reflect current roles and responsibilities.

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Home providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Home providers.
- The state provides assurance that FMAP for 1945 Health Home services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health home enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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 - MI2025MS0002O - (MI-25-1500) - Health Homes

1945 Health Home Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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- Health Home services will be available statewide
- Health Home services will be limited to the following geographic areas
- Health Home 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:

- Alcona
- Alger
- Allegan
- Alpena
- Antrim
- Arenac
- Baraga
- Barry
- Bay
- Benzie
- Berrien
- Branch
- Calhoun
- Cass
- Charlevoix
- Cheboygan
- Chippewa
- Clare
- Clinton
- Crawford
- Delta
- Dickinson
- Eaton
- Emmet
- Genesee
- Gladwin
- Gogebic
- Grand Traverse
- Graiot
- Hillsdale
- Houghton
- Huron
- Ingham
- Ionia
- Iosco
- Iron
- Isabella
- Jackson
- Kalamazoo
- Kalkaska
- Kent
- Keweenaw

43. Lake
44. Leelanau
45. Lenawee
46. Livingston
47. Luce
48. Mackinac
49. Macomb
50. Manistee
51. Marquette
52. Mason
53. Mecosta
54. Menominee
55. Midland
56. Missaukee
57. Monroe
58. Montcalm
59. Montmorency
60. Muskegon
61. Newaygo
62. Oakland
63. Oceana
64. Ogemaw
65. Ontonagon
66. Osceola
67. Oscoda
68. Otsego
69. Ottawa
70. Presque Isle
71. Roscommon
72. Saginaw
73. St. Clair
74. St. Joseph
75. Sanilac
76. Schoolcraft
77. Shiawassee
78. Tuscola
79. Van Buren
80. Washtenaw
81. Wayne
82. Wexford

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1945 Health Home Providers

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Types of Health Home Providers

Designated Providers

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

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

Provider Type	Description
Lead Entity (LE)	<ul style="list-style-type: none"> • Be a regional entity as defined in Michigan's Mental Health Code (330.1204b). • Must contract with and pay a negotiated rate to HHPs, • Must maintain a network of providers that support the BHHs to service beneficiaries with a serious mental illness/serious emotional disturbance diagnosis, • Have authority to access Michigan Medicaid claims and encounter data for the BHH target population, • Have authority to access Michigan's Waiver Support Application and CareConnect360, • Provides leadership for implementation and coordination of health home activities, • Serves as a liaison between the health homes site and MDHHS

Provider Type	Description
	<p>staff/contractors,</p> <ul style="list-style-type: none"> • Champions practice transformation based on health home principles, • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities, • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitors Health Home performance and leads quality improvement efforts, • Designs and develops prevention and wellness initiatives, and referral tracking, • Must have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including: <ul style="list-style-type: none"> o Identification of providers who meet the BHH standards, o Provision of infrastructure to support BHHs in care coordination, o Collecting and sharing member-level information regarding health care utilization and medications, o Providing quality outcome protocols to assess BHH effectiveness, and o Developing training and technical assistance activities that will support BHH in effective delivery of health home services.
Health Home Partner (HHP)	<p>Provider Qualifications and Standards:</p> <p>The HHP must:</p> <ul style="list-style-type: none"> • Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. • Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following: <ul style="list-style-type: none"> o Community Mental Health Services Programs (CMHSPs) o Federally Qualified Health Center/Primary Care Safety Net Clinic o Rural Health Clinic o Tribal Health Center o Clinical Practices or Clinical Group Practices o Community/Behavioral Health Agencies

1945 Health Home Providers

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Teams of Health Care Professionals

Health Teams

1945 Health Home Providers

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

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

- Health Home Director (0.25 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SOAR Navigator, Housing Specialist (3.00-5.00 FTE)
- Medical Consultant (.10 FTE)
- Psychiatric Consultant (.10 FTE)

All providers referenced above must meet the following criteria:

Health Home Director

- Provides leadership for implementation and coordination of health home activities

Behavioral Health Specialist

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

Nurse Care Manager

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

Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SOAR Navigator, Housing Specialist

- Appropriate certification/training

Medical Consultant

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

Psychiatric Consultant

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

In addition to the above Required Provider Infrastructure Requirements, eligible BHH providers should coordinate care with the following professions:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

Supports for Health Home Providers

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

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Home services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance use disorder services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

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

Other Health Home Provider Standards

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

The Michigan BHH Lead Entity (LE) must:

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

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

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

(See attached for further requirements of the LE and HHPs)

Document is titled "MDHHS Behavioral Health Home Provider Requirements and Expectations- FINAL "

Name	Date Created	
MDHHS Behavioral Health Home Provider Requirements and Expectations- FINAL (8-11-25)	8/12/2025 10:08 AM EDT	

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1945 Health Home Payment Methodologies

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Payment Methodology

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

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

Describe below

See P4P section of the payment methodology.

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

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

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS00020	SPA ID	MI-25-1500
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	System-Derived		

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

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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

Provider Type

Established in 2014, Michigan's Behavioral Health Home (BHH) supports chronically ill Medicaid and Healthy Michigan Plan beneficiaries in managing their conditions through an intensive level of care management and coordination. Enrollment in the BHH program is offered to beneficiaries with a serious and persistent mental health condition, also referred to as serious mental illness (SMI) or serious emotional disturbance (SED).

Health home services provide integrated, person-centered, and comprehensive care to eligible beneficiaries, addressing the complexity of comorbid physical and behavioral health conditions. Michigan's BHH model is comprised of a team, including a Lead Entity (LE) and contracted, Health Home Partners (HHPs). The LE is responsible for the payment and programmatic oversight of the health home model and HHPs must provide the six federally mandated core health home services.

Care Management PMPM Rate

Summary

BHH PMPM rates based on the current staffing structure were established in 2020. To support the program's continued success, MDHHS has developed revised SFY 2026 rates. The largest contributor to the case rate increase is the shift from 2019 salary benchmarks to estimated SFY 2026 staffing expenses. Additional contributors include the addition of the SOAR navigator and housing specialist as optional care team members.

As described in the attachments (1) MDHHS BHH and SUDHH Case Rate Provider-Facing Memo 20250730 and (2) MDHHS BHH and SUDHH Case Rate Development 20250630, the BHH PMPM rate assumes a composite tier rate that reflects assumed utilization of different staffing assumptions to serve Intensive Acuity Tier and Moderate Acuity Tier beneficiaries. Assumed acuity distribution was developed by review of historical BHH beneficiary utilization patterns. As outlined in Figure 1 below, the composite BHH Case Rate is \$445.18.

FIGURE 1: Composite BHH AND SUDHH Case Rate Development

BHH acuity tiers	ASSUMED ACUITY DISTRIBUTION	CASE RATE BY TIER	CASE RATE COMPONENT
Moderate Acuity	74.30%	\$ 437.58	\$ 325.12
Intensive Acuity	25.70%	\$ 558.33	\$ 143.49
BHH Case Rate with P4P			\$ 468.61
5% P4P Withhold			\$ 23.43
BHH Case Rate			\$ 445.18

Indirect Costs

The composite rate above incorporates an indirect service cost load of 15%. This aligns the indirect cost load with federal guidance surrounding the maximum allowed de minimus rate outlined in 2 CFR § 200.414(f).

Caseload

The composite BHH rate was developed with a caseload assumption of one hundred beneficiaries.

Rate Development: Staffing Assumptions and Fringe Benefits

Below, in Figure 2, are staffing costs used to develop the BHH Moderate Acuity and Intensive Acuity Tier rates. These rates were then blended into a composite rate using the utilization assumptions in Figure 1.

Salary amounts were determined through MDHHS's annual cost comparison work, which leverages annual provider-reported salary and wage survey and—for the FY 2025 report—May 2025 Bureau of Labor Statistics data for Michigan. This information was then trended by an independent actuary to mid-point FY 2026 to arrive at the salary amounts provided in Figure 2.

The fringe rate, outlined in Figure 2, reflects 37.9% of the annual salaries and wages with estimated annual fringe benefit amounts rounded to the nearest thousand for each job position.

The rate development approach described above leverages annual MDHHS cost reporting along with trending and fringe

benefits reviewed by an independent actuary. As such, the rate development approach supports efficient and economical rates, consistent with 1902(a)(30)(A), as well as rates sufficient to maintain provider enrollment and cost effective in comparison to other service delivery models. Additionally, this approach allows for ongoing rate monitoring and evaluation on an annual basis.

Acuity Tiers and Case Rate Build Up

The Intensive Acuity tier, outlined below in Figure 2, includes staffing costs for an additional 2.0 FTEs than the Moderate Acuity Tier. These FTEs are associated with Peer Specialists, specifically the addition of 1.0 SOAR Navigator FTE and 1.0 Housing Specialist FTE.

FIGURE 2: BEHAVIORAL Health home case rate buildups by acuity level

A. BHH MODERATE ACUITY	FTE	SALARY	FRINGE	TOTAL
Health Home Director	0.25	\$ 106,000	\$ 40,000	\$ 36,500
Nurse Care Manager	1.00	\$ 93,000	\$ 35,000	\$ 128,000
Behavioral Health Clinician/ Behavioral Health Specialist	0.25	\$ 74,000	\$ 28,000	\$ 25,500
Peer Specialist	3.00	\$ 46,000	\$ 17,000	\$ 189,000
Medical Consultant	0.10	\$ 203,000	\$ 77,000	\$ 28,000
Psychiatric Consultant	0.10	\$ 360,000	\$ 136,000	\$ 49,600
Total Staff				4.70
Total Staff Cost				\$ 456,600
Indirect (15.0%)				\$ 68,490
Total Costs				\$ 525,090
Total Costs per 100 Beneficiaries per Month				\$ 437.58
Caseload Efficiency				100.0%
Total Costs per Encounter per Month with P4P				\$ 437.58

A. BHH INTENSIVE ACUITY	FTE	SALARY	FRINGE	TOTAL
Health Home Director	0.25	\$ 106,000	\$ 40,000	\$ 36,500
Nurse Care Manager	1.00	\$ 93,000	\$ 35,000	\$ 128,000
Behavioral Health Clinician/ Behavioral Health Specialist	0.25	\$ 74,000	\$ 28,000	\$ 25,500
Peer Specialist	5.00	\$ 46,000	\$ 17,000	\$ 315,000
Medical Consultant	0.10	\$ 203,000	\$ 77,000	\$ 28,000
Psychiatric Consultant	0.10	\$ 360,000	\$ 136,000	\$ 49,600
Total Staff				6.70
Total Staff Cost				\$ 582,600
Indirect (15.0%)				\$ 87,390
Total Costs				\$ 669,990
Total Costs per 100 Beneficiaries per Month				\$ 558.33
Caseload Efficiency				100.0%
Total Costs per Encounter per Month with P4P				\$ 558.33

Unit(s) of Service

A unit of service is defined as one billable unit per service month. To be reimbursed for a billable unit of service, HHPs must provide one of the six required health home services. The PMPM rate will be paid for each unit of service. Once a patient has consented to receive services and has been enrolled in the health home program, the PMPM rate can be billed.

Provider Payment

MDHHS provides a PMPM rate to the LE based on the number of enrolled beneficiaries. Contracted health home partners must deliver one of the six required health home services to receive payment from the LE. This monthly payment is subject to recoupment from the LE if the beneficiary does not receive a health home service during the calendar month.

Service Documentation

HHPs must submit the BHH service encounter code in addition to any pertinent International Classification of Disease, Tenth Revision, Z codes (to indicate the many applicable social determinants of health) to the LE.

Payment for health home services is dependent on the submission of appropriate service encounter codes. Valid encounters must be submitted by HHPs to the LE within 90 days of providing a health home service to assure timely service verification. Health home staff must document all services provided to the beneficiary in the beneficiary's care plan.

Verification and Reconciliation of Encounters and Cost Data

MDHHS conducts ongoing reconciliation of Behavioral Health Home (BHH) encounters using a six-month retrospective review to verify documented service delivery against submitted encounters. If this review determines that a beneficiary did not receive a health home service in a given calendar month, MDHHS initiates recoupment of the PMPM rate from the LE.

Additionally, BHH program costs are documented and tracked in the Financial Status Report (FSR) submitted annually by LEs. The BHH program team works closely with MDHHS Accounting at yearend to resolve any discrepancies identified in the FSR and to complete final yearend reconciliation.

Pay for Performance (P4P) Methodology

P4P Eligibility

MDHHS will administer pay for performance (P4P) incentive payments to BHH providers based on performance on three quality measures aligned with NCQA HEDIS and Health Home Core Set specifications. The State selected these measures in collaboration with LEs and HHPs to reflect core elements of the BHH model and the needs of the target population. All HHPs who have been active in the BHH program for the entire performance year are eligible to receive P4P payments. The following performance measures and weights will be used and are subject to change in future years to align with evolving best practices, federal guidance, state priorities, and metric specifications. All measures will be maintained in the BHH

Handbook at <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/behavioral-health-home/provider-resources> :

- Follow-Up After Hospitalization (FUH-7) – weighted 50 percent
- Controlling High Blood Pressure (CBP-HH) – weighted 20 percent
- Access to Preventive/Ambulatory Health Services (AAP) – weighted 30 percent

These measures are specific to the BHH program. They are not duplicative of other Medicaid managed care incentive payment arrangement administered by PHIPs

P4P Benchmarks/Performance

For each measure, the State will compare an LE's regional BHH program performance to both the statewide and regional performance levels. Eligible providers will receive:

- 100 percent of the available P4P allocation for a measure if the BHH program performance exceeds both the statewide and regional benchmark.
- 75 percent of the measure allocation if the BHH program exceeds either the statewide or the regional benchmark, but not both.
- 0 percent of the allocation if neither benchmark is exceeded and the measure does not meet inclusion thresholds, scoring follows the redistribution rules described in the SPA and BHH Handbook at <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/behavioral-health-home/provider-resources> .

The State applies this scoring methodology uniformly across all eligible providers to ensure transparency, consistency, and equitable application of the P4P framework

P4P Timeline

The Measurement Year (MY) is defined as the first year the BHH SPA is in effect. During the MY, MDHHS will establish baseline performance values. HHPs are eligible for P4P payments for meeting defined process requirements as described in the BHH Handbook at <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/behavioral-health-home/provider-resources> .

Each subsequent fiscal year in which the BHH SPA is in effect is defined as a Performance Year (PY). Within nine months following the end of each PY, the State will evaluate the HHPs performance and notify LEs of their P4P determinations. LEs must distribute earned incentive payments to contracted HHPs within 30 calendar days of receiving payment from the State. LEs must submit a P4P distribution plan to the State before receiving the incentive payment and distributing the funds to the HHPs.

P4P Redistribution

A performance measure will be included in the P4P scoring pool only when the numerator is at least 5 and the denominator is at least 30. If a measure does not meet these thresholds, the P4P allocation for that measure will be redistributed equally across the remaining eligible measures. This ensures that incentive resources remain tied to regions that demonstrate consistent service delivery and compliance with program requirements.

If performance benchmarks for a give PY are not met, the State will distribute the full P4P pool equally among eligible providers, maintaining a recoupment rate below 30% during the PY. Subsequent PYs will operate in accordance with this structure.

P4P Transparency/Consistency

The State ensures transparency and consistency in administering the P4P methodology through:

1. Uniform application of benchmarking and scoring across all LE regions using standardized measure specifications and consistent data validation procedures, including automated checks, numerator/denominator reconciliation, and provider appeal processes.
2. Clear payment flow requirements, whereby LEs must:
 - Pass through no less than 95 percent of P4P payments to HHPs;
 - Retain no more than 5 percent for allowable administrative activities directly tied to BHH operations;
 - Remit all P4P payments to HHPs within 30 calendar days of receipt.
3. Annual reporting, through which the State provides LEs with final P4P results, measure-level performance, payment allocations, and calculation methodologies. Summary results are presented annually to all participating LEs.
4. Ongoing data oversight, including encounter validation, minimum data completeness standards, and required participation in technical assistance or corrective action processes as needed.

These provisions ensure the P4P methodology is transparent, equitable, and consistently applied across all LEs and HHPs.

Rebasing Rates

MDHHS will rebase rates at a minimum once every three years. Consistent with SFY 2026 rates, MDHHS will utilize an outside actuary to review salary and wage data, apply appropriate trending, and incorporate relevant program requirements, to establish rates that are cost effective, efficient, and sufficient to support quality services.

Managed Care Considerations

Payment policies have been developed to prevent duplication of care management activities and to coordinate payment for BHH services. MDHHS will also ensure compliance with applicable state and federal audit and documentation requirements.

See rate workup and other documentation attached.

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Assurances

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

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

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

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

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

Optional Supporting Material Upload

Name	Date Created	
MDHHS BHH and SUDHH Case Rate Provider-Facing Memo 20250730	11/13/2025 3:50 PM EST	
MDHHS BHH and SUDHH Case Rate Development 20250630	11/13/2025 3:50 PM EST	

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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Service Definitions

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

Comprehensive Care Management

Definition

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

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

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

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

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists

Description

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

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,

- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

Nurse Practitioner

Description

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

Nurse Care Coordinators

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

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

Nurses

Medical Specialists

Physicians

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Physician's Assistants

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Provider Type	Description
Medical Assistant	(Must have appropriate certification/training) <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,

Provider Type	Description
	<ul style="list-style-type: none"> • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> • Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.
Youth Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports youth/young adults to identify personal barriers and challenges, • Encourages increased engagement in services, if identified by youth/young adult, • Empowers youth/young adult to identify and connect to additional community supports and resources when this support is requested by youth/young adult, • Supports youth/young adult to advocate for their needs, preferences, and goals, • Collaborates with the agency and care team to ensure information is accessible, youth-friendly and understandable, • Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Parent Support Partner	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports parent/caregiver to identify barriers to participation or progress • Encourages increased engagement in services, as identified by parent/caregiver • Empowers families to identify and access additional community supports and resource, when this support is requested by parent/caregiver • Supports parent/caregiver to advocate effectively for their family's needs, • Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable, • Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, • Assists in the development of social networks and community connections, when desired by the parent/caregiver, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups,

Provider Type	Description
Community Health Worker	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, • Collects medical records and additional information to complete SSI/SSDI applications, • Prepares SOAR medical summaries for SSI/SSDI applications, • Accompanies beneficiaries to appointments at the Social Security Administration, • Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> • Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, • Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing • Collaborates with beneficiaries to develop personalized housing goals and objectives • Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, • Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, • Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, • Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, • Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking,

Provider Type

Description

- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Coordinates and provides access to chronic disease management including self-management support,
- Implements wellness and prevention initiatives,
- Facilitates health education groups,
- Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,
- Accompanies beneficiaries to appointments and support groups,
- Coordinates and provides access to individual and family supports, including referral to community social supports, and,
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

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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.

Key support roles include Peer Support Specialists and Peer Recovery Coaches. Peer support services and peer recovery services are provided by an individual with a lived experience and journey in receiving public mental health and/or substance use disorder services and supports. The Peer Support Specialists and Peer Recovery Coaches helps to remove barriers and obstacles and links the beneficiary to resources in the recovery community.

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

Peer Support Specialists must be supervised by a Qualified Mental Health Professional (QMHP). The amount, duration, and scope of supervision can vary depending on the demonstrated competency and experience of the peer support provider, as well as the service array, and may range from direct oversight to periodic care consultation.

Peer Recovery Coaches must be supervised by a Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner.

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

Medical Assistants are multi-skilled health professionals specifically educated to work in ambulatory care settings performing both administrative and clinical duties. MAs help support care coordination for beneficiaries by scheduling appointments, arranging hospital admissions and laboratory services, instructing patient about medication and special diets, preparing and administering medications, and authorizing prescription refills.

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

Peer Support Specialists, CHWs, MAs, and other Care Coordinators will, at a minimum, provide:

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

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

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

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists

Description

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

unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

Nurse Practitioner

Description

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

Nurse Care Coordinators

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

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

Nurses

Medical Specialists

Physicians

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Physician's Assistants

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

- Dieticians
- Nutritionists
- Other (specify)

Provider Type	Description
Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Community Health Worker	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, • Collects medical records and additional information to complete SSI/SSDI applications, • Prepares SOAR medical summaries for SSI/SSDI applications, • Accompanies beneficiaries to appointments at the Social Security Administration, • Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Provider Type	Description
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> • Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, • Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing • Collaborates with beneficiaries to develop personalized housing goals and objectives • Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, • Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, • Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, • Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, • Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Medical Assistant	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> • Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS00020	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	02/05/2026	Effective Date	10/1/2025
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	System-Derived		

Health Promotion

Definition

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

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

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

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

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider

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

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on managing a population of patients versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

Nurse Practitioner

Description

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

Nurse Care Coordinators

Nurses

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

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

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Provider Type	Description
Peer Support Specialist	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Medical Assistant	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management

Provider Type	Description
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> ▪ Provide leadership for implementation and coordination of health home activities, ▪ Serve as a liaison between the health homes site and MDHHS staff/contractors, ▪ Champion practice transformation based on health home principles, ▪ Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, ▪ Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, ▪ Monitor health home performance and leads quality improvement efforts, ▪ Design and develops prevention and wellness initiatives, and referral tracking.
Community Health Worker	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> ▪ Conducts referral tracking, ▪ Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, ▪ Coordinates and provides access to chronic disease management including self-management support, ▪ Implements wellness and prevention initiatives, ▪ Facilitates health education groups, ▪ Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, ▪ Accompanies beneficiaries to appointments and support groups, ▪ Coordinates and provides access to individual and family supports, including referral to community social supports, and, ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> ▪ Conducts referral tracking, ▪ Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, ▪ Coordinates and provides access to chronic disease management including self-management support, ▪ Implements wellness and prevention initiatives, ▪ Facilitates health education groups, ▪ Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, ▪ Accompanies beneficiaries to appointments and support groups, ▪ Coordinates and provides access to individual and family supports, including referral to community social supports, and, ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

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MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS00020	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
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	System-Derived		

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

Definition

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

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

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

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

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider

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

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

- Nurse Practitioner

Description

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

Nurse Care Coordinators

Nurses

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

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

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

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

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Provider Type	Description
Lead Entity	<ul style="list-style-type: none">• Provide leadership for implementation and coordination of health home activities,• Serve as a liaison between the health homes site and MDHHS staff/contractors,• Champion practice transformation based on health home principles,• Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities,• Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management,• Monitor health home performance and leads quality improvement efforts,• Design and develops prevention and wellness initiatives, and referral tracking.
Community Health Worker	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,

Provider Type	Description
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, • Collects medical records and additional information to complete SSI/SSDI applications, • Prepares SOAR medical summaries for SSI/SSDI applications, • Accompanies beneficiaries to appointments at the Social Security Administration, • Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> • Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, • Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing • Collaborates with beneficiaries to develop personalized housing goals and objectives • Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, • Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, • Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, • Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, • Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • Meets regularly with the care team to plan care and discuss cases, and

Provider Type	Description
	exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Medical Assistant	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Health Home Partners	Any of the selected provider types above at the HHP.

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Package Header

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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 advanced directives
- *Assistance with maximizing level of functioning in the community

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

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

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider

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

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

Nurse Practitioner

Description

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

Nurse Care Coordinators

Description

Nurse Care Manager
(Licensed Registered Nurse, Licensed Practical Nurse)

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

Nurses

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

Other (specify)

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Provider Type	Description
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Youth Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports youth/young adults to identify personal barriers and challenges, • Encourages increased engagement in services, if identified by youth/young adult, • Empowers youth/young adult to identify and connect to additional community supports and resources when this support is requested by youth/young adult, • Supports youth/young adult to advocate for their needs, preferences,

Provider Type	Description
Parent Support Partner	<p>and goals,</p> <ul style="list-style-type: none"> ▪ Collaborates with the agency and care team to ensure information is accessible, youth-friendly and understandable, ▪ Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, and ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic. <p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> ▪ Supports parent/caregiver to identify barriers to participation or progress ▪ Encourages increased engagement in services, as identified by parent/caregiver ▪ Empowers families to identify and access additional community supports and resource, when this support is requested by parent/caregiver ▪ Supports parent/caregiver to advocate effectively for their family's needs, ▪ Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable, ▪ Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, ▪ Assists in the development of social networks and community connections, when desired by the parent/caregiver, and ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> ▪ Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, ▪ Collects medical records and additional information to complete SSI/SSDI applications, ▪ Prepares SOAR medical summaries for SSI/SSDI applications, ▪ Accompanies beneficiaries to appointments at the Social Security Administration, ▪ Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, ▪ Coordinates and provides access to individual and family supports, including referrals to community social supports, and ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> ▪ Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, ▪ Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing ▪ Collaborates with beneficiaries to develop personalized housing goals and objectives ▪ Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, ▪ Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, ▪ Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, ▪ Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, ▪ Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, ▪ Coordinates and provides access to individual and family supports, including referrals to community social supports, and ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Provider Type	Description
Community Health Worker	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Medical Assistant	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinant of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> • Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities, • Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management, • Monitor health home performance and leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS00020 | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS00020	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	02/05/2026	Effective Date	10/1/2025
Superseded SPA ID	MI-24-1500		
	System-Derived		

Referral to Community and Social Support Services

Definition

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

*Collaboration/coordination with community-based organizations and other key community stakeholders

*Emphasis on resources closest to the patient's home with least barriers

*Identification of community-based resources

*Availability of resource materials pertinent to patient needs

*Assist in attainment of other resources, including benefit acquisition

*Referral to housing resources as needed

*Referral tracking and follow-up

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

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

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider

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

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

Nurse Practitioner

Description

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

Nurse Care Coordinators

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in the initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
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Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

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Other (specify)

Description

Physicians, Nurse Practitioner, Physician's Assistant

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Description

Physicians, Nurse Practitioner, Physician's Assistant

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

Provider Type	Description
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> • Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, • Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing • Collaborates with beneficiaries to develop personalized housing goals and objectives • Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, • Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, • Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, • Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, • Builds and maintains relationships with landlords, property managers,

Provider Type	Description
	<p>and community organizations to expand housing options for beneficiaries,</p> <ul style="list-style-type: none"> ▪ Coordinates and provides access to individual and family supports, including referrals to community social supports, and ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Community Health Worker	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> ▪ Conducts referral tracking, ▪ Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, ▪ Coordinates and provides access to chronic disease management including self-management support, ▪ Implements wellness and prevention initiatives, ▪ Facilitates health education groups, ▪ Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, ▪ Accompanies beneficiaries to appointments and support groups, ▪ Coordinates and provides access to individual and family supports, including referral to community social supports, and, ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> ▪ Conducts referral tracking, ▪ Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, ▪ Coordinates and provides access to chronic disease management including self-management support, ▪ Implements wellness and prevention initiatives, ▪ Facilitates health education groups, ▪ Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, ▪ Accompanies beneficiaries to appointments and support groups, ▪ Coordinates and provides access to individual and family supports, including referral to community social supports, and, ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> ▪ Conducts referral tracking, ▪ Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, ▪ Coordinates and provides access to chronic disease management including self-management support, ▪ Implements wellness and prevention initiatives, ▪ Facilitates health education groups, ▪ Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, ▪ Accompanies beneficiaries to appointments and support groups, ▪ Coordinates and provides access to individual and family supports, including referral to community social supports, and, ▪ Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Provider Type	Description
Youth Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports youth/young adults to identify personal barriers and challenges, • Encourages increased engagement in services, if identified by youth/young adult, • Empowers youth/young adult to identify and connect to additional community supports and resources when this support is requested by youth/young adult, • Supports youth/young adult to advocate for their needs, preferences, and goals, • Collaborates with the agency and care team to ensure information is accessible, youth-friendly and understandable, • Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Parent Support Partner	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports parent/caregiver to identify barriers to participation or progress • Encourages increased engagement in services, as identified by parent/caregiver • Empowers families to identify and access additional community supports and resource, when this support is requested by parent/caregiver • Supports parent/caregiver to advocate effectively for their family's needs, • Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable, • Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, • Assists in the development of social networks and community connections, when desired by the parent/caregiver, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, • Collects medical records and additional information to complete SSI/SSDI applications, • Prepares SOAR medical summaries for SSI/SSDI applications, • Accompanies beneficiaries to appointments at the Social Security Administration, • Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Medical Assistant	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> • Provide leadership for implementation and coordination of health home activities,

Provider Type

Description

- Serve as a liaison between the health homes site and MDHHS staff/contractors,
- Champion practice transformation based on health home principles,
- Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (CMHSPs) and inpatient facilities,
- Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management,
- Monitor health home performance and leads quality improvement efforts,
- Design and develops prevention and wellness initiatives, and referral tracking.

1945 Health Home Services

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Health Home Patient Flow

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

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

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

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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