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State/Territory Name: Wisconsin

State Plan Amendment (SPA) #: 22-0013

This file contains the following documents in the order listed:

WI - Submission Package - WI2022MS0003O - (WI-22-0013) - Health Homes

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

Center for Medicaid & CHIP Services

September 15, 2022

Lisa Olson
Medicaid Director
Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53701

Re: Approval of State Plan Amendment WI-22-0013 SUD Health Home

Dear Ms. Olson,

On June 27, 2022, the Centers for Medicare and Medicaid Services (CMS) received Wisconsin State Plan Amendment (SPA) WI-22-0013. The SPA proposes to revise the maximum fee rates for substance use disorder (SUD) health home rates. Two new billing tiers have been added to the per-member-per-month reimbursement rate that providers receive for administering the six core health home services. The billing requirements to qualify for tiers of reimbursement will no longer be determined by direct time (time spent with the member in-person or via telehealth) but rather by delivery of core service time.

We approve Wisconsin State Plan Amendment (SPA) WI-22-0013 with an effective date(s) of May 01, 2022.

If you have any questions regarding this amendment, please contact Mai Le-Yuen at 312.353.2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

James G. Scott

Director

Center for Medicaid & CHIP Services

WI - Submission Package - WI2022MS0003O - (WI-22-0013) - Health Homes

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

CMS-10434 OMB 0938-1188

Package Header

Package ID WI2022MS0003O

SPA ID WI-22-0013

Submission Type Official

Initial Submission Date 6/27/2022

Approval Date 9/15/2022

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Wisconsin

Medicaid Agency Name: Department of Health Services

Submission Component

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

Submission - Summary

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Approval Date 9/15/2022

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID WI-22-0013

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Population and Enrollment Criteria	5/1/2022	WI-21-0012
Health Homes Payment Methodologies	5/1/2022	WI-21-0012
Health Homes Services	5/1/2022	WI-21-0012
Health Homes Monitoring, Quality Measurement and Evaluation	5/1/2022	WI-21-0012

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID WI2022MS0003O
SPA ID WI-22-0013
Submission Type Official
Initial Submission Date 6/27/2022
Approval Date 9/15/2022
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The Department proposes changes to the Medical Assistance (MA) maximum fee rates for substance use disorder (SUD) Health Home rates. Two new billing tiers have been added to the per-member-per-month reimbursement rate that providers receive for administering the six core health home services. The billing requirements to qualify for tiers of reimbursement will no longer be determined by direct time (time spent with the member in-person or via telehealth) but rather by delivery of core service time, regardless of whether the member is present.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	$289999
Second	2023	$695997

Federal Statute / Regulation Citation

Section 1945 of the Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
WI 22-0013 Submission Package.	7/13/2022 4:10 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
Submission Type	Official	**Initial Submission Date**	6/27/2022
Approval Date	9/15/2022	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

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

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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WI - Submission Package - WI2022MS0003O - (WI-22-0013) - Health Homes

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

CMS-10434 OMB 0938-1188

Package Header

Package ID WI2022MS0003O
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Categories of Individuals and Populations Provided Health Home Services

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

☑ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

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

Families and Adults

☑ Medically Needy Children Age 18 through 20

☑ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☑ Medically Needy Aged, Blind or Disabled

☑ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with:

- [ ] Two or more chronic conditions
- [x] One chronic condition and the risk of developing another

Specify the conditions included:

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

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

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

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

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

https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf
https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4789.pdf
https://www.drugabuse.gov/sites/default/files/soa.pdf

- [ ] One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

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

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

Describe the process used:

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

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

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

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Health Homes Payment Methodologies

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Payment Methodology

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

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

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided
Hub providers may bill one of Five tiers of services per member per month (PMPM) depending on the intensity of services provided. Hub and spoke providers must meet minimum core service hours to be reimbursed for each of the Five intensity tiers.
Members receiving high intensity Level 5 services are reevaluated regularly to determine the appropriateness of this level of service.

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

Health Homes Payment Methodologies

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SPA ID WI-22-0013

Initial Submission Date 6/27/2022

Effective Date 5/1/2022

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

5/1/2022

Website where rates are displayed

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

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

1. The costs built into the rate for each intensity level are based on the number of expected hours spent administering the six core services per member per month, the distribution of professionals expected to administer those services, the cost of employing these professionals, and the associated administrative overhead costs. The estimated number of hours spent at each intensity level and the distribution of professionals accounting for these hours are based on data provided by the pilot sites, a review of comparable services at the state and national level, and the expertise of state program sta . The cost of employing the professionals is based on salaries provided by the pilot sites, the reimbursement of similar professional for other Wisconsin Medicaid services, and Wisconsin Department of Workforce Development (DWD) data.
2. Hubs and Spokes are teams of providers supported by a PMPM payment. Payment will be made monthly, covering the previous month's service by Hub site providers. Providers will be required to use the following Healthcare Common Procedure Coding System procedure codes when submitting professional claims for reimbursement:H001: Comprehensive Annual AssessmentH006: Monthly Engagement in Services.
3. Hub providers may bill for the comprehensive assessment once for each new member that enrolls in the health home and annually for members whose health and support needs dictate the need.
Providers must meet minimum core service hours requirements to bill each intensity level for a given member. The corresponding intensity levels and core health home service hours are as follows:
Level 1 - 1 hour of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 2 - 4.5 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 3 - 8 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 4 - 13 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
Level 5 - 18 hours of core services plus one direct contact (either face-to-face, over the phone, or via telehealth)
The core hours do not include the provision of any services that are reimbursed under other Medicaid bene ts and only the six Health Home Services are paid or reimbursed under the methodology described in this SPA. Hours spent conducting the initial assessment do not count toward the minimum service requirements.
Health home providers must submit a claim to receive payment.
4. Hub providers are required to submit quarterly reports that include core hours spent with each member, and record of a direct contact with each member. These reports will be reviewed against submitted claims to ensure that the proper intensity level was billed for each member. Hub providers are also required to ll out a complexity scale for each member during their comprehensive assessment.. Hub providers are expected to update this complexity scale for a member if their condition changes.
5. The PMPM method will be reviewed periodically to determine if the rate is economically efficient and consistent with quality of care. Rates will be updated accordingly.

Periodically language was added to give us flexibility to do exactly what we did when we made the last update to include more intensity levels for reimbursement. This means when potential inefficiencies are either brought to our attention by the pilot sites, or identified by DHS through program review.

Health Homes Payment Methodologies

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Assurances

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

Describe below how non-duplication of payment will be achieved

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

The State assures that no duplication of services and reimbursement. Case management, the only similar service, we require the pilot sites to coordinate with the other entities (HMO, MCO, Counties) which provide case management to ensure no duplication of services. If a member is enrolled in an MCO or HMO that also provides care coordination related services, each entity (the Health Home and the MCO/HMO) must designate a sole point of contact to coordinate care and determine roles for non-duplication of services. In addition, we also explicitly directed the Hub site that operates in the county in which the AIDS/HIV Health Home operates to not enroll a member who was also enrolled in the AIDS/HIV Health Home, or to perform enrollment options counseling in tandem with the AIDS/HIV Health Home staff to help the member determine which Health Home would best meet that member's needs. So, there can be only one HH serving a member at a time.

☑ 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	
Hub and Spoke SPA Redline_Pages	9/8/2022 4:09 PM EDT	
Hub and Spoke SPA Clean Pages	9/8/2022 4:10 PM EDT	

This view was generated on 9/27/2022 2:46 PM EDT

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Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

CMS-10434 OMB 0938-1188

Package Header

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User-Entered

Service Definitions

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

Comprehensive Care Management

Definition

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

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

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

☑ Nurse Practitioner

Description

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

☑ Nurse Care Coordinators

Description

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

- [ ] Nurses
- [ ] Medical Specialists
- [x] Physicians

Description

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

- [x] Physician's Assistants

Description

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

- [ ] Pharmacists
- [x] Social Workers

Description

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

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

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

Care Coordination

Definition

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description

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

- [ ] Nurse Practitioner

☑ Nurse Care Coordinators

Description

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

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☑ Social Workers

Description

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

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

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

Health Promotion

Definition

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

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

The H&S team will also provide health education to the member and their self-identified support systems regarding chronic conditions, prevention education, and promoting healthy lifestyle choices, such as:

- Smoking prevention and cessation
- Stress reduction
- Nutritional counseling
- Obesity reduction and prevention
- Engaging in regular physical activity
- Disease-specific or chronic care management
- Personal goal-setting for wellness and recovery

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

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

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

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

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

member in identifying and accessing health promotion activities and resources.

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

Description

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

- [x] Nurses

Description

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

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

Description

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

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

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

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

Definition

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description

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

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

Description

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

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

Description

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

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

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

Individual and Family Support (which includes authorized representatives)

Definition

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

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

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

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

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

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description

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

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

Description

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

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

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

Referral to Community and Social Support Services

Definition

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

- Benefit eligibility (disability, food share, etc.);
- Support to return to meaningful activity/work;

- Subsidized or supportive housing;
- Peer or family support;
- Legal services as appropriate;
- Others as appropriate

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

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

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

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

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

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

☐ Nurse Practitioner

☑ Nurse Care Coordinators

Description

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

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☑ Social Workers

Description

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

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

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

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

Package Header

Package ID	WI2022MS0003O	**SPA ID**	WI-22-0013
Submission Type	Official	**Initial Submission Date**	6/27/2022
Approval Date	9/15/2022	**Effective Date**	5/1/2022
Superseded SPA ID	WI-21-0012		
	User-Entered		

Health Homes Patient Flow

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

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

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

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

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

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WI - Submission Package - WI2022MS0003O - (WI-22-0013) - Health Homes

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

CMS-10434 OMB 0938-1188

Package Header

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Superseded SPA ID	WI-21-0012		
	User-Entered		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

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

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

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

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | WI2022MS0003O | WI-22-0013 | SUD Health Home-SUD-focused

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Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [x] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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