Table of Contents

State/Territory Name: MI

State Plan Amendment (SPA) #:16-0500-Cost Sharing

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) G2c Cost Sharing Form – Targeting – Revised 11-16-16

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 N. Michigan
Suite 600
Chicago, Illinois 60601

March 15, 2017

Chris Priest, Medicaid Director
Medical Services Administration
Michigan Department of Health and Human Services
400 South Pine Street, P.O. Box 30479
Lansing, Michigan 48909-7979

ATTN: Erin Black

Dear Mr. Priest:

Enclosed for your records is an approved copy of the following State Plan Amendment:

- Transmittal #: 16-1500: Health Homes – Technical Corrections
- Effective: October 1, 2016
- Approval Date: March 15, 2017

If you have any questions, please contact Keri Toback at (312) 353-1754 or keri.toback@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Date: 03/15/2017

Head of Agency: Nick Lyon

Title/Dept : Director, Department of Health and Human Services

Address 1: 400 S Pine

Address 2:

City : Lansing

State: MI

Zip: 48909

MACPro Package ID: MI2016MH0003O

SPA ID: MI-16-1500

Subject
Approval of 16-1500 Health Homes SPA Amendment

Dear Nick Lyon

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.
The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for an amendment to MI 16-1500.

Reviewable Unit	Effective Date
Health Homes Intro	10/1/2016
Health Homes Population and Enrollment Criteria	7/1/2014
Health Homes Geographic Limitations	10/1/2016
Health Homes Services	7/1/2014
Health Homes Providers	7/1/2014
Health Homes Service Delivery Systems	7/1/2014
Health Homes Payment Methodologies	7/1/2014
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2014

If you have any questions about this approval, please contact Keri Toback of my staff at (312) 353-1754 or keri.toback@cms.hhs.gov.

Sincerely,

Ruth Hughes
(Name)

None
(Title)

Approval Documentation

Name	Date Created	Type
No items available		

Package Information

Package ID MI2016MH0003O
Program Name Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions
SPA ID MI-16-1500
Version Number 3
Submitted By Erin Black
Package Disposition

Submission Type Official
State MI
Region Chicago, IL
Package Status Closed
Submission Date 12/29/2016
Approval Date 3/15/2017 5:13 PM EDT

Submission - Summary

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID MI2016MH0003O
Submission Type Official - Review 1
Approval Date 3/15/2017
Superseded SPA ID N/A

SPA ID MI-16-1500
Initial Submission Date 12/29/2016
Effective Date 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 Type

- (•) Official Submission Package
- ( ) Draft Submission Package

Allow this official package to be viewable by other states?
- ( ) Yes
- (•) No

Key Contacts

Name	Title	Phone Number	Email Address
Black, Erin	Federal Liaison, Medical Services Administration	(517)284-1192	blacke@michigan.gov

SPA ID and Effective Date

SPA ID MI-16-1500

Reviewable Unit	Proposed Effective Date
Health Homes Intro	10/1/2016
Health Homes Population and Enrollment Criteria	7/1/2014
Health Homes Geographic Limitations	10/1/2016
Health Homes Services	7/1/2014
Health Homes Providers	7/1/2014
Health Homes Service Delivery Systems	7/1/2014
Health Homes Payment Methodologies	7/1/2014
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2014

Executive Summary

Summary Description Including Goals and Objectives

This SPA 16-1500 is amending the existing SPA 14-0008. The effective date for payments is still July 1, 2014, per the current SPA 14-0008. As noted with the attached email submission done late December, this SPA 16-1500 is simply eliminating one pilot county effective October 1, 2016, and reflects a reduction in the anticipated federal funding of $900,000 related to this change. That is the only requested change to the existing Health Homes program. In the 2014-15 Michigan Executive Budget, the State committed to pilot Medicaid Health Homes in up to three regions for individuals with a serious and persistent mental health condition beginning July 1, 2014. Michigan will designate the community mental health service programs (CMHSPs) as Health Homes that will serve as the central point for directing patient-centered care among beneficiaries with a serious and persistent mental health condition and high rates of inpatient hospitalization or emergency department (ED) use. Individuals may also have a coexisting chronic medical condition (e.g., congestive heart failure, insulin dependent diabetes, chronic obstructive pulmonary disorder, seizure disorder, etc.). CMHSP Health Homes are accountable for reducing avoidable healthcare costs (specifically preventing hospital admissions/readmissions and avoidable emergency room visits) and providing timely post-discharge follow-up. Health Homes are intended to improve beneficiary outcomes by addressing whole-person healthcare needs through provisions of comprehensive, integrated behavioral health (mental health and substance use disorder), medical, care coordination and management services. Health Homes meet CMS' and Michigan's shared goal of improving beneficiary experience of care (including both care and experience), improving population health, and reducing per capita cost of healthcare spending.

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review

SPA ID MI-16-1500 replaces SPA ID MI.1125.R00.00 (Transmittal number MI-14-008)

Disaster-Related Submission

This submission is related to a disaster

- ○ Yes
- ◉ No

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2017	$900,000.00
Second	2018	$900,000.00

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Governor's Office Review

- ○ No comment
- ○ Comments received

Describe Chris Priest, Director
Medical Services Administration

- ○ No response within 45 days
- ◉ Other

Authorized Submitter

The following information will be provided by the system once the package is submitted to CMS.

Name of Authorized Submitter	Erin Black
Title	None
Phone number	5174104430
Email address	blacke@michigan.gov
Authorized Submitter's Signature	Erin Black

☑ I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

Submission - Public Comment

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID	MI2016MH0003O	**SPA ID**	MI-16-1500
Submission Type	Official - Review 1	**Initial Submission Date**	12/29/2016
Approval Date	3/15/2017	**Effective Date**	N/A
Superseded SPA ID	N/A		

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

Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not required and comment was not solicited
- ○ Public notice was not required, but comment was solicited
- ◉ Public notice was required and comment was solicited

Indicate how the public notice was issued and public comment was solicited

☑ Newspaper Announcement

Name of Paper	Date of Publication	Locations covered
Flint Journal	9/29/2016	Public notice was provided in accordance with 42 CFR 447.205 and was published in the newspaper.
Grand Rapids Press	9/29/2016	Public notice was provided in accordance with 42 CFR 447.205 and was published in the newspaper.
Kalamazoo Gazette	9/29/2016	Public notice was provided in accordance with 42 CFR 447.205 and was published in the newspaper.
Saginaw News	9/29/2016	Public notice was provided in accordance with 42 CFR 447.205 and was published in the newspaper.

☐ Publication in state's administrative record, in accordance with the administrative procedures requirements

☐ Email to Electronic Mailing List or Similar Mechanism

☐ Website Notice

☐ Public Hearing or Meeting

☐ Other method

Name	Date Created	Type
Newspaper Notice for Home Health SPA 16-1500	12/29/2016 11:35 AM EST	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	Type
No items available		

Indicate the key issues raised during the public comment period (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Tribal Input

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID MI2016MH0003O

SPA ID MI-16-1500

Submission Type Official - Review 1

Initial Submission Date 12/29/2016

Approval Date 3/15/2017

Effective Date N/A

Superseded SPA ID N/A

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

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- (•) Yes
- ( ) No

- [x] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner

- [ ] Indian Health Programs
- [ ] Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

☑ Indian Tribes

Name of Tribe	Date of consultation:	Method/Location of consultation:
All Michigan Tribes	10/10/2016	Letter to Tribal Chairs and Health Directors

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	Type
L_16-56_537440_7	12/29/2016 9:55 AM EST	PDF

Indicate the key issues raised (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

☐ Eligibility

☐ Benefits

☐ Service delivery

☐ Other issue

Submission - SAMHSA Consultation

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID MI2016MH0003O

SPA ID MI-16-1500

Submission Type Official - Review 1

Initial Submission Date 12/29/2016

Approval Date 3/15/2017

Effective Date N/A

Superseded SPA ID N/A

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

☑ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
3/27/2014

Health Homes Intro

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID	MI2016MH0003O	**SPA ID**	MI-16-1500
Submission Type	Official - Review 1	**Initial Submission Date**	12/29/2016
Approval Date	3/15/2017	**Effective Date**	10/1/2016
Superseded SPA ID	N/A		

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

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

This SPA 16-1500 is amending the existing Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions Health Homes Program. The effective date for payments is still July 1, 2014, per the current program. As noted with the attached email submission done late December, this SPA 16-1500 is simply eliminating one pilot county effective October 1, 2016, and reflects a reduction in the anticipated federal funding of $900,000 related to this change. That is the only requested change to the existing Health Homes program. In the 2014-15 Michigan Executive Budget the state committed to pilot Medicaid Health Homes in up to three regions for individuals with a serious and persistent mental health condition beginning July 1, 2014. Michigan will designate the community mental health service programs (CMHSPs) as Health Homes that will serve as the central point for directing patient-centered care among beneficiaries with a serious and persistent mental health condition and high rates of inpatient hospitalization or emergency department (ED) use. Individuals may also have a coexisting chronic medical condition (e.g., congestive heart failure, insulin dependent diabetes, chronic obstructive pulmonary disorder, seizure disorder, etc.). CMHSP Health Homes are accountable for reducing avoidable health care costs (specifically preventing hospital admissions/readmissions and avoidable emergency room visits) and providing timely post-discharge follow-up. Health Homes are intended to improve beneficiary outcomes by addressing whole-person health care needs through provision of comprehensive, integrated behavioral health (mental health and substance use disorder), medical, care coordination and management services. Health Homes meet CMS' and Michigan's shared goals of improving beneficiary experience of care (including both care and experience), improving population health, and reducing per capita cost of health care spending.

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 Population and Enrollment Criteria

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID	MI2016MH0003O	**SPA ID**	MI-16-1500
Submission Type	Official - Review 1	**Initial Submission Date**	12/29/2016
Approval Date	3/15/2017	**Effective Date**	7/1/2014
Superseded SPA ID	N/A		

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

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

☑ One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

The criteria are specified in Section 330.1100d of the Michigan Mental Health Code.

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

The MDHHS will use an automatic assignment with opt-out method to enroll eligible Medicaid beneficiaries into a Health Home. Individuals potentially eligible for Health Home services will be identified and assigned to a CMHSP Health Home using Medicaid claims and encounter data. The MDHHS will determine whether in addition to having a serious and persistent mental health condition the individual also has high rates of inpatient hospitalization or ED use with or without a chronic medical condition.

Upon assignment to a CMHSP Health Home individuals will be contacted to participate in a face-to-face encounter with the Home Health provider in order for the Health Home to conduct an orientation with the beneficiary to explain health home services, describe the process for the beneficiary to decline Health Home services, conduct or update a comprehensive health risk assessment, and conduct or update a comprehensive integrated care plan. The MDHHS may also elect to inform potentially eligible individuals via U.S. mail and other methods as necessary of the Health Home benefit (e.g., names of Health Home sites in the county, a brief description of health home services, and the process for individuals to opt-out of receiving health home services from the assigned Health Home provider).

Beneficiaries who opt out of the Health Home benefit will be permitted to elect to receive the Health Home benefit at any time as long as they continue to meet service eligibility requirements. Beneficiaries who opt out of receiving Health Home services may do so without jeopardizing their access to other medically necessary services from the Health Home provider.

Beneficiaries new to Medicaid or referred for the Health Home benefit from hospitals or other settings will be assessed for the Health Home benefit eligibility by the Health Home with an approval determination made by the MDHHS.

☑ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Name	Date Created	Type
Information on Beneficiary Opt Out Notice	12/29/2016 10:25 AM EST	PDF
CWN Health Home Opt-Out Form (9-10-14)	12/29/2016 11:17 AM EST	PDF

Health Homes Geographic Limitations

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID MI2016MH0003O

Submission Type Official - Review 1

Approval Date 3/15/2017

Superseded SPA ID N/A

SPA ID MI-16-1500

Initial Submission Date 12/29/2016

Effective Date 10/1/2016

- ○ 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. Grand Traverse
2. Manistee

Health Homes Services

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID MI2016MH0003O

Submission Type Official - Review 1

Approval Date 3/15/2017

Superseded SPA ID N/A

SPA ID MI-16-1500

Initial Submission Date 12/29/2016

Effective Date 7/1/2014

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 addresses all stages of health to maximize current functionality and prevent individuals from developing additional chronic conditions and complications. It consists of systematic processes to assess health risks and identify high risk sub- groups using health risk assessment/ health questionnaires; develop comprehensive integrated care plans to address all service needs; assign care management roles to Health Home team members; use standardized, evidence based, protocols and clinical pathways for management and monitoring of chronic conditions; monitor individual and population health status and service use to assure beneficiary adherence and application of clinical pathways by health care practitioners ; and develop and disseminate reports on satisfaction, health status, cost and quality to guide health home service delivery and design.

Nurse Care Managers complete comprehensive assessments, help beneficiaries identify and work toward personal health goals for improved self-management and provide health education customized to address health literacy levels and cultural preferences. Health Homes rely on care management information systems for individual and population care management, and provider teams follow evidence-based practice guidelines to foster access to care; use collaborative practice models that include the PCP and other care team providers; provide patient self-management support (may also involve other team members); work with beneficiaries to optimize control of their chronic conditions and prevent long-term complications; assist in transitions between settings; provide patient education with teach back to ensure understanding. Comprehensive care management services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Registered Nurse Care Manager or Primary Care Liaison, in collaboration with the consumer's mental health and SUD practitioners.

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

In addition to maintaining their own electronic health records (EHRs), Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home service components.

Care Coordination Tool
Michigan's Integrated Care Analytics Program (known as Care Connect 360 or CC 360) is a querying tool that enables providers to access comprehensive

retrospective Medicaid claims and encounter data to support care coordination services. CC 360 will contain lookup features so that Health Homes can view beneficiaries':
- Current and prior health conditions (e.g., SUD, COPD, CHF, diabetes)
- Rendering services provider, date of service and length of stay (as applicable)
- Prescription drug utilization history (e.g., Rx fill date, drug name, quantity, prescriber and pharmacy provider)
- History and reason for use of hospitalization and ED services, including diagnoses

Population Health Management Reports
Health Homes may also receive routine reports from PIHPs to support population health analysis, which can be used for identification of trends, predictive analysis, and care tracking to support and enrich beneficiary/provider monitoring functions that improve health outcomes, support integrated models of care, lower costs and enhance patient engagement in care. Reports enable creation of population health profiles, multi-morbidity and relative risk scores and the identification of care gaps (e.g., percentage of beneficiaries with diabetes who have not received a urine protein test).

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] 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
Community mental health services providers	Health home providers will be Community Mental Health Service Providers (CMHSPs) operating under the Michigan Mental Health Code. CMHSPs must meet all state-defined standards of a Health Home including adequate staffing for functions of Health Home Director, Primary Care Liaison, and Nurse Care Manager.

Care Coordination

Definition

Care coordination is part of implementing comprehensive care plans by providing appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination involves: telephonic appointment reminders, outreach and follow-up when face to face contact is not required; communication with family members; administering assessments and follow-up reminders; assisting with medication reconciliation; making appointments; providing patient education materials; assisting with transportation, DME and other arrangements; obtaining missing records and consultation reports; participating in hospital and ED transitional care; and documentation and reporting via electronic and other record systems.

Care coordination assists to improve self-management of mental illness as well as chronic physical conditions. Supports provided include: development and implementation of a beneficiary's individualized recovery plan; coping with stressor situations; education and consultation to beneficiaries' families and their support system; fostering interpersonal, social and self-management skills and adapting to home, school, and work environments; symptom self-monitoring and self-management to mitigate interference with daily living, financial management, personal development, or school or work performance; helping increase social support skills and networks to enable and maintain the beneficiary's independent living; interventions for avoiding out-of-home placement and building stronger family support skills and knowledge of strengths and limitations; encouraging mental health and substance use relapse prevention strategies and plans. Care coordination services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or Primary Care Liaison in collaboration with the provider's mental health and SUD practitioners.

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

In addition to maintaining their own EHRs, Health Homes will utilize available forms of health HIT to facilitate HIE necessary for carrying out selected Health Home service components.

Care Coordination Tool
The Care Connect 360 and encounter will contain lookup features so that Health Homes can view beneficiaries':
- Current and prior health conditions (e.g., SUD, COPD, CHF, diabetes)
- Rendering services provider, date of service and length of stay (as applicable)
- Prescription drug utilization history (e.g., Rx fill date, drug name, quantity, prescriber and pharmacy provider)

- History and reason for use of hospitalization and ED services, including diagnoses

Population Health Management Reports
Health Homes may also receive routine reports from PIHPs to support population health analysis, which can be used for identification of trends, predictive analysis, and care tracking to support and enrich patient/provider monitoring functions that improve health outcomes, support integrated models of care, lower costs and enhance patient engagement in care. Reports enable creation of population health profiles, multi-morbidity and relative risk scores and the identification of care gaps (e.g., percentage of individuals with diabetes who have not received a urine protein test).

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] 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
Community mental health services providers	Health home providers will be Community Mental Health Service Providers (CMHSPs) operating under the Michigan Mental Health Code. CMHSPs must meet all state-defined standards of a Health Home including adequate staffing for functions of Health Home Director, Primary Care Liaison, and Nurse Care Manager.

Health Promotion

Definition

Health promotion services involve the provision of health education to the individual (and family member/significant other when appropriate) specific to his/her chronic illness or needs as identified in the assessment. The service includes assistance with medication reconciliation and provides assistance for the individual to develop a self-management plan and self-monitoring and management skill promotion of and connection to healthy lifestyle and wellness (nutrition, substance abuse prevention, smoking prevention and cessation, nutrition counseling, increasing physical activity). Health promotion also involves connecting the beneficiary with peer supports including self-help/self-management and advocacy groups, providing support for improving social network and educating the individual about accessing care in appropriate settings. Health promotion services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or Primary Care Liaison in collaboration with the provider's mental health and SUD practitioners.

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

In addition to maintaining their own EHRs, Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home service components.

Care Coordination Tool
Michigan's CareConnect 360 will contain lookup features so that health homes can view beneficiaries':
- Current and prior health conditions (e.g., SUD, COPD, CHF, diabetes)
- Rendering services provider, date of service and length of stay (as applicable)
- Prescription drug utilization history (e.g., Rx fill date, drug name, quantity, prescriber and pharmacy provider)
- History and reason for use of hospitalization and ED services, including diagnoses

Population Health Management Reports
Health Homes may also receive routine reports from PIHPs to support population health analysis, which can be used for identification of trends, predictive analysis, and care tracking to support and enrich patient/provider monitoring functions that improve health outcomes, support integrated models of care, lower costs and enhance beneficiary engagement in care. Reports enable creation of population health profiles, multi-morbidity and relative risk scores and the identification of care gaps (e.g., percentage of beneficiaries with diabetes who have not received a urine protein test).

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] 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
CMHSPs	Health home providers will be Community Mental Health Service Providers (CMHSPs) operating under the Michigan Mental Health Code. CMHSPs must meet all state-defined standards of a Health Home including adequate staffing for functions of Health Home Director, Primary Care Liaison, and Nurse Care Manager.

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

Definition

Transitional care is designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the beneficiary's goals, preferences, and clinical status. It includes logistical arrangements, education of the beneficiary and family, and coordination among the health professionals involved in the transition. Transitional care encompasses both the sending and the receiving aspects of the transfer, and is essential for persons with complex care needs.

Transitional care in a Health Home consists of team-based efforts to foster continuity of care and reduce avoidable hospital ED and inpatient admissions, readmissions and length of stay. At a minimum, key functions of transitional care include receiving notifications of admissions and discharges from hospitals and other care facilities; outreach to beneficiaries to ensure appropriate follow up after transitions; outbound phone calls by the care manager or other team member within 48 hours of discharge; and scheduled visits for beneficiaries with the PCP and/or specialist within one week of discharge. Protocol-driven transitional care activities and patient contacts include: review discharge summary and instructions; perform medication reconciliation; ensure that follow up appointments and tests are scheduled and coordinated; assess the beneficiary's risk status and arrange for follow up care management if indicated. Comprehensive transitional care services are provided primarily by the Nurse Care Manager and may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or Primary Care Liaison in collaboration with the provider's mental health and SUD practitioners.

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

In addition to maintaining their own EHRs, Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home service components.

Care Coordination Tool
Michigan's Care Connect 360 tool contains lookup features so that Health Homes can view beneficiaries':

- Current and prior health conditions (e.g., SUD, COPD, CHF, diabetes)
- Rendering services provider, date of service and length of stay (as applicable)
- Prescription drug utilization history (e.g., Rx fill date, drug name, quantity, prescriber and pharmacy provider)
- History and reason for use of hospitalization and ED services, including diagnoses

Population Health Management Reports
Health Homes may also receive routine reports from PIHPs to support population health analysis, which can be used for identification of trends, predictive analysis, and care tracking to support and enrich beneficiary/provider monitoring functions that improve health outcomes, support integrated models of care, lower costs and enhance patient engagement in care. Reports enable creation of population health profiles, multi-morbidity and relative risk scores and the identification of care gaps (e.g., percentage of beneficiaries with diabetes who have not received a urine protein test).

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] 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
CMHSPs	Health home providers will be Community Mental Health Service Providers (CMHSPs) operating under the Michigan Mental Health Code. CMHSPs must meet all state-defined standards of a Health Home including adequate staffing for functions of Health Home Director, Primary Care Liaison, and Nurse Care Manager.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services provide expanded access and availability; provide continuity in relationships between individual beneficiary/family with physician and care manager; outreach to the beneficiary and his or her family and perform advocacy on their behalf to identify and obtain needed resources such as medical transportation and other benefits to which they may be eligible; educate the beneficiary in self-management of their chronic condition; provide opportunities for the family to participate in assessment and care treatment plan development; ensure that Health Home services are delivered in a manner that is culturally and linguistically appropriate; referral to support services that are available in the beneficiary's community; assist with "natural supports;" promote personal independence; empower the beneficiary to improve his/her own environment; include the beneficiary's family in the quality improvement process including surveys to capture experience with Health Home services; and allow beneficiaries /families access to electronic health record information or other clinical information. Individual and family support services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or Primary Care Liaison in collaboration with the provider's mental health and SUD practitioners.

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

Not applicable.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists

☑ Other (specify)

Provider Type	Description
CMHSPs	Health home providers will be Community Mental Health Service Providers (CMHSPs) operating under the Michigan Mental Health Code. CMHSPs must meet all state-defined standards of a Health Home including adequate staffing for functions of Health Home Director, Primary Care Liaison, and Nurse Care Manager.

Referral to Community and Social Support Services

Definition

Referral to community and social support services provide the beneficiaries with referrals to a wide array of support services that will help them overcome access or service barriers, increase self-management skills and achieve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health. The types of community and social support services to which beneficiaries will be referred may include, but are not limited to:

- Wellness programs, including smoking cessation, fitness, weight loss programs
- Specialized support groups (i.e. cancer, diabetes support groups)
- Substance treatment links in addition to treatment - supporting recovery with links to support groups, recovery coaches, 12-step
- Housing resources
- Social integration
- Assistance with the identification and attainment of other benefits
- Supplemental Nutrition Assistance Program
- Connection with the Office of Rehabilitation Service to assist person in developing work/education goals and then identifying programs/jobs
- Legal assistance resources
- Faith based organizations
- Access to employment and educational program or training

Referral to community and social support services are primarily provided by any member of the health home team, but are driven by protocols and guidelines developed by the Nurse Care Manager or Primary Care Liaison in collaboration with the provider's mental health and SUD practitioners.

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

Information submitted with the original SPA package. Please refer to SPA ID MI.1125.R00.00 (MI-14-0008)

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
CMHSPs	Health home providers will be Community Mental Health Service Providers (CMHSPs) operating under the Michigan Mental Health Code. CMHSPs must meet all state-defined standards of a Health Home including adequate staffing for functions of Health Home Director, Primary Care Liaison, and Nurse Care Manager.

Provider Type	Description

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

Submitted with SPA

Name	Date Created	Type
HH Care Management Diagram (14-008) (6-23-14)	12/29/2016 10:41 AM EST	

Health Homes Providers

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

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Approval Date 3/15/2017

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Initial Submission Date 12/29/2016

Effective Date 7/1/2014

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

Describe the Provider Qualifications and Standards

Health home providers will be Community Mental Health Service Providers (CMHSPs) operating under the Michigan Mental Health Code. CMHSPs must meet all state-defined standards of a Health Home including adequate staffing for functions of Health Home Director, Primary Care Liaison, and Nurse Care Manager.

Health Home directors may be Michigan-licensed mental health professionals who meet MDCH requirements per Section 330.1100b(15) of the Michigan Mental Health Code regarding training and experience i.e. M.D. or D.O., psychologist, master's social worker, professional counselor, marriage and family therapist, or registered professional nurse. Alternately, Directors may be bachelor's prepared experienced leaders (ten+ years)in a community mental health setting. Directors oversee daily operations, champion practice transformation and progress toward health and wellness, develop agreements with community providers, and facilitate planning, policies and protocols to ensure effective care coordination and transitional care.

Primary Care Liaisons may be Michigan licensed physicians (M.D. or D.O.), physician's assistants or nurse practitioners. Liaisons work with health home teams to champion practice transformation, health promotion, and standards-based care, consult regarding enrollee health and wellness concerns, and foster population health management initiatives.

Nurse Care Managers must be Michigan licensed registered nurses with relevant experience and skills. They lead health assessment and comprehensive care plan development and implementation; conduct medication reconciliation and transitional care; foster beneficiary self-management; provide health education and coaching; use HIT and data analytics to monitor, respond to alerts, coordinate with external providers to foster wellness initiatives; and consult with teams about beneficiary health.

☐ Home Health Agencies

- [ ] Case Management Agencies
- [ ] Community/Behavioral Health Agencies
- [ ] Federally Qualified Health Centers (FQHC)
- [ ] Other (Specify)

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

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Michigan's Health Homes for individuals with serious and persistent mental health conditions will provide care management and coordination services consistent with principles of the planned care. Planned care is a concept initially defined by the IHI and generally involves the establishment of structures so that Health Homes:

- Ensure a team approach to service delivery where staff members use their skills together in a concerted effort to deliver or ensure the provision of evidence-based clinical management and self-management support.

- Ensure meaningful and informed beneficiary involvement in his/her care. The premise is that beneficiaries should understand and know how to monitor and manage their care and how to get help when there is a need for follow-up on their plans of care.

- Utilize a clinical information system (e.g., patient registries) to access information about a beneficiary or a group of beneficiaries quickly and to plan beneficiaries care based on that information. The information enables care teams to provide the appropriate support and care of patients and assess the results; hence, clinical information systems are both a decision aid and a reminder system.

- Assure the successful application of reliable planned care in service settings, particularly through active leadership support. Leadership is important for laying the groundwork for a care team approach by articulating how more reliable and planned care meets important organization and beneficiary goals.

Designated providers of Health Home services to individuals with serious and persistent mental health conditions will be eligible CMHSP identified by the MDHHS to meet the standards of a Health Home. CMHSP Health Home must be adequately staffed by teams of health care professionals that represent the following functions: health home director, primary care liaison, and Nurse Care Manager.

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

All Health Homes must participate in State-sponsored activities designed to support CMHSPs in transforming service delivery. The CMHSPs are currently participating in a year-long learning collaborative modeled after the Institute for Healthcare Improvement (IHI) Collaborative Model for Achieving Breakthrough Improvement. Through the collaborative, CMHSPs participate in monthly webinars and will receive periodic onsite training and individualized technical assistance that will focus on the following:

- Planned care / team-based care where members of the Health Home team consistently work together and are responsible for the same panel of members; management and coordination is directed by the same individual care plan and members serve as the accountable point of contact

- Knowledge of and ability to use screening tools for chronic illness, SUD, mental illness, medication use and prevalent risk factors

- Delivery of evidence based health services including chronic illness care, including self-management for beneficiaries and families

- Emphasis on transitions of care including appropriate follow-up from inpatient to other settings, participations in discharge planning and transfers from levels and systems of care

- Proactive delivery of health promotion and prevention

- Comprehensive health assessment of physical health, behavioral health (i.e., mental health disorders, substance abuse disorders, and developmental disabilities), and long-term services and supports, incorporating relevant information from relevant sources into a patient registry

- Use of data including disease registries, clinical care protocols, and care alerts/triggers to identify potential gaps in care, treatment adherence, and actionable data from analytics tools

Other Health Homes Provider Standards

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

Health Home CMHSPs must be enrolled with MDHHS, agree to comply with Medicaid requirements, and meet other state-defined standards. Standards include participation in a readiness assessment to determine ability to meet service delivery requirements, and MDHHS-sponsored activities supporting the successful implementation and sustainability of Health Home services. Activities include: training; professional development to foster Health Home competencies and best practices; monitoring and performance reporting; continuous improvement activities; and evaluation. Other requirements include: use of HIT, HIE, care management tools and resources made available by the MDHHS; establishing links and protocols with external health care partners, including legally compliant data sharing agreements, to assure access to necessary services and efficient transitional care. Providers must demonstrate sufficient core team member capacity to serve eligible beneficiaries including qualified individuals serving as Health Home Director, Primary Care Liaison, and Nurse Care Manager.

Health Homes must minimally provide basic onsite collaboration whereby primary care and behavioral health services are planned, coordinated and made available, as appropriate, in the Health Home setting. Sharing the same practice space is optional, however behavioral health and primary care providers at the same location will coordinate provision of primary care services that may occur at the Health Home site or be provided by Health Home staff at offsite primary care locations. Health Homes must utilize teams to deliver services including specified core functions; implement an individualized comprehensive care plan for each client; regularly communicate to discuss shared patients; use information systems and information sharing protocols to inform a common, individualized patient record; and maximize referral opportunities resulting from close proximity.

Name	Date Created	Type
No items available		

Health Homes Service Delivery Systems

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

Package Header

Package ID MI2016MH0003O

SPA ID MI-16-1500

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Initial Submission Date 12/29/2016

Approval Date 3/15/2017

Effective Date 7/1/2014

Superseded SPA ID N/A

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

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

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

- ( ) Yes
- (•) No

Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided

- [ ] The current capitation rate will be reduced
- [x] The State will impose additional contract requirements on the plans for Health Homes enrollees

Provide a summary of the contract language for the additional requirements

MDHHS administers the Medicaid managed care program under a Section 1915(b) waiver and after competitive procurement, contracts with licensed HMOS to be Medicaid Health Plans (MHPs). MHPs provide Medicaid covered services to eligible populations including adults, pregnant women, children, disabled adults, foster children, and children with complex medical needs. Contractually, MHPs must provide high quality health care with access to primary and preventive care and person-centered continuity of care. MDHHS also contracts with Prepaid Inpatient Health Plans (PIHPs) under concurrent Section 1915(b)/(c) waivers to provide comprehensive mental health and substance abuse services for Medicaid beneficiaries with severe mental health conditions. PIHPs in turn, contract with CMHSPs to provide community level mental health services and to serve

as Health Homes. PIHPs are required to support CMHSPs to implement effective processes for eligibility and enrollment, coordinated care management, communications and coordinati n with MHPs.

The MDHHS requires coordination agreements between PIHPs and MHPs operating in counties where the Health Home benefit is implemented to assure continuity of care for beneficiaries served by both plans and complementary, coordinated, non-duplicative services. Coordination agreements specify MHP and PIHP responsibilities including: points of contact at each entity to coordinate collaborative activities e.g. assessment, care planning, and data exchange; notification protocols i.e. recent psych and other hospital inpatient and ED and crisis visits; communications to coordinate care management; and referral protocols for Medicaid beneficiaries with a serious mental health condition. Agreements call for regular communication to review and update plans of care, report the ongoing status of mutually served beneficiaries, facilitate individual referrals, and clarify issues related to covered medical services on behalf of MHP beneficiaries.

☐ Other

☐ Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

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Submission Type	Official - Review 1	**Initial Submission Date**	12/29/2016
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Superseded SPA ID	N/A		

Payment Methodology

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

☑ Fee for Service

☑ Individual Rates Per Service

☑ 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

The Health Home payment rate was established based on a clinical staffing model and average expected service intensity for individuals with a serious mental health condition who often have multiple, coexisting chronic physical health conditions. MDHHS established a monthly Health Home payment rate which reflects personnel costs of the required team of health care professionals providing Health Home services (i.e., Health Home Director, Primary Care Liaison and Nurse Care Manager). The Health Home payment rate also reflects related indirect and overhead costs derived from the CMHPs that are not direct staff costs but which are necessary for the implementation of Health Home services. MDHHS will annually evaluate the

Health Home payment rate to determine whether the rate requires adjustment due to staffing costs of the team of health care professionals, changes in related indirect and overhead costs or other factors determined by the MDHHS. The monthly health home payment rate is $137.19. Rate components for each team member and indirect and overhead costs are as follows:

Health Home Director (.10 FTE : 75) = $12.79; Nurse Care Manager (1.0 FTE : 75) = $83.28; Primary Care Liaison - mostly NP (.10 FTE : 75) = $18.62; Indirect and Overhead (e.g., analytics, reporting, admin. supports) = $22.50. The total Monthly Case Rate = $137.19.

The Health Home service rate will be assessed and re-based if necessary by MDHHS on an annual basis.

- ☐ Per Member, Per Month Rates
- ☐ Comprehensive Methodology Included in the Plan
- ☐ Incentive Payment Reimbursement

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

N/A

- ☐ 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)

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

Jul 1, 2014

Website where rates are displayed

www.michigan.gov/medicaidproviders

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

The Health Home payment rate was established based on a clinical staffing model and average expected service intensity for individuals with a serious mental health condition who often have multiple, coexisting chronic physical health conditions. MDHHS established a monthly Health Home payment rate which reflects personnel costs of the required team of health care professionals providing Health Home services (i.e., Health Home Director, Primary Care Liaison and Nurse Care Manager). The Health Home payment rate also reflects related indirect and overhead costs derived from the CMHPs that are not direct staff costs but which are necessary for the implementation of Health Home services. MDHHS will annually evaluate the Health Home payment rate to determine whether the rate requires adjustment due to staffing costs of the team of health care professionals, changes in related indirect and overhead costs or other factors determined by the MDHHS. The monthly health home payment rate is $137.19. Rate components for each team member and indirect and overhead costs are as follows:

Health Home Director (.10 FTE : 75) = $12.79; Nurse Care Manager (1.0 FTE : 75) = $83.28; Primary Care Liaison - mostly NP (.10 FTE : 75) = $18.62; Indirect and Overhead (e.g., analytics, reporting, admin. supports) = $22.50. The total Monthly Case Rate = $137.19.

The Health Home service rate will be assessed and re-based if necessary by MDHHS on an annual basis.

The Health Home payment rate was established based on a clinical staffing model and average expected service intensity for individuals with a serious mental health condition who often have multiple, coexisting chronic physical health conditions. The MDHHS will pay the CMHSP Health Homes a monthly fee-for-service rate for care management and coordination services and supports that are

not covered by any of the currently available Medicaid funding mechanisms and provided to beneficiaries determined by the MDHHS to be eligible for Health Home services. All payments made to the CMHSP are contingent on the Health Home meeting service delivery requirements for initial and ongoing service provision. Health Home components (e.g., comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support and referral to community and social services) may or may not require a face-to face interaction with a beneficiary.

In order for a CMHSP Health Home to receive an initial payment the following activities must be completed and documented by the Health Home for each eligible beneficiary:

Conduct an in-person orientation with beneficiary to explain Health Home services.

Describe Health Home services as an option and provide the beneficiary with an opt-out form as well as describe the process for the beneficiary to decline Health Home services.

Conduct or update a comprehensive health risk assessment with the beneficiary to determine care management, care coordination and support needs and risk of the beneficiary.

Conduct or update a comprehensive, integrated care plan.

The population eligible for Michigan's Health Home benefit has serious and persistent mental health conditions with high rates of hospital inpatient or emergency department use. Beneficiaries may also have a coexisting, chronic physical health condition (e.g., congestive heart failure, chronic obstructive pulmonary disorder, diabetes, seizure disorder, etc.). As such, this high-risk population at minimum requires monthly monitoring by the Health Home team and more frequently as indicated by clinical practice guidelines for each health condition, including mental illness conditions. Each Health Home is required by MDHHS to document all Health Home services conducted with or on behalf of a beneficiary. In addition, on a monthly basis Health Homes must report to MDHHS all services conducted by including a description of the Health Home service type on an encounter. Any encounter that does not contain Health Home service indicators will be denied for payment. Health Homes must maintain documentation in clinical records and assure that services conducted are consistent with a beneficiary's individualized care plan, established clinical guidelines based on beneficiaries' health status and risk, and CMHSP organizational protocols.

Assurances

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

Describe below how non-duplication of payment will be achieved

Health Home service payments will not result in any duplication of payment or services between Medicaid programs, services, or benefits (i.e. managed care, other delivery systems including waivers, any future Health Home state plan benefits, and other state plan services). In addition to offering guidance to providers regarding this restriction, the State may periodically examine recipient files to ensure that Health Home participants are not receiving similar services through other Medicaid-funded programs.

☑ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☑ 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).

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions - MI - 2016

Not Started | In Progress | Complete

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Monitoring

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

The MDHHS retained Milliman Inc. to develop the following methodology to measure savings for Medicaid Health Home services.

Health Homes will be implemented in targeted geographic areas across the state. Changes in total per member per month (PMPM) health care costs will be evaluated over time for two distinct populations, those enrolled in Health Homes and those not enrolled in Health Homes, the latter serving as a control group. The control group will be developed by applying the Health Home population selection criteria and analyzing the control group's costs over the same period of

time as the intervention group. Adjustments will be made to the control group to account for factors that may influence costs outside of the health homes intervention. These adjustments may include:

- Age/gender;
- Eligibility group;
- Geography, including urban/rural differences;
- Impact of members opting out of the program; and
- Other risk adjustment techniques

The PMPM costs for the intervention population over the course of the program will be tracked and analyzed and compared to the PMPM costs of the control group population. Monthly case rates paid to Health Homes will be removed from program savings to determine the net savings attributable to the Health Homes program. Adjustments may be made for beneficiaries that are cost outliers in both the control and intervention groups.

For the above described cost savings calculation, all Medicaid services will be included within the PMPM costs, which include long term care and support services. To ensure the most accurate comparison between the control group and the intervention group, the same data collection methods will be used for both years, such as using the same amount of claims run out. Enrollees dually eligible for Medicare and Medicaid coverage will be evaluated separately, as not having access to Medicare claims data precludes analysis of savings among the dually eligible population.

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)

In addition to maintaining their own electronic health records (EHRs), Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home service components.

Care Coordination Tool
Michigan's Integrated Care Analytics Program (known as Care Connect 360 or CC 360) is a querying tool that enables providers to access comprehensive retrospective Medicaid claims and encounter data to support care coordination services. CC 360 will contain lookup features so that Health Homes can view beneficiaries':

- Current and prior health conditions (e.g., SUD, COPD, CHF, diabetes)
- Rendering services provider, date of service and length of stay (as applicable)
- Prescription drug utilization history (e.g., Rx fill date, drug name, quantity, prescriber and pharmacy provider)
- History and reason for use of hospitalization and ED services, including diagnoses

Population Health Management Reports
Health Homes may also receive routine reports from PIHPs to support population health analysis, which can be used for identification of trends, predictive analysis, and care tracking to support and enrich beneficiary/provider monitoring functions that improve health outcomes, support integrated models of care, lower costs and enhance patient engagement in care. Reports enable creation of population health profiles, multi-morbidity and relative risk scores and the identification of care gaps (e.g., percentage of beneficiaries with diabetes who have not received a urine protein test).

Quality Measurement and Evaluation

☑ 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

☑ 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

☑ 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

☑ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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