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State/Territory Name: MI

State Plan Amendment (SPA) #: 14-0008

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

December 11, 2014

Stephen Fitton, Medicaid Director
Medical Services Administration
Federal Liaison Unit
Michigan Department of Community Health
400 South Pine
Lansing, Michigan 48933

ATTN: Loni Hackney

Dear Mr. Fitton:

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

- Transmittal: #14-0008 Health Home
- Effective: July 1, 2014

If you have any questions, please contact Leslie Campbell at (312) 353-1557 or Leslie.Campbell@cms.hhs.gov.

Sincerely,

/s/
Alan Freund
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MI-14-0008

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

N/A

☑ **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

State Information

State/Territory name:	**Michigan**
Medicaid agency:	Department of Community Health

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Proposed Effective Date

07/01/2014 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
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 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.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 899280.00
Second Year	2015	$ 3597122.00

Federal Statute/Regulation Citation

Section 1945 of the Social Security Act

Governor's Office Review

○ **No comment.**

○ **Comments received.**
Describe:

○ **No response within 45 days.**

◉ **Other.**
Describe:
Stephen Fitton, Director
Medical Services Administration

Transmittal Number: MI-14-0008 Supersedes Transmittal Number: N/A Proposed Effective Date: Jul 1, 2014 Approval Date:

Date Received: June27, 2014	Date Approved: December 11, 2014
Plan Approved – One Copy Attached	
Effective Date of Approved Material: July 1, 2014	Signature of Regional Official: /s/
Typed Name: Alan Freund	Title: Acting Associate Regional Administrator
Remarks:	

Health Homes Population Criteria and Enrollment

Population Criteria

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

☐ **Two or more chronic conditions**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

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

☒ **One or more 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.

Geographic Limitations

☐ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

◉ **By county**
Specify which counties:
Manistee County, Grand Traverse County and Washtenaw County

○ **By region**
Specify which regions and the make-up of each region:

○ **By city/municipality**
Specify which cities/municipalities:

○ **Other geographic area**
Describe the area(s):

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**
Describe the process used:

◉ **Automatic Assignment with Opt-Out of Health Homes provider**
Describe the process used:
The MDCH 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 MDCH 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 MDCH 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 MDCH.

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**
Describe:

☐ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☐ **The State 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 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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Providers

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**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☑ **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**

Describe the Provider Qualifications and Standards:

☐ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

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

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes 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 MDCH 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.

Provider Standards

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

Health Home CMHSPs must be enrolled with MDCH, 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 MDCH-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 MDCH; 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.

Health Homes Service Delivery Systems

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

☑ **Fee for Service**

☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **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:
MDCH 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. MDCH 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 MDCH 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**

Describe:

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

Yes

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

No

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**
☐ **Alternative Model of Payment (describe in Payment Methodology section)**
☐ **Other**
Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

Health Homes Payment Methodologies

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

☐ **Fee for Service**

☑ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

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

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

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

☐ **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. MDCH 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. MDCH 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 MDCH. 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 MDCH on an annual basis.

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

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 MDCH 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 MDCH 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 MDCH 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 MDCH 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.

☐ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (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 PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

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

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a

provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.

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 provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☐ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Transmittal Number: MI-14-0008 Supersedes Transmittal Number: N/A Proposed Effective Date: Jul 1, 2014 Approval Date:
Attachment 3.1-H Page Number: 7

Health Homes Service Delivery Systems

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

☐ **Fee for Service**

☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☑ **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:
MDCH 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. MDCH 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 MDCH 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

☐ **Fee for Service**
☐ **Alternative Model of Payment (describe in Payment Methodology section)**
☐ **Other**
Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
MDCH will use the technical specifications for Plan All-Cause 30 Day Readmissions as published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014).

Measure Specification, including a description of the numerator and denominator: For Health Home enrollees age 18 and older, the percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Numerator Description - number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination;

Denominator Description - number of Index Hospital Stays for each age, gender, and total combination.

Data Sources: Medicaid claim and encounter data. This measure requires risk adjustment. There are no standardized risk adjustment tables for Medicaid; per the CMS Technical Specifications and Resource Manual for Federal Fiscal year 2013 Reporting, Michigan will report unadjusted rates.
Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
The MDCH 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

☑ **The State provides assurance that it will require 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.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☐ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

The rate of acute inpatient care and services (total, maternity, mental health, surgery, and medicine)

Measure Specification, including a description of the numerator and denominator.
Numerator: total number of inpatient discharges. Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year. Refer to the codes in Table IU.A to identify total inpatient discharges. Use the guidelines and formulas outlined in the technical speciation published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014) to report inpatient discharges.

Denominator: Health Home enrollee months
Data Sources:
MMIS (i.e., CHAMPS) claims and encounter data; Health Home enrollment data
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ○ **Continuously**
- ◉ **Other**

Daily

Emergency Room Visits

Measure:

The rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enroll

Measure Specification, including a description of the numerator and denominator.
Numerator: Count the total number of ED visits for Health Home enrollees that Medicaid paid for during the measurement year, following the technical specifications published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014).

Denominator: Health Home enrollee months
Data Sources:
MMIS (i.e., CHAMPS) claims and encounter data; Health Home enrollment data.
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Daily

Skilled Nursing Facility Admissions

Measure:

The number of admissions to a nursing facility from the community that result in a short-term (less tl

Measure Specification, including a description of the numerator and denominator.
Numerator: Identify all admissions to nursing facilities following the technical specifications published in the Core Set of Health Care Quality Measures for Medicaid Health Home Programs (March 2014). An enrollee may be counted more than once in the numerator if the individual had more than one admission to a nursing facility followed by a discharge to the community during the measurement year.

Denominator: Number of Health Home enrollee months.
Data Sources:
MMIS (i.e., CHAMPS) claims and encounter data; Health Home enrollment data.
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Daily

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:
Hospital Admission Rates
Hospital admissions are collected through claims data for admits provided under fee-for-service and through encounter data for admits provided under capitated managed care. Member month data collected from eligibility files.
Chronic Disease Management
Diagnosis/procedure codes, pharmacy and service utilization collected from claims data for those services provided under fee-for-service and encounter data for those services provided under capitated managed care based on disease specific evidence based protocols for: mental illness, substance use disorder, HIV, hepatitis, diabetes mellitus (with or without complications), anemia, heart disease, cerebrovascular disease, COPD, asthma, chronic kidney disease and lupus).
Coordination of Care for Individuals with Chronic Conditions
Chronic disease management data is collected through administration claims/encounter data, nurse care manager assessments, health home payment and health home encounter data verifying services received by clients (e.g., primary care, mental health, SUD treatment, mental health services, prescriptions, etc.). This data is obtained through the State's MMIS (i.e., CHAMPS) payment system. RN Care management notes and assessments provide evidence of interaction and referrals and will be evaluated at time of monitoring.
Assessment of Program Implementation
Indicators of program implementation are collected from enrollment data, claims/encounter data, client assessment data and interim progress reports.
Processes and Lessons Learned
The State will phase enrollment to ensure ability to evaluate processes and apply lessons learned. DHCF and DBH will also collect input on implementation as well as to make recommendations on implementation strategies to ensure issues are addressed quickly and effectively. Process and lessons learned are collected through key informant interviews and interim progress reports.
Assessment of Quality Improvements and Clinical Outcomes
Quality improvement indicators are collected from enrollment data, claims/encounter data, medical record, and consumer assessment data. As detailed in the quality measures section, the State has identified a list of quality and outcomes measures that apply lessons learned from previous care management pilots that served high cost/high risk individuals. The outcome measures are intended to measure both quality and cost outcomes. Quality will be measured at multiple levels.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.