Michigan Department of Health and Human Services
MI Care Team

Frequently Asked Questions and Answers

MI Care Team Provider Questions
Care Team and Caseload
Question: Is the Community Health Worker a required component of the care team? If so, what are the requirements for this position in terms of a degree? **Answer**: Yes. The Community Health Worker (CHW) is a required member of the care team. The CHW is not required to hold any specific educational degree. However, the CHW must be appropriately trained to assure that the CHW can competently complete all assigned work.
Question: What is the caseload benchmark or estimate for a health home care team to manage? **Answer**: There is no pre-determined caseload benchmark. The number of beneficiaries per site and/or beneficiaries per team is site-specific. MI Care Team recognized sites are expected to offer health home and other health services of the center so that such services are available and accessible promptly, as appropriate, and in a manner which will assure continuity of service to eligible beneficiaries.
Question: What is the minimal education and licensure required for the Behavioral Health Consultant position? **Answer**: The Behavioral Health Consultant must, at a minimum, be a licensed, Master's-level behavioral health professional.
Question: Can the nurse care manager be a Licensed Practical Nurse (LPN)? **Answer**: No, a nurse care manager must be a Registered Nurse (RN).
Question: The Home Health Coordinator—this person is a liaison between the State and its contractors. Who is that person employed by? **Answer**: The expectation is that the Health Home Coordinator will be employed by the actual MI Care Team site.
Question: Can one RN cover all Care teams as we have 5 practice sites or will each practice site be required to have a RN care coordinator? **Answer**: Yes, it is allowable for one RN to cover multiple care teams at multiple sites.

Question:
What is the rationale for mandating the RN credential for the nurse care coordinator?

Answer:
The required RN credential comports with the literature and with health home models implemented in other states. The RN's role includes but is not limited to helping the beneficiary navigate through the system, and providing information to help manage the beneficiary's illness.

Question:
If we have a Limited Licensed Psychologist, is that acceptable for the team requirement?

Answer:
No, the MI Care Team site must have access to a fully licensed psychologist and/or psychiatrist.

Question:
We partner extensively with our regional health plan with shared care management/case management for various sub populations in the past. Would shared nurse care management/coordination with our regional health plan meet the standard for RN Care Manager?

Answer:
No. MI Care Team providers are required to have a distinct RN Care Manager within the MI Care Team health home care team.

Michigan Primary Care Transformation (MiPCT) Project and Other Programs

Question:
Can you participate in both MiPCT and the MI Care Team Health Home program?

Answer:
Providers participating in MI Care Team cannot provide services under this program to beneficiaries who are concurrently receiving care management and/or care coordination services in any other federally sponsored program, including but not limited to MiPCT. Providers participating in this Health Home program cannot bill and/or receive payment for any care management and/or care coordination service which is duplicative of any care management and/or care coordination service received by a beneficiary through any other federally sponsored program.

As an example, if a Federally Qualified Health Center (FQHC) or Tribal Health Center (THC) has ten sites, and five of those sites are receiving payments as MiPCT sites, those five MiPCT sites are not permitted to be health home providers, but the other five (non-MiPCT) sites may be health home providers.

Question:
Can you participate in both the State Innovation Model (SIM) and the MI Care Team Health Home program?

Answer:
MDHHS cannot answer this question at this time because the SIM project is still under development.

Question:
Can an individual participate in MI Care Team and the Serious Mental Illness (SMI) Health Home program concurrently?

Answer:
If the beneficiary participates in the SMI Health Home program, the beneficiary cannot also be concurrently enrolled in the MI Care Team primary care Health Home program.

Question:
Can a health center end participation in MiPCT if they are awarded the opportunity to be a health home provider?

Answer:
Yes.

Question:
It was my understanding a provider could participate in MI Health Link, but that the beneficiary could not be enrolled in both. Can you please provide clarification?

Answer:
Individual beneficiaries cannot be concurrently enrolled in MI Health Link and the MI Care Team Health Home program, because both programs include care coordination services. Providers may concurrently serve beneficiaries enrolled in either program.

Billing and Payment

Question:
What are the Health Homes billable codes?

Answer:
The MI Care Team program will use dedicated reporting codes to reflect monthly encounters. The dedicated reporting codes will be provided at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information. Submission of these reporting codes is required in order to maintain the monthly case rate. Additional billing details and guidance can be found in the MI Care Team Handbook.

Question:
What is the place(s) of service for a health home service?

Answer:
In general, most MI Care Team health home services will take place in the clinic setting (i.e., in the FQHC or THC). Some services may take place in the community setting.

Question:
Who can bill – are eligible providers only the primary care provider, behavioral health provider and psychologist/psychiatrist?

Answer:
Dedicated MI Care Team health home care coordination services are to be reported by the FQHC or THC entity.

Question:
Are health homes codes included in the FQHC or THC annual reconciliation process?

Answer:
No. MI Care Team health home services are not included.

Question:
Do we need to apply for a Health Resources and Services Administration (HRSA) change in scope to provide health homes services?

Answer:
No.

Question:
Would we use our primary site National Provider Identifier (NPI) to bill for Health Homes services?

Answer:
The MI Care Team Health Home providers will receive a distinct identifier to use for reporting MI Care Team health home services. This identifier will only be used for documenting MI Care Team services. Additional billing details and guidance can be found in the MI Care Team Handbook. MI Care Team providers should continue using their standard NPI for payment of regular clinical services.

Question:
Will there be Medicaid Health Plan or FFS Payment in addition to the monthly case rate?

Answer:
Yes. Clinical services (medical, dental, behavioral health) are separate and distinct from health home services and will continue to be paid by the Medicaid Health Plan or Medicaid FFS as applicable. Qualifying clinical services will continue to receive the wraparound rate through the cost settlement process as they currently do. The monthly case rate is specific to MI Care Team care coordination services and provides a mechanism for awardees to be reimbursed for services that are not otherwise eligible for payment.

Question:
Would you be eligible for payment incentives for both a Patient Centered Medical Home (PCMH) and MI Care Team health homes?

Answer:
Being a MI Care Team provider does not preclude an entity from receiving PCMH incentives.

Question:
What is the timing of payments relative to implementation – cash flowing the cost of hiring team?

Answer:
The initial care plan rate was structured to account for the cost of staffing leading up to the enrollment of a beneficiary. Payment is contingent upon enrollment of the beneficiary, documentation of beneficiary consent, development of the initial care plan, and submission of an encounter.

Question:
Is there a base grant dollar amount or just the opportunity for reimbursement for services otherwise not eligible for reimbursement?

Answer:
There is no base grant dollar amount to be paid to awardees. However, the MI Care Team Health Home program provides the opportunity for awardees to be reimbursed for services not otherwise eligible for reimbursement.

Question:
What is the timeframe for the Health Action Plan rate? For example, what happens to this payment if the patient moves out of the service area after one month or one week of services?

Answer:
The Health Action Plan payment would be part of the patient's first visit, so the care team would still be paid for this encounter regardless of whether the patient moves out of the service area after the first visit.

Question:
To be reimbursed the monthly case rate payments, must the recipient agree to be a participant?

Answer:
Yes. A beneficiary must consent to participate in the MI Care Team Health Home program, and beneficiary consent must be obtained before any payments are made.

Miscellaneous

Question:
What are the expectations regarding PCMH status if we are not currently certified at level one?

Answer:
In order to serve as a MI Care Team Health Home provider, an FQHC or THC must achieve PCMH recognition and/or accreditation from a national recognizing/accrediting body (National Committee for Quality Assurance [NCQA], Accreditation Association for Ambulatory Health Care [AAAHC] or Joint Commission) before the Health Home program becomes operational. PCMH application may be pending, but must be resolved within 6 months of the entity beginning to provide Health Home services.

Question:
Who will beneficiary eligibility letters go out to?

Answer:
Beneficiary eligibility letters will go out to all eligible beneficiaries in a geographic area. Awarded sites will receive a list of all eligible beneficiaries with whom the site has an existing relationship.

Question:
For the depression or anxiety diagnosis, is there a limitation on the degree of disturbance? Specifically are Community Mental Health (CMH) clients eligible? If so, which diagnoses would qualify?

Answer:
Eligible beneficiaries are required to have a clinical diagnosis code of depression and/or anxiety per International Classification of Diseases (ICD)-10. CMH clients may be eligible if they have such an ICD diagnosis code.

Question:
Are all Medicaid/Managed Medicaid enrollees eligible?

Answer:
Yes, provided they meet all program eligibility requirements.

Question:
How exactly is a person enrolled in the program? Fax in a form? Over the phone?

Answer:
It is anticipated that enrollment will occur electronically through the Waiver Support Application (WSA). MI Care Team sites will receive training regarding the WSA.

Question:
If you are participating in the program as a Care Team – then are you required to see any patient who signs up?

Answer:
Yes – if a patient meets the eligibility criteria and expresses an interest in signing up, then they must be admitted to the program.

Question:
If an individual wants to become part of the MI Care Team and isn't currently a health center patient, will they need to change their PCP?

Answer:
We recognize the importance of existing beneficiary-PCP relationships, and encourage beneficiaries to reach out to their managed care plans to ensure they receive optimal clinical and social support services. However, if an individual in a health plan wants to become part of the MI Care Team health home, and is not currently a health center patient, the individual will need to change their PCP. The FQHC and/or THC would need to be in network in order for a member to choose it as a PCP.

Question:
Can you tell us more about Care Connect 360 or is there a link you can give us to learn more about it?

Answer:
Care Connect 360 is an online, claims-based integrated care analytics resource. This tool allows authorized providers to view information about a patient's past claims and service utilization, including Admission, Discharge and Transfer (ADT) files, managed care enrollment status, prescribed medications, etc. Training on Care Connect 360 will be provided as part of provider training.