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State/Territory Name: **MICHIGAN**

State Plan Amendment (SPA) #: **20-1501**

This file contains the following documents in the order listed:

MI - Submission Package - MI2020MS0003O - (MI-20-1501) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	MI2020MS0003O	**Submission Type**	Official
Program Name	Opioid Health Home	**State**	MI
SPA ID	MI-20-1501	**Region**	Chicago, IL
Version Number	2	**Package Status**	Approved
Submitted By	Erin Black	**Submission Date**	7/1/2020
Package Disposition		**Approval Date**	9/9/2020 1:52 PM EDT
Priority Code	P2		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
Division of Program Operations
601 East 12th Street; Suite 0300
Kansas City, MO 64106

Center for Medicaid & CHIP Services

September 09, 2020

Robert Gordon
Director, Department of Health and Human Services
Michigan Department of Health and Human Services
400 S Pine
Lansing, MI 48909

Re: Approval of State Plan Amendment MI-20-1501 Opioid Health Home

Dear Robert Gordon:

On July 01, 2020, the Centers for Medicare and Medicaid Services (CMS) received Michigan State Plan Amendment (SPA) MI-20-1501 for Opioid Health Home to The Michigan Department of Health and Human Services (MDHHS) is seeking approval from Centers of Medicare and Medicaid Services (CMS) to revise the current Opioid Health Home (OHH) State Plan Amendment (SPA) to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination of services to Medicaid beneficiaries with an opioid use disorder diagnosis. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorder; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care..

We approve Michigan State Plan Amendment (SPA) MI-20-1501 on September 09, 2020 with an effective date(s) of October 01, 2020.

For payments made to Health Homes providers for Health Homes participants who newly qualify based on the Health Homes program's increased geographical coverage under this amendment, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 10/1/2020 to 9/30/2022.

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

Name	Date Created	
No items available		

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

Sincerely,

James G. Scott

Director

Center for Medicaid & CHIP Services

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date 9/9/2020
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 | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O
SPA ID MI-20-1501
Submission Type Official
Initial Submission Date 7/1/2020
Approval Date 9/9/2020
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID MI-20-1501

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2020	MI-18-1500
Health Homes Geographic Limitations	10/1/2020	MI-18-1500
Health Homes Population and Enrollment Criteria	10/1/2020	MI-18-1500
Health Homes Providers	10/1/2020	MI-18-1500
Health Homes Payment Methodologies	10/1/2020	MI-18-1500
Health Homes Services	10/1/2020	MI-18-1500

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID	MI2020MS0003O	**SPA ID**	MI-20-1501
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Approval Date	9/9/2020	**Effective Date**	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives

The Michigan Department of Health and Human Services (MDHHS) is seeking approval from Centers of Medicare and Medicaid Services (CMS) to revise the current Opioid Health Home (OHH) State Plan Amendment (SPA) to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination of services to Medicaid beneficiaries with an opioid use disorder diagnosis. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorder; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's OHH model is comprised of a team of providers, including a Lead Entity (LE) and its contracted designated Health Home Partners (HHP). Providers must meet the specific qualifications set forth in the SPA, this policy, and provide the six federally required core health home services. Michigan's OHHs must coordinate with other community-based providers to manage the full breadth of beneficiary needs.

MDHHS will provide a monthly case rate to the LE based on the number of OHH beneficiaries with at least one OHH service during a given month. HHPs must contract or establish a memorandum of understanding (MOU) with an LE in order to be a designated HHP and to receive payment. The LE will reimburse the HHP for delivering health home services. Finally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$6200000
Second	2022	$6200000

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 | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

Package ID MI2020MS0003O

SPA ID MI-20-1501

Submission Type Official

Initial Submission Date 7/1/2020

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Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

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

Describe Kate Massey, Director
Medical Services Administration

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

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Superseded SPA ID	MI-18-1500		
	User-Entered		

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

Opioid Health Home

Executive Summary

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

The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicaid and Medicare Services (CMS) to revise the current OHH SPA to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. Michigan's OHH model is comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHPs) that can best serve the needs of each unique beneficiary. HHPs will be comprised of two settings – HHP Opioid Treatment Programs (OTPs) and HHP Office Based Opioid Treatment Providers (OBOTs). The State will provide a monthly case rate to the LE based on OHH beneficiaries with at least one OHH service. The LE will pay HHPs directly on behalf of the State. LEs and HHPs must meet the provider qualifications set forth in the SPA, MDHHS policy and provide the six federally required core health home services. HHPs must contract or establish memorandums of understanding with a LE. The LE and HHPs must be connected to other community-based providers to manage the full breadth of beneficiary needs. Finally, MDHHS will employ a pay-for- performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT); 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

General Assurances

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

Health Homes Geographic Limitations

Package Header

Package ID MI2020MS0003O

SPA ID MI-20-1501

Submission Type Official

Initial Submission Date 7/1/2020

Approval Date 9/9/2020

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Superseded SPA ID MI-18-1500

User-Entered

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

Specify the geographic limitations of the program

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

Specify which counties:

1. Alcona
2. Alger
3. Alpena
4. Antrim
5. Baraga
6. Benzie
7. Calhoun
8. Charlevoix
9. Cheboygan
10. Chippewa
11. Crawford
12. Delta
13. Dickinson
14. Emmet
15. Gogebic
16. Grand Traverse
17. Houghton
18. Iosco
19. Iron
20. Kalamazoo
21. Kalkaska
22. Keweenaw
23. Leelanau
24. Luce
25. Mackinac
26. Macomb
27. Manistee
28. Marquette
29. Menominee
30. Missaukee
31. Montmorency
32. Ogemaw
33. Ontonagon
34. Oscoda
35. Otsego
36. Presque Isle
37. Roscommon
38. Schoolcraft
39. Wexford

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

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Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes 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

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

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Population Criteria

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

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

Specify the conditions included:

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

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

Opioid Use Disorder as represented by the F11 code in the ICD-10 dataset.

- [ ] One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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	User-Entered		

Enrollment of Participants

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

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

Name:

Hybrid Autoenrollment Process

Description:

Enrollment Processes
Potential Opioid Health Home (OHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The Lead Entity (LE) will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to fully enroll the Medicaid beneficiary into the OHH benefit. The selection of a health home provider is optional, the beneficiary may have other choices of health home providers, and the beneficiary may disenroll from the benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home is voluntary and the potential enrollee must agree to receive health home services and provide consent that is maintained in the enrollee's health record.

Lead Entities will provide information about the OHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. LEs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the OHH.

- Lead Entity Identification of Potential Enrollees

The LE will be responsible for identifying potential enrollees that have a qualifying OHH diagnosis in the WSA to a perspective HHP and provide information regarding OHH services to the Medicaid beneficiary in coordination with the HHP.

- Provider Recommended Identification of Potential Enrollees

Health Home Partners are permitted to recommend potential enrollees for the OHH benefit via the WSA. OHH providers must provide documentation that indicates whether a potential OHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of an individualized care plan. The LE must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

The LE will work with HHPs and the beneficiary to identify the optimal setting of care (e.g., Opioid Treatment Program vs. Office Based Opioid Treatment Provider, geographic considerations, historical relationships, etc.). The LE will document the assigned HHP in the WSA. The beneficiary may opt-out (disenroll) at any time with no impact on other entitled Medicaid services.

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

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

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

Provider Type	Description
Health Home Partner (HHP)	• Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. • Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following: o Community Mental Health Services Program (Community Mental Health Center) o Federally Qualified Health Center/Primary Care Safety Net Clinic o Hospital based Physician Group o Opioid Treatment Program o Physician based Clinic o Physician or Physician Practice o Rural Health Clinics o Substance Use Disorder Provider other than Opioid Treatment Program o Tribal Health Center

Provider Type	Description
Lead Entity (LE)	• Be a regional entity as defined in Michigan's Mental Health Code (330.1204b). • Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269). • Have authority to access Michigan Medicaid claims and encounter data for the OHH target population. • Have authority to access Michigan's WSA and CareConnect360. • Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including: • Identification of providers who meet the HHP standards • Provision of infrastructure to support HHPs in care coordination • Collecting and sharing member-level information regarding health care utilization and medications • Providing quality outcome protocols to assess HHP effectiveness • Developing training and technical assistance activities that will support HHPs in effective delivery of HH services • Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The LE will be responsible for recruiting health homes partners that provide an array of MAT options, including Opioid Treatment Programs (OTPs) and Office-based Opioid Treatment providers (OBOTs). OTPs must meet all state and federal licensing requirements of an OTP. OBOT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT. The following represents the care team requirement per 100 enrollees:

- Health Home Director (0.50 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker, Medical Assistant (2.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

All providers referenced above must meet the following criteria:

Health Home Director
- Must have professional working experience relative to Substance Use Disorders with leadership experience in care management and coordination activities

Behavioral Health Specialist
- Must have 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 a who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate

Nurse Care Manager
- Must be a licensed registered nurse in Michigan

Peer Recovery Coach, Community Health Worker or Medical Assistant
- Must obtain appropriate certification/training

Medical Consultant
- Must be a primary care physician, physician's assistant, or nurse practitioner

Psychiatric Consultant
- Must be a licensed psychologist, psychiatrist, psychiatric nurse practitioner (can be off-site)

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

Supports for Health Homes Providers

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

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

Description

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

Other Health Homes Provider Standards

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

The State's minimum requirements and expectations for Health Homes providers are as follows:

The Michigan OHH Lead Entity must:
1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
2. Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269).
3. Have authority to access Michigan Medicaid claims and encounter data for the OHH target population.
4. Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including:
   a. Identification of providers who meet the HHP standards
   b. Provision of infrastructure to support HHPs in care coordination
   c. Collecting and sharing member-level information regarding health care utilization and medications
      I. Providing quality outcome protocols to assess HHP effectiveness
      I) Developing training and technical assistance activities that will support HHPs in effective delivery of health home services
5. Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.
6. Must pay providers directly on behalf of the State for the OHH Program at the State defined rate.
7. The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the OHH with providers; MDHHS will retain overall oversight and direct administration of the LE; The LE will also serve as part of the Health Homes team by providing care management and care coordination services.

The Lead Entity and the Health Home Partner 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 OHH 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, screening for services 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, including recovery services, informed by evidence-based clinical practice guidelines
   c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
   d. Coordinate and provide access to physical, mental health, and substance use disorder 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
11. Ensure Priority Populations as outlined in amendment #2 in the LE contract with MDHHS, have priority assess to treatment. Access timeliness standards and interim services requirements for these populations are provided below.

Name	Date Created	
OHH Provider Requirements and Expectations V1 (3.23.20)	6/11/2020 2:06 PM EDT	PDF

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

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Payment Methodology

The State's Health Homes 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

Pay for Performance (see attached 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 attached.

- [ ] 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

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

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Agency Rates

Describe the rates used

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

Health Homes Payment Methodologies

Package Header

Package ID	MI2020MS0003O	**SPA ID**	MI-20-1501
Submission Type	Official	**Initial Submission Date**	7/1/2020
Approval Date	9/9/2020	**Effective Date**	10/1/2020
Superseded SPA ID	MI-18-1500		
	User-Entered		

Rate Development

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

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

Comprehensive Description See the payment methodology attached.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

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	User-Entered		

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 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	
OHH Payment Methodology V1 (3.23.20)	6/11/2020 2:17 PM EDT	

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

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

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

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 (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*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
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge

*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*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

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

- [ ] Physician's Assistants

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

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

Provider Type	Description
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • 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 • Training and technical assistance • Data management and reporting

Care Coordination

Definition

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

A key support role includes the Peer Recovery Coach and Community Health Worker (CHW). Peer Recovery Coach services are provided by a person in a journey of recovery from addictions or co-occurring disorders who identifies with a beneficiary based on a shared background and life experience. The Peer Recovery Coach serves as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as everyone determines his or her own way. The Peer Recovery Coach helps to remove barriers and obstacles and links the beneficiary to resources in the recovery community.

Services provided by a Peer Recovery Coach support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery, including outreach for persons who are still active in their addiction, up to and including individuals who have been in recovery for several years.

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

The Peer Recovery Coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of their choice to build recovery connections and supports. Utilizing a strength-based perspective and emphasizing assessment of recovery capital, services are designed to include prevention strategies and the integration of physical and behavioral health services to attain and maintain recovery and prevent relapse. Beneficiaries utilizing Peer Recovery Coach services must freely choose the individual who is providing Peer Recovery Coach services.

The Peer Recovery Coach shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.

CHWs are professionals identified by the American Public Health Association. CHWs are frontline public health workers who have an understanding of the community they serve. The CHW 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.

Peer Recovery Coaches, CHWs, and other Care Coordinators will, at a minimum, provide:
*Emphasis will be placed on in-person contacts; however telephonic outreach may be used for lower-risk Health Home members who require less frequent face to face contact
*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

LEs and HHPs will utilize their EHR to record care coordination and 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 (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*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
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
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*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*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
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Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • 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 • Training and technical assistance • Data management and reporting

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 care coordination and 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 (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*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
*Supports primary care providers in identifying and behaviorally intervening with patients
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*Develops and maintains relationships with community based mental health and substance abuse providers
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☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
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*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*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)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
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Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care services connect the beneficiary to needed health services available within the community. Health services include care provided outside of the health home. Health homes will be expected to coordinate and track their participants:
*Notification of admissions/discharge
*Receipt of care record, continuity of care document, or discharge summary
*Post-discharge outreach to assure appropriate follow-up services
*Medication reconciliation
*Pharmacy coordination
*Proactive care (versus reactive care)
*Specialized transitions when necessary (e.g., age, corrections)
*Home visits

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

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 (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
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*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
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☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.

Provider Type	Description
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • 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 • Training and technical assistance • Data management and reporting.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services reduce barriers to the beneficiaries' care coordination, increase skills and engagement and improve overall health outcomes. Specific activities may include, but are not limited to:
*Use of community supports (e.g., community health workers, peer supports, support groups, self-care programs, as appropriate)
*Facilitation of improved adherence to treatment
*Advocacy for individual and family needs
*Efforts to assess and increase health literacy
*Use of advance directives
*Assistance with maximizing level of functioning in the community
*Assistance with the development of social networks

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

The 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 (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*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
*Supports primary care providers in identifying and behaviorally intervening with patients
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*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including

mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
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- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
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- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
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Referral to Community and Social Support Services

Definition

Referrals to community and social support services provide recipients with referrals to a wide array of support services that help recipients overcome access or service barriers, increase self-management skills and improve overall health. Specific activities may include, but are not limited to:
*Collaboration/coordination with community-based organizations and other key community stakeholders
*Emphasis on resources closest to the patient's home with least barriers
*Identification of community-based resources

*Availability of resource materials pertinent to patient needs
*Assist in attainment of other resources, including benefit acquisition
*Referral to housing resources as needed
*Referral tracking and follow-up

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

While the community and social services supports network may not have direct access to the enrollee's health record, MDHHS anticipates that the 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 (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*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
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
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*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
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☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
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☐ Nurses

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☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • 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 • Training and technical assistance • Data management and reporting.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2020MS0003O | MI-20-1501 | Opioid Health Home

Package Header

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Health Homes Patient Flow

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

See attached.

Name	Date Created	
OHH Patient Flow V1 (7.28.20)	8/27/2020 10:55 AM EDT	

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