MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Correction made to form number on 6-1-2016. See highlighted text.

Bulletin Number: MSA 16-13

Distribution: Federally Qualified Health Centers, Hospitals, Local Health Departments, Medicaid Health Plans, Community Mental Health Services Programs, Prepaid Inpatient Health Plans, Practitioners, Rural Health Clinics, Tribal Health Centers

Issued: May 19, 2016

Subject: MI Care Team Implementation (Primary Care Health Home Benefit)

Effective: July 1, 2016

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

Note: Continuation of the MI Care Team policy/benefit after eight (8) quarters of the effective date is subject to Michigan Department of Health and Human Services (MDHHS) review and approval.

Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act and the State Plan Amendment, the purpose of this policy is to provide for the coverage and reimbursement of MI Care Team Health Home services. This policy is effective for dates of service on and after July 1, 2016. The policy applies to fee-for-service and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who meet MI Care Team eligibility criteria. In addition, this policy will have an operations guide for providers, called the MI Care Team Handbook.

1. General Information

Effective July 1, 2016, MDHHS will implement a new care management and care coordination primary care Health Home benefit called the MI Care Team. The goals of the program are to ensure seamless transitions of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting.

2. Beneficiary Eligibility

Eligible beneficiaries meeting geographic area requirements cited in the provider eligibility section of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who have a diagnosis of depression and/or anxiety in addition to a diagnosis of one of the following:

- Asthma
- Diabetes
- Hypertension
- Heart Disease
- Chronic Obstructive Pulmonary Disease

3. Beneficiary Enrollment

A. Enrollment Processes

The MI Care Team uses a two-pronged enrollment approach where both MDHHS and the Health Home providers participate. The process is as follows:

- MDHHS will identify potential eligible beneficiaries using claims data and send each beneficiary a letter notifying them of their eligibility. MDHHS will also provide a list of potential eligible beneficiaries to designated MI Care Team providers with those whom they have an established relationship. The list of eligible beneficiaries will be updated and maintained on a monthly basis. Enrollment is contingent on beneficiary consent (see Beneficiary Consent below), and beneficiary assignment will occur only after a beneficiary visits a MI Care Team provider, fills out the consent and enrollment forms, and establishes an individualized care plan. These steps must be documented.

- MI Care Team providers are permitted to recommend potential eligible beneficiaries for enrollment to MDHHS. MI Care Team providers must provide documentation that indicates that a prospective MI Care Team beneficiary meets all eligibility for the benefit, including presence of qualifying conditions, consent, and establishment of an individualized care plan. MDHHS shall authorize all beneficiary eligibility and process approved enrollments.

B. Beneficiary Consent

Beneficiaries must provide a signed enrollment form (MSA-1030) and a signed consent to share health information form (DCH-3927) to enroll in and receive the MI Care Team benefit. Signed enrollment and consent forms must be collected and stored in the beneficiary's health record. Providers are responsible for verifying receipt of signed enrollment and consent forms and providing proper documentation to MDHHS. All documents must be maintained in compliance with MDHHS record-keeping requirements.

C. MI Care Team Benefit Plan Assignment

Once the steps outlined above are completed, the beneficiary will be assigned a benefit plan of "HHMICARE" associated to their Medicaid member ID in CHAMPS. It is incumbent upon MI Care Team providers to verify a beneficiary's "HHMICARE" assignment prior to rendering services. Beneficiaries without the benefit plan assignment "HHMICARE" will not be eligible for MI Care Team payment.

D. Beneficiary Disenrollment

Beneficiaries may disenroll from the MI Care Team benefit at any time. Beneficiaries who decline enrollment initially may elect to enroll at a later date contingent on meeting eligibility requirements. Beneficiaries who decline services or disenroll may do so without jeopardizing their access to other medically necessary services.

Other than beneficiary-initiated disenrollment, disengaged beneficiaries will be categorized into the following two groups, which have unique disenrollment processes:

- Beneficiaries who have moved out of an eligible geographic area, died, or are otherwise no longer eligible for Medicaid program benefits will have their eligibility files updated per the standard MI Bridges protocol. Providers will receive updated files accordingly.

- Beneficiaries who are unresponsive for reasons other than moving or death. Providers must make three unsuccessful beneficiary contact attempts within three consecutive months for MDHHS to deem a beneficiary as unresponsive. Providers will not receive payment for unsuccessful contacts. Providers must provide documentation for each unsuccessful contact attempt. After the final unsuccessful attempt, providers will recommend disenrollment to MDHHS with proper documentation.

Providers and MDHHS must maintain a list of disenrolled beneficiaries and providers must try to re-establish contact with these beneficiaries at least bi-annually, as applicable.

E. Beneficiary Changing MI Care Team Providers

To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen MI Care Team provider. However, beneficiaries may change MI Care Team providers, and should notify their current MI Care Team provider immediately if they intend to do so. The current and future MI Care Team providers must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new provider's appointment availability. Only one MI Care Team provider may be paid per beneficiary per month. The new MI Care Team provider will also not be eligible for the initial "Access and Health Action Plan" payment if that one-time payment was already made to another MI Care Team provider (see the MI Care Team Payment Section of this policy for more information).

4. Covered Services

MI Care Team services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. These services include the following:

- Comprehensive Care Management, including but not limited to:
  - Assessment of each beneficiary, including behavioral and physical health care needs;
  - Assessment of beneficiary readiness to change;
  - Development of an individualized care plan;
  - Documentation of assessment and care plan in the Electronic Health Record; and
  - Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.

- Care Coordination and Health Promotion, including but not limited to:
  - Organization of all aspects of a beneficiary's care;
  - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;
  - Information sharing between providers, patient, authorized representative(s), and family;
  - Resource management and advocacy;
  - Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
  - Appointment making assistance, including coordinating transportation;
  - Development and implementation of care plan;
  - Medication adherence and monitoring;
  - Referral tracking;
  - Use of facility liaisons;
  - Use of patient care team huddles;
  - Use of case conferences;
  - Tracking of test results;
  - Requiring discharge summaries;
  - Providing patient and family activation and education;
  - Providing patient-centered training (i.e., diabetes education, nutrition education, etc.); and
  - Connection of beneficiary to resources (i.e., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

- Comprehensive Transitional Care, including but not limited to:
  - Connecting the beneficiary to health services;
  - Coordinating and track the beneficiary's use of health services;
  - Providing and receiving notification of admissions and discharges;
  - Receiving and reviewing care records, continuity of care documents, and discharge summaries;

- Post-discharge outreach to assure appropriate follow up services;
- Medication reconciliation;
- Pharmacy coordination;
- Proactive care (versus reactive care);
- Specialized transitions when necessary (i.e., age, corrections); and
- Home visits.

- Patient and Family Support, including but not limited to:
  - Reducing barriers to the beneficiary's care coordination;
  - Increasing patient and family skills and engagement;
  - Use community supports (i.e., Community Health Workers, peer supports, support groups, self-care programs, etc.);
  - Facilitating improved adherence to treatment;
  - Advocating for individual and family needs;
  - Assessing and increase individual and family health literacy;
  - Use of advance directives;
  - Providing assistance with maximizing beneficiary's level of functioning; and
  - Providing assistance with development of social networks.

- Referral to Community and Social Support Services, including but not limited to:
  - Providing beneficiaries with referrals to support services;
  - Collaborating/Coordinating with community-based organizations and key community stakeholders;
  - Emphasizing resources closest to the beneficiary's home
  - Emphasizing resources which present the fewest barriers;
  - Identifying community-based resources;
  - Providing resource materials pertinent to patient needs;
  - Assisting in attaining other resources, including benefit acquisition;
  - Providing referral to housing resources; and
  - Providing referral tracking and follow up.

- Use of Health Information Technology to link services, including but not limited to:
  - Use an Electronic Health Record with meaningful use attainment;
  - Use CareConnect360 for care coordination, transition and planning; and
  - Use telemedicine as needed.

5. Provider Eligibility Requirements

Eligible providers were selected by MDHHS through its Invitation-to-Bid (ITB) process. Applicants were selected on the basis of meeting the requirements outlined in the ITB. MI Care Team providers that were selected will assure all requirements are met and maintained. Failure to meet and maintain these requirements can result in loss of MI Care Team eligibility.

A. Geographic Area

Eligible providers must implement the MI Care Team in geographic areas determined by the ITB process.

B. Provider Types

Eligible provider types for the MI Care Team are Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, and Tribal Health Centers (THCs).

C. Provider Requirements

Providers must meet the requirements indicated in the ITB, Memorandum of Agreement (MOA), and the MI Care Team Handbook.

D. Provider Infrastructure Requirements

MI Care Team providers will assure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The on-site care team must consist of, at a minimum, the following:

- Primary Care Provider
  - Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan (i.e., full licensure and certification, as applicable)

- Behavioral Health Consultant
  - Must be a licensed master's level social worker in Michigan

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

- Community Health Worker (CHW)
  - Must be at least 18 years of age
  - Must possess a high school diploma or equivalent
  - Must be supervised by licensed professional members of the care team
  - MDHHS strongly encourages the completion of the CHW Certificate Program

- Health Home Coordinator
  - Must be an administrative staff person employed by the eligible provider

- Access to a Psychiatrist/Psychologist for consultation purposes (can be off-site)
  - Must be a doctoral-level licensed psychiatrist or psychologist in Michigan

In addition to the above Required Provider Infrastructure, eligible providers should coordinate care with the following professions:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

6. Provider Enrollment and MI Care Team Designation

All eligible providers having been selected through the ITB process and meeting the requirements in the Provider Eligibility Requirements section of this policy will be allowed to enroll as a designated MI Care Team provider contingent upon adherence to this policy and the MI Care Team MOA. MDHHS will provide, in writing, the MOA and any other contingencies needed to obtain or preserve MI Care Team designation. Providers must sign and attest to adhere to this policy and the MOA and return to MDHHS. Only after MDHHS receives this signed attestation will a provider become a designated MI Care Team provider.

A. Training and Technical Assistance

MDHHS requires provider participation in state-sponsored training and technical assistance as a standard condition for continued MI Care Team designation. A readiness assessment will be completed for each designated MI Care Team site, which will provide a basis for training and technical assistance needs.

B. Use of Applicable Health Information Technology (HIT)

MDHHS requires MI Care Team providers to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources will be provided by MDHHS.

7. Provider Disenrollment

To maximize continuity of care and the patient-provider relationship, MDHHS expects MI Care Team providers to establish a lasting relationship with enrolled beneficiaries. However, designated MI Care Team providers wishing to discontinue MI Care Team services must notify MDHHS at least six months in advance of ceasing MI Care Team operations. MI Care Team services may not be discontinued without MDHHS approval of a provider created cessation plan and protocols for beneficiary transition.

8. MI Care Team Payment

Payment for MI Care Team services is contingent on designated MI Care Team providers meeting the requirements laid out in this policy and in the MOA, and as determined by MDHHS. Failure to meet these requirements may result in loss of MI Care Team provider designation.

A. General Provisions for MI Care Team Payment

To provide MI Care Team services and bill Medicaid, a provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS), including enrollment as a billing agent or utilization of an existing billing agent to bill for and receive the MI Care Team payments. Designated MI Care Team providers will have their own CHAMPS identifier which must be used to submit encounters for MI Care Team Services. This identifier will only be used for documenting MI Care Team services. The Group (Type 2 - Organization) National Provider Identifier (NPI) number must be used as the billing provider on all MI Care Team service encounters submitted. The billing provider loop or field is mandatory to complete. The Provider (Type 1 - Individual) NPI number of the provider who performed the service encounter, or the supervising physician, should be entered as the rendering provider. If the provider who performed the service is not enrolled in CHAMPS (e.g., CHW), then a supervising primary care provider must be entered as the rendering provider (i.e., primary care physician, nurse practitioner, physician's assistant). Designated MI Care Team providers should continue using their standard National Provider Identifier (NPI) for payment of regular (non-MI Care Team) clinical services.

Designated MI Care Team providers will be paid one of two monthly case rates, which are as follows:

- Health Action Plan Rate
  The MI Care Team uses a once-in-a-lifetime-per-beneficiary "Health Action Plan" rate to be paid only for the first month that a beneficiary participates in the MI Care Team program. This once-in-a-lifetime-per-beneficiary rate represents reimbursement for certain actions and services, including but not limited to initial care plan development. This service must be delivered in person.

- Ongoing Care Coordination Rate
  For all subsequent months following the Health Action Plan payment, the "Ongoing Care Coordination" will be paid for eligible MI Care Team beneficiaries.

Details and guidance regarding applicable service encounter and diagnosis codes can be found in the MI Care Team Handbook.

Please note that payment for MI Care Team services is in addition to the existing fee-for-service payments, encounters, or daily rate payments for direct clinical services. MDHHS' payment methodology is designed to only reimburse for the cost of the MI Care Team staff for the delivery of Health Home services that are not covered by any other currently available Medicaid reimbursement mechanism.

B. Recoupment of Payment

The monthly payment is contingent on a MI Care Team beneficiary receiving a MI Care Team service during the month. The payment is subject to recoupment if the beneficiary does not receive a MI Care Team service during the calendar month. The recoupment lookback will occur four months after the monthly payment is made. Thus, four months after the month a payment is made (for example, in November MDHHS would look back at July's payment), CHAMPS will conduct an automatic recoupment process that will look for an appropriate code. If a core MI Care Team service is not provided during a calendar month, that month's payment will be subject to recoupment by MDHHS. Once a recoupment has occurred, there shall be no further opportunity to submit a valid MI Care Team encounter code and/or claim.

9. MI Care Team and Managed Care Beneficiaries

MI Care Team providers and Medicaid Health Plans are expected to work together to coordinate services for eligible members who wish to enroll in the MI Care Team benefit. Both the providers and the health plans will be given a list of their members deemed eligible for the MI Care Team program. MDHHS will require providers and health plans to confer to optimize communication to beneficiaries. MI Care Team providers will primarily be responsible for conducting outreach to eligible beneficiaries.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Chris Priest, Director
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