Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date: Attachment 3.1-H Page Number: 1

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-15-2000

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:

MI Care Team

State Information

State/Territory name:	**Michigan**
Medicaid agency:	Department of Health and Human Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Erin Black
Title:	Federal Liaison
Telephone number:	(517) 335-5303
Email:	Blacke@michigan.gov

The primary contact for this submission package.

Name:	Chris Priest

Title:	Medicaid Director
Telephone number:	(517) 335-5303
Email:	PriestC1@michigan.,gov

The secondary contact for this submission package.

Name:	Dick Miles
Title:	Director, Bureau of Medicaid Policy and Health System Innovation, M
Telephone number:	(517) 373-2378
Email:	MilesR6@michigan.gov

The tertiary contact for this submission package.

Name:	Jackie Prokop
Title:	Director, Program Policy Division
Telephone number:	(517) 335-5184
Email:	Prokopj@michigan.gov

Proposed Effective Date

04/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
In 2014, upon recommendation from the gubernatorial-created Mental Health and Wellness Commission, the State of Michigan appropriated funding to implement primary care health homes, or Section 2703 of the Affordable Care Act (ACA), in Michigan's Federally Qualified Health Centers (FQHC) and Tribal Health Centers (THC). The commission was charged to strengthen the entire delivery spectrum of mental health services throughout the state of Michigan. The appropriation is contingent upon serving Medicaid and Healthy Michigan Plan beneficiaries who have one behavioral health condition and another chronic health condition. This will improve behavioral health in an integrated environment. The program will include all of the health home services mandated by the ACA, including: Care management, care coordination, health promotion, transitional care, patient and family support, and appropriate community referrals.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 4050000.00
Second Year	2017	$ 8100000.00

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:
Chris Priest, Director
Medical Services Administration

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Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number: 2

Submission - Public Notice

Indicate whether public notice 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 public notice was solicited:

Newspaper Announcement

Newspaper	
Name:	
Date of Publication: (mm/dd/yyyy)	
Locations Covered:	

Newspaper	

☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication: _____ (mm/dd/yyyy)

☐ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification: _____ (mm/dd/yyyy)

Description: _____

☐ **Website Notice**

Select the type of website:

☐ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: _____ (mm/dd/yyyy)

Website URL: _____

☐ Website for State Regulations

Date of Posting: _____ (mm/dd/yyyy)

Website URL: _____

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments _____

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number: 3

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☑ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

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

Tribal consultation was conducted in the following manner:

Indian Tribes

Indian Tribes	
Name of Indian Tribe: All Tribal Chairs and Health Directors Date of consultation: 03/18/2015 (mm/dd/yyyy) Method/Location of consultation: A letter was mailed to federally recognized Tribal Chairs and Health Directors and posted on the Michigan Department of Health and Human Services (MDHHS') Website (L 15-19).	
Name of Indian Tribe: All Tribal Chairs and Health Directors Date of consultation: 09/02/2015 (mm/dd/yyyy) Method/Location of consultation: A letter was mailed to federally recognized Tribal Chairs and Health Directors and posted on the Michigan Department of Health and Human Services (MDHHS') Website (L 15-56).	
Name of Indian Tribe: Michigan Tribal Health Directors Association Date of consultation: 04/15/2015 (mm/dd/yyyy) Method/Location of consultation: Face to face presentation / New Buffalo, Michigan	
Name of Indian Tribe: Michigan Tribal Health Directors Association Date of consultation: 10/14/2015 (mm/dd/yyyy) Method/Location of consultation: Face to face presentation / Sault Ste. Marie, Michigan	
Name of Indian Tribe: Michigan Tribal Health Directors Association Date of consultation: 07/15/2015 (mm/dd/yyyy) Method/Location of consultation: Telephonic	
Name of Indian Tribe: Saginaw Chippewa Tribe Date of consultation: 04/09/2015 (mm/dd/yyyy) Method/Location of consultation: Telephonic	

Indian Health Programs

Indian Health Programs	
Name of Indian Health Programs: All Tribal Chairs and Health Directors Date of consultation: 03/18/2015 (mm/dd/yyyy) Method/Location of consultation:	

Indian Health Programs	
A letter was mailed to federally recognized Tribal Chairs and Health Directors and posted on the Michigan Department of Health and Human Services (MDHHS') Website (L 15-19).	
Name of Indian Health Programs: All Tribal Chairs and Health Directors Date of consultation: 09/02/2015 (mm/dd/yyyy) Method/Location of consultation: A letter was mailed to federally recognized Tribal Chairs and Health Directors and posted on the Michigan Department of Health and Human Services (MDHHS') Website (L 15-56).	
Name of Indian Health Programs: Michigan Tribal Health Directors Association Date of consultation: 04/15/2015 (mm/dd/yyyy) Method/Location of consultation: Face to face presentation / New Buffalo, Michigan	
Name of Indian Health Programs: Michigan Tribal Health Directors Association Date of consultation: 07/15/2015 (mm/dd/yyyy) Method/Location of consultation: Telephonic	
Name of Indian Health Programs: Michigan Tribal Health Directors Association Date of consultation: 10/14/2015 (mm/dd/yyyy) Method/Location of consultation: Face to face presentation / Sault Ste. Marie, Michigan	

☑ **Urban Indian Organization**

Urban Indian Organizations	
Name of Urban Indian Organization: All Tribal Chairs and Health Directors Date of consultation: 09/02/2015 (mm/dd/yyyy) Method/Location of consultation: A letter was mailed to federally recognized Tribal Chairs and Health Directors and posted on the Michigan Department of Health and Human Services (MDHHS') Website (L 15-56).	
Name of Urban Indian Organization: All Tribal Chairs and Health Directors Date of consultation: 03/18/2015 (mm/dd/yyyy) Method/Location of consultation: A letter was mailed to federally recognized Tribal Chairs and Health Directors and posted on the Michigan Department of Health and Human Services (MDHHS') Website (L 15-19).	
Name of Urban Indian Organization: Michigan Tribal Health Directors Association Date of consultation:	

Urban Indian Organizations	
04/15/2015 (mm/dd/yyyy) Method/Location of consultation: Face to face presentation / New Buffalo, Michigan	
Name of Urban Indian Organization: Michigan Tribal Health Directors Association Date of consultation: 07/15/2015 (mm/dd/yyyy) Method/Location of consultation: Telephonic	
Name of Urban Indian Organization: Michigan Tribal Health Directors Association Date of consultation: 10/14/2015 (mm/dd/yyyy) Method/Location of consultation: Face to face presentation / Sault Ste. Marie, Michigan	

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number: 4

Submission - SAMHSA Consultation

☑ **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	
Date of consultation: 09/03/2015 (mm/dd/yyyy)	

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number: 5

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**

Other Chronic Conditions	
Anxiety	
COPD	

Other Chronic Conditions	
Depression	
Hypertension	

☐ **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**

Other Chronic Conditions	

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:

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:

The state intends to target specific counties contingent on provider selection and target condition prevalence. Based on the 10/1/2015 informal call with CMS, Michigan will provide specific counties prior to the SPA's approval.

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 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 will identify beneficiaries meeting eligibility criteria using claims data, send eligible beneficiaries a notification letter, and inform providers with an existing relationship with these beneficiaries for outreach purposes. The beneficiary letter will provide contact information for eligible locations in their area. For beneficiaries not captured in claims data, providers can recommend enrollment by submitting to the State an attestation form. The State will verify all beneficiary eligibility and process approved enrollments in compliance with approved state plan provisions, which will take two weeks from verification to enrollment.

A beneficiary must provide consent to enroll, which will be retained in their health record. Beneficiaries may disenroll at any time. Beneficiaries who decline enrollment in the benefit at the outset may elect to receive the benefit at any time contingent on eligibility requirements. Beneficiaries who decline or disenroll may do so without jeopardizing their access to other medically necessary services.

Disengaged beneficiaries, and those having moved outside of an eligible geographic area or died will be recommended for disenrollment. Except for moving and death, disengaged beneficiaries will be disenrolled after the provider has made three unsuccessful contact attempts within a quarter (providers will not be reimbursed for unsuccessful contacts). After the final attempt, providers will recommend disenrollment to the State with appropriate rationale. The State will verify and process disenrollments. Providers and the State must maintain a list of disenrolled beneficiaries and providers must try to re-establish contact with these beneficiaries at least bi-annually, as applicable.

☑ **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.**

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number: 6

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:

☐ **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:

Federally Qualified Health Centers (FQHC): FQHCs must be enrolled as a Medicaid provider. They must meet all federal requirements to ensure their designation as an FQHC (Section 330 Health Center grantee or FQHC look-alike) is in good standing. FQHCs must also meet all state requirements for participation, along with all standard provider policies for participation with Medicaid. FQHCs must apply for participation and all designated providers within the FQHC must participate in an initial health home training. The medical staff of the FQHC will act as the designated provider and will be responsible for the overall provision of health home services.

☑ **Other (Specify)**

Provider	
Name: Tribal Health Center (THC) Provider Qualifications and Standards: Tribal Health Center (THC): THCs must be enrolled as a Medicaid provider. They must meet all federal requirements of the Indian Health Service. THCs must also meet all state requirements for participation, along with all standard provider policies for participation with Medicaid. THCs must apply for participation and all designated providers within the THC must participate in an initial health home training. The medical staff of the THC will act as the designated provider and will be responsible for the overall provision of health home services.	

☐ **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:

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

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

In order to serve as a Health Homes provider, each FQHC and THC must provide each Health Homes beneficiary with access to an interdisciplinary care team capable of meeting the beneficiary's mental and physical health needs. The beneficiary's specific needs will dictate the size and scope of provider involvement. At a minimum, each FQHC and THC must provide the following on-site care team members who are qualified to perform functions including but not limited to the following:

Primary care Provider (i.e., primary care physician, physician assistant, or nurse practitioner):
•Lead the care team in providing medical care services;
•Lead in selecting strategies to implement evidence based wellness and prevention initiatives;
•Lead care plan development, including development of specific goals for all enrollees;
•Lead communication with medical providers, subspecialty providers (including mental health and substance abuse service providers), long term care providers and hospital providers regarding patient care and records including admission/discharge;
•Lead in providing health education, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs;
•Lead in monitoring assessments and screenings to assure findings are integrated in the care plan;
•Use the EHR and other HIT to link services, facilitate communication among team members, and provide feedback;

•Lead in meeting regularly with the care team to plan care, review cases, and exchange information with team members as part of the daily routine of the clinic.

Behavioral Health Consultant (e.g., LMSW):
•Screen/evaluate individuals for mental health and substance abuse disorders;
•Refer to licensed mental health provider and/or SUD therapist as necessary;
•Provide brief intervention for individuals with behavioral health problems;
•Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the clinic;
•Support primary care providers in identifying and providing behavioral interventions;
•Focus on managing a population of patients versus providing specialty care;
•Work with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions;
•Develop and maintain relationships with community based mental health and substance abuse providers;
•Identify community resources (i.e. support groups, workshops, etc.) for patient to use to maximize wellness;
•Provide patient education.

Nurse Care Manager (i.e., RN):
•Participate in selecting strategies to implement evidence based wellness and prevention initiatives;
•Participate in initial care plan development including specific goals for all enrollees;
•Communicate with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding patient care and records including admission/discharge;
•Provide education in health conditions, treatment recommendations, medications, and strategies to implement care plan goals including both clinical and non-clinical needs;
•Monitor assessments and screenings to assure findings are integrated in the care plan;
•Facilitate the use of the EHR and other HIT to link services, facilitate communication among team members, and provide feedback;
•Monitor and report performance measures and outcomes;
•Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the clinic.

Community Health Worker:
•Coordinate and provide access to individual and family supports, including referral to community social supports;
•Meet regularly with the care team to plan care and discuss cases, and exchange information with team members as part of the daily routine of the clinic;
•Identify community resources (i.e. social services, workshops, etc.) for patient to use to maximize wellness;
•Referral tracking;
•Coordinate and provide access to chronic disease management including self-management support;
•Implement wellness and prevention initiatives;
•Facilitate health education groups;
•Provide education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

Health Homes Coordinator (i.e., Administrative Staff):
•Provide leadership to implement and coordinate health home activities;
•Serve as the liaison between the MPCA and MDCH Health Home staff;
•Champion practice transformation based on Health Home principles;
•Develop and maintain working relationships with primary and specialty care providers including CMHSPs and inpatient facilities;
•Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management;
•Monitor Health Home performance and lead improvement efforts;
•Lead in monitoring and reporting performance measures and outcomes;
•Design and develop prevention and wellness initiatives;
•Referral tracking;
•Provide training and technical assistance;
•Perform data management and reporting.

(Access to) a Psychologist and/or Psychiatrist:
•The care team must have access to a doctoral-level psychologist and/or psychiatrist for consultation purposes;

•Communicate treatment methods, advice and/or recommendations to the Behavioral Health Provider for inclusion.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
Under Michigan's approach to Medicaid Health Home implementation in Federally Qualified Health Centers (FQHC) and Tribal Health Centers (THC) the objective is to provide efficient care, increase access, create a continuum of care, reduce costs, avoid preventable emergency room visits, and improve patient outcomes. To achieve these objectives health home providers will be required to meet the following standards.

1. Enrollment/Recognition/Certification
a. Health home providers must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies
b. Be a Section 330 Health Center program grantee of any type, Federally-Qualified Health Center Look-Alike, Tribal 638 facility, or Urban Indian organization
c. Health home providers must adhere to all federal and state laws in regard to Health Homes recognition/certification, including the capacity to perform all core services specified by CMS. Providers shall meet the following recognition/certification standards:
i. Achieve Patient Centered Medical Home (PCMH) from national recognizing body (NCQA, AAAHC, JC) before health homes becomes operational. PCMH application can be pending

2. A personal care team will be assigned to each patient
a. Ensure each patient has an ongoing relationship with a personal member of their care team who is trained to provide first contact and support continuous and comprehensive care, where both the patient and the care team recognize each other as partners in care. Behavioral health is embedded into primary care, with real-time consult available to primary care provider
b. Care teams are staffed according to model selected

3. Whole Person Orientation
a. Provide or take responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care
b. Meaningful use of technology for patient communication
c. Develop a person centered care plan for each individual that coordinates and integrates all clinical and non-clinical health care related needs and services

4. Coordinated/Integrated Care
a. Dedicate a care coordinator responsible for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes and communication with external specialists
b. Communicate with patient, and authorized family and caregivers in a culturally and linguistically appropriate manner
c. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services and health promotion
d. Directly provide or have an Memorandum of Agreement (MOA) in place to coordinate or provide:
i. Mental health/behavioral health and substance use disorder services
ii. Oral health services
iii. Chronic disease management
iv. Coordinated access to long term care supports and services
v. Recovery services and social health services (available in the community)
vi. Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco treatment/cessation, and health coaching)
e. Conduct outreach to local health systems and establish bi-directional referral processes whereby the health system communicates directly with the Health Homes and the Health Homes communicates directly with the health system to maximize appropriate care transitions
f. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
g. Review and reconciliation of medications
h. Assessment of social, educational, housing, transportation, and vocational needs that may contribute to disease and/or present as barriers to self-management (Social workers, CHW)
i. Maintain a reliable system and written standards/protocols for tracking patient referrals; Health Homes providers will utilize CareConnect 360 or another medium to assist with tracking and follow-up efforts

5. Emphasis on Quality and Safety
a. Health homes providers must adhere to all applicable privacy, consent, and data security statutes
b. Demonstrate use of clinical decision support within the practice workflow specific to the conditions identified in the health homes project
c. Demonstrate use of a population management tool such as a patient registry and the ability to evaluate results and implement interventions that improve outcomes
d. Each Health Home shall implement formal screening tools such as SBIRT, PHQ9, GAD, diabetes and asthma risk tests to assess treatment needs
e. 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

6. Enhanced Access
a. Provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations
b. Monitor access outcomes such as the average 3rd next available appointment and same day scheduling availability
c. Use of email, text messaging, patient portals and other technology as available to the practice to communicate with patients is encouraged
d. Implement policies and procedures to operation with open access scheduling and available same day appointments

7. Health Information Technology
a. Must have an Electronic Health Record (EHR) in place with capability of behavioral health information integration.
b. Provider must have achieved Meaningful Use stage 1 as defined by the Centers for Medicare and Medicaid Services.
c. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members as well as between the health team and individual and family caregivers, and provide feedback to practices; as feasible and appropriate.
d. Health Home providers must have the capacity to electronically report to the state or its contracted affiliates information about the provision of core services and outcome measures.

8. Health Homes Team
a. Support Health Homes team participation in all related activities and trainings including travel costs associated with Health Homes activities.
b. Work collaboratively with MDHHS and contractors to adapt and adopt program processes for Health Home care team use in the participating sites(s).
c. Actively engage in Health Home process and outcome achievement activities including ongoing coaching, data feedback and customized improvement plans to meet initiative goals.
d. Commit a management staff member (such as the Health Home Coordinator) and a clinician champion serving on the care team(s) at the participating site(s) to contribute actively to and support the project.
e. Commit a staff member to serve as the liaison to the beneficiary's assigned managed care health plan.
f. Submit evidence of active care plan development or active care plan maintenance/management in to the state's Medicaid Management Information System known as the Community Health Automated Medicaid Processing System (CHAMPS).

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 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:

☐ **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.**

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date: Attachment 3.1-H Page Number: 8

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 payment mechanism for MI Care Team is a monthly case rate. Payment for Health Homes services are contingent on the approved Health Homes providers meeting the requirements set forth in their Health Homes applications, as determined by MDHHS. Failure to meet these requirements may result in loss of Health Homes status and termination of payments. The monthly payment for Health Homes is in addition to the existing fee for services, encounter or daily rate payments for direct services.

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.

There are two rates associated with the Health Home program. There is an "Assessment and Health Action Plan" rate to be paid in the first month of a beneficiary's participation and an "Ongoing Care Coordination" rate to be paid in subsequent months. Both rates reflect personnel costs of the required team of health care professionals providing Health Home services. The Health Home rates also reflect related indirect and overhead costs for these positions. MDHHS' payment methodology is designed to only reimburse for the costs associated with the aforementioned Health Homes' staff for the delivery of services that are not covered by any other currently available Medicaid reimbursement mechanism. MDHHS will annually evaluate the Health Home payment rates to determine whether the rates require adjustment due to staffing costs of the team of health care professionals, changes in related indirect and overhead costs, or other factors determined by MDHHS.

The "Assessment and Health Action Plan" rate is developed based on the estimated time that would be spent by each member of the Home Health care team to assess the individual and develop a care plan. The hourly rates for each position, fully loaded to include indirect and overhead costs, are then utilized to determine the total rate. This in-person assessment is required for the provider to enroll the individual into the Health Home.

The "Ongoing Care Coordination" rate is based on the number of full time equivalent (FTE) employees needed at each level on the care team to maintain monthly care coordination with the enrolled individuals. The ratios of FTEs per enrollee and the salaries for each position were then utilized to compute a monthly payment needed for each position on the care team. The monthly payments for each position were then added together to arrive at the total monthly rate. All "Ongoing Care Coordination" payments made to the Health Home provider are contingent on the provider making an established contact with the beneficiary during the payment month. Health home services contacts, as described in the core service definitions, may or may not require face-to-face interaction with a beneficiary.

If a core health homes service is not rendered, that month's payment will be subject to recoupment. Four

months after the month a monthly payment is made, MDHHS will conduct an automatic recoupment process that will look for an approved claim that documents that the health home provided at least one of the five core health homes services (excluding the Health IT requirement) during the month in review.

☐ **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.

Health Home care coordination is done at the primary care practice level, thus creating an intimate level of care coordination and management. The more intensive aspects of Health Home care coordination include a lower employee to beneficiary ratio for Community Health Workers (CHWs) as compared to the Michigan Medicaid managed care plan contract for care coordination and social support services. In addition, Health Home providers will be required to use the IMPACT and Nuka care coordination models and require team huddles at the primary care practice level, which provides an intensive level of behavioral health integration.

As provided in their contracts, managed care plans and their care coordinators/managers will communicate with Health Home providers to ensure that both entities promote coordination of services and avoid duplication of services.

☑ **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-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number: 9

Submission - 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 eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health homes are required to have a functioning Electronic Health Record (EHR) in order to participate. Health Home Providers will utilize their EHR to facilitate progress made on the overall care plan and adjust the plan accordingly in unison with the needs of the beneficiary. Health Homes will provide reporting via the EHR. Issues identified during the assessment will be incorporated into the care plan which is documented in the EHR.

The establishment of a centralized, claims-based health information exchange (HIE) will assist care coordinators with maintaining a comprehensive care plan for each beneficiary enrolled in the health home.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

☑ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Care Coordination

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

A key support role includes the Community Health Worker (CHW). CHWs are professionals identified by the American Public Health Association. CHWs are frontline public health workers who have an understanding of the community they serve. The CHW serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

CHWs and other Care Coordinators will, at a minimum, provide:
- Emphasis will be placed on in-person contacts; however telephonic outreach may be used for lower-risk Health Home members who require less frequent face to face contact (lower-risk is defined at the Health Homes level by clinicians on the Health Homes care team in consideration of management of chronic conditions)
- Appointment making assistance, including coordinating transportation
- Development and implementation of care plan
- Medication adherence and monitoring
- Referral tracking
- Use of facility liaisons, as available (i.e., nurse care managers)
- Patient care team huddles
- Use of case conferences, as applicable
- Tracking test results
- Requiring discharge summaries

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health Home Providers will utilize their EHR to record care coordination and health promotion activities and make adjustments to these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

☑ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Community Health Workers

Description

Health Promotion

Definition:
Health Promotion begins with the initial health homes visit or while establishing a formal care plan. The health home will assess the readiness to change and provide the beneficiary with the appropriate level of encouragement and support for the adoption of these healthy behaviors and/or lifestyle changes. Healthy behaviors and/or lifestyle interventions include but are not limited to:

- Development of self-management plans
- Evidenced-based wellness and promotion
- Patient education
- Patient and family activation
- Addressing clinical and social needs
- Patient-centered training (e.g., diabetes education, nutrition education)
- Connection to resources for smoking prevention and cessation, substance use disorder treatment and prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing based on beneficiaries' needs and preferences.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health Home Providers will utilize their EHR to record care coordination and health promotion activities and make adjustments to these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

☑ **Physicians' Assistants**

Description

- [ ] **Pharmacists**

Description

- [x] **Social Workers**

Description

- [ ] **Doctors of Chiropractic**

Description

- [ ] **Licensed Complementary and Alternative Medicine Practitioners**

Description

- [ ] **Dieticians**

Description

- [ ] **Nutritionists**

Description

☑ **Other (specify):**

Name

Community Health Workers

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
Comprehensive transitional care services connect the beneficiary to needed health services available within the community. Health services include care provided outside of the health home. Health homes will be expected to coordinate and track their participants:

- Notification of admissions/discharge
- Receipt of care record, continuity of care document, or discharge summary
- Post-discharge outreach to assure appropriate follow-up services
- Medication reconciliation
- Pharmacy coordination
- Proactive care (versus reactive care)
- Specialized transitions when necessary (e.g., age, corrections)
- Home visits

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
CareConnect360, an MDHHS supported application, is anticipated to support Health Home services by providing access to admission, discharge, and transfer information. CareConnect360 will also provide a resource to health homes providers to track labs, and pharmacy data. In addition, the application will include data on health status and utilization patterns based on claims data. Together, this will allow for seamless transitions of care so that the beneficiary is received and accommodated appropriately at every health service and community setting.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

☑ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The EHR and CareConnect360 will assist providers in supporting beneficiaries and their families with helpful information to empower and educate themselves and subsequently maximize self-management of health.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

☑ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Community Health Workers

Description

Referral to community and social support services, if relevant

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

- Assist in attainment of other resources, including benefit acquisition
- Referral to housing resources as needed
- Referral tracking and follow-up

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
While the community and social services supports network may not have direct access to the enrollee's health record, MDHHS anticipates that the EHR and CareConnect360 will afford providers the ability to track, follow-up and evaluate referrals to these services. In addition, HIT will provide beneficiaries and their families with helpful resource materials to empower and educate themselves and subsequently maximize self-management of health.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Community Health Workers

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
Eligible Health Homes patients will present at a qualified Health Homes clinic for enrollment into the program. At this time, the patient must complete consent and enrollment forms to formally begin participation in the program. If the patient is completely new to the qualified Health Homes provider, then a full new patient orientation of the practice and the Health Homes program will be provided. On a patient's first Health Home visit, the enrollment will entail an introduction to the core Health Homes team and a care plan will be developed that attends to the patient's particular needs. In addition, necessary arrangements will be provided for needed services outside of the four walls of the Health Homes provider. Follow-up appointments and community supports will be determined by the care team and implicated providers will be called upon as needed and as directed through the usage of care team huddles. It should be noted that while every patient will interface with the care team, the extent to which a given care team member's services are required will be dependent upon the conditions or preference of the patient.

☑ **Medically Needy eligibility groups**

◎ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.

All Medically Needy receive the same services.

There is more than one benefit structure for Medically Needy eligibility groups.

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:
Attachment 3.1-H Page Number: 10

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

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

Measure Specifications: 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: number of Index Hospital Stays with a readmission within 30 days among Health Homes beneficiaries.

Denominator: number of Index Hospital Stays among Health Homes beneficiaries.

Data will be stratified by CMS identified age groups and in the aggregate.

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.
MDHHS will contract with an academic research institution to execute a cost-savings analysis for the primary care Health Homes program. Broadly, the cost-focused analyses will consider the consequences of improved care coordination and clinical management for beneficiaries enrolled in the program, and will also measure total expenditures for individuals enrolled in the program comparing the implementation period with the period immediately prior to program implementation. In addition to the pre-post comparison, the contractor will also compare total expenditures for beneficiaries enrolled in the intervention (program) with expenditures for a concurrent control population identified on the basis of their specific eligible conditions and receipt of care in federally qualified health centers. These dual approaches will provide a robust evaluation of the program. All analyses will be presented in aggregate terms and also as PMPM. Data source is MDHHS Data Warehouse.

Measure Specifications: Administrative Claims Data pre- and post-Health Homes implementation; administrative claims data for the intervention and control populations, which will be formally defined in the contractor's methodology.

Adjustments will be made for cost outliers in the analysis.

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).
All Health Homes providers must have Electronic Health Record (EHR) capabilities with meaningful use attainment. These systems will be used to link care in all settings of care to ensure seamless coordination and delivery of services. CareConnect 360 will also be utilized for care transition and planning purposes. In addition, telemedicine will be utilized for the provision of medical services as appropriate, particularly in rural or other areas that may lack density of psychiatrists/psychologists or other needed specialty providers.

Added to the maintenance of their own EHRs, approved Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home services. Health Homes will utilize CareConnect360, which is a care coordination tool that allows providers to access comprehensive retrospective Medicaid claim and encounter data. It supports queries that allow Health Homes to view the following beneficiary information:

- Current and prior health conditions
- Rendering services provider, date of service, and length of stay (if applicable)
- Pharmacy claims data
- Hospitalization and ED utilization, including diagnoses

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:	
Per the CMS Core Utilization Measures (March, 2014) – The rate of acute inpatient care and Measure Specification, including a description of the numerator and denominator. Numerator Description: Inpatient utilization per 1,000 enrollee months among Health Home beneficiaries by discharge date during the measurement year. Denominator Description: Health Home enrollees per 1,000 enrollee months. Data will be stratified by CMS identified age groups, in the aggregate, and by eligibility category. Data Sources: MDHHS Data Warehouse Frequency of Data Collection: **Monthly** **Quarterly** ◉ **Annually** **Continuously** **Other**	

Emergency Room Visits

Measure:

Per the CMS Core Utilization Measures (March, 2014) – The rate of ambulatory care sensitiv

Measure Specification, including a description of the numerator and denominator.
Numerator Description: Ambulatory care sensitive emergency department (ED) visits per 1,000 enrollee months among Health Home beneficiaries by discharge date during the measurement year.

Denominator Description: Health Home enrollees per 1,000 enrollee months.

Data will be stratified by CMS identified age groups, in the aggregate, and by eligibility category.
Data Sources:
MDHHS Data Warehouse
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- ◎ **Annually**
- **Continuously**
- **Other**

Skilled Nursing Facility Admissions

Measure:

Per the CMS Core Utilization Measures (March, 2014) – The number of admissions to a nurs

Measure Specification, including a description of the numerator and denominator.
Numerator Description:

- Short Term Admission Rate – number of short term admissions per 1,000 enrollee months among Health Home beneficiaries.
- Long Term Admission Rate – number of long term admissions per 1,000 enrollee months among Health Home beneficiaries.

Denominator Description: Health Home enrollees per 1,000 enrollee months.

Data will be stratified by CMS identified age groups and in the aggregate.
Data Sources:
MDHHS Data Warehouse
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- ◎ **Annually**
- **Continuously**
- **Other**

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 admission rates will be collected through administrative claims and encounter data for Medicaid Fee-For-Service and Managed Care beneficiaries, respectively. The member month information will be collected from eligibility files. All of this information is housed in the MDHHS Data Warehouse.

Chronic Disease Management
The evaluation of chronic disease management will be facilitated through the collection of a mixture of health and service utilization data. Diagnosis and procedure codes, pharmacy, and service utilization will be collected from claims data for Medicaid Fee-For-Service beneficiaries while those enrolled in Managed Care will be collected from encounter data based on disease specific evidence based protocols for: depression, anxiety, diabetes, hypertension, COPD, heart disease, and asthma.

Coordination of Care for Individuals with Chronic Conditions
MDHHS will use claims, encounter, and pharmacy data to monitor care coordination for the primary care Health Homes population. In addition, nurse care manager assessments, Health Home payment, and specific care coordination codes defined by MDHHS will be analyzed to verify specific elements of care coordination.

Assessment of Program Implementation
MDHHS will assess program implementation through the collection of administrative claims and encounter data, client enrollment and assessment data, interim progress reports, and participating in provider-based learning collaboratives that will include a discussion of the program's progress amongst peers.

Processes and Lessons Learned
MDHHS will work with provider partners to host learning collaboratives that will allow for early adopters of the primary care Health Homes to share their experiences and to offer advice. It is anticipated that the program will "phase" into Health Homes as some will be ready to implement sooner than others, therefore creating mentors to the later adopters. In addition, MDHHS and providers will form an advisory group where select members will have a forum in which to discuss Health Homes implementation progress and experiences on an ongoing basis.

Assessment of Quality Improvements and Clinical Outcomes
Quality Improvement and Clinical Outcome improvements will be assessed through the collection of enrollment, administrative claims/encounter data, medical records, and consumer assessment data. The quality measures will reflect the target population and will build on previously existing data points that MDHHS has established through former projects, which are appropriate to high cost/risk beneficiaries. These will reflect both quality and cost outcomes.

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.

Transmittal Number: MI-15-2000 Supersedes Transmittal Number: N/A Proposed Effective Date: Apr 1, 2016 Approval Date:

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.

Michigan Health Homes Process Narrative – "Lori" Hypothetical Health Home Scenario

Patient Background:
Lori is a 36 year old single female with current primary diagnoses of obesity, diabetes, and depression. She lived with her father, also a diabetic, until he passed away last year. Since her initial diagnosis of depression at age 25, Lori has gained 87 lbs; her current weight is 222 lbs and her height is 5'3". Her depression led her to make poor dietary choices, and she lives a mostly sedentary lifestyle and works an office job. Four years ago, Lori was diagnosed with type-2 diabetes. She generally adheres to medication plans, but sometimes when her depression is at its worst, she shuts down emotionally and does not take her prescriptions. In the past year, Lori has been to the emergency room four times for uncontrolled diabetes; she went once on her own, twice, her coworkers took her when she presented as weak and seemed to be in an altered mental state, and the last time, a neighbor found Lori on her back porch after she had collapsed. At her most recent hospital visit, Lori told staff that she wishes she would die; everyone would be better off. She was sent home with the neighbor who brought her, but the neighbor indicated that she could not monitor Lori or her medication.

Lori does not have a primary care physician, but she does go to a walk-in clinic sometimes. She often asks for pain medicine to help her sleep. A physician at the clinic prescribes insulin, but Lori lacks reliable transportation so she lapses on filling her insulin prescriptions regularly, or she uses the expired insulin from her deceased father. She has never had a case manager, or any community assistance. She only interacts with her coworkers and the one neighbor, but tries to avoid anything extracurricular as she is embarrassed by her weight and how she has "let herself go."

Initiating Health Home Services:
Shortly after Lori's last ER visit, she was added to a list of persons to be actively sought for engagement by a Health Home network because her Hemoglobin A1c (HbA1c) levels have consistently been above 9.0. The referral came to Central State Community Health Center (CSCHC) through the local emergency department who has agreed to refer potentially eligible participants to the program. When CSCHC reviewed the referral, Wendy, the Nurse Care Manager (NCM) at CSCHC assigned Melissa, a Community Health Worker (CHW), to contact Lori and encourage her participation. After two phone conversations, Melissa drove to Lori's address, and met her at her home after work one evening. Lori acknowledged that she had received a letter about the Health Home program a few months before in the mail, but didn't really feel she needed the program as she "has a doctor." After explaining the benefits of the CSCHC Health Homes program, and that she was under no obligation to participate, Melissa asked if Lori would simply meet her at CSCHC the next day to see if she thought it might work for her. Lori agreed.

At the health center, Lori was greeted again by Melissa, who then formally introduced her to Wendy, the Nurse Care Manager (NCM), Mary, the Behavioral Health Consultant (BHC), and Dr. Rose, the Primary Care Physician (PCP). During this initial meeting, Wendy (NCM) provided a program orientation including a description of Health Home services and explained to Lori the benefits of her full participation. Wendy asked Lori to help her complete a brief health screening including physical and chemical dependency questionnaire, and Mary (BHC) assists with the completion of a PHQ-9. The group discussed Lori's support system at home, and Lori found herself opening up about things she has never shared. After the meeting, which lasted approximately 20 minutes, Lori was with Wendy who asked Lori if she would be willing to participate. Lori agreed to complete a Health Home program enrollment form and also provide her consent to share health information for the care she would be receiving within the Health Home program. Wendy explained how important this consent was for all of the care team members listed on her consent to be able to discuss Lori's health and progress. Wendy was then joined by Melissa and the two of them went over a 13 question Patient Activation Measure (PAM) assessment with Lori. The PAM is designed to help the Health Home care team target the tools and resources that will benefit Lori the most, and to provide insight into how to improve

Lori's unhealthy behaviors and improve her health. Melissa told Lori that these forms would be shared with the care team, and then she walked Lori to the front desk to schedule a follow-up appointment with Dr. Rose.

One week later, Lori arrived at CSCHC for her next appointment. Lori initially meets with Dr. Rose for a comprehensive examination. While talking to Lori during this exam, Dr. Rose suspects that Lori suffers from depression. Dr. Rose then initiates a request for Mary, the Behavioral Health Consultant (BHC), to administer a Patient Health Questionnaire (PHQ-9) screen. The result of the screen was 21, confirming the diagnosis of depression. After the exam and screening, Lori meets again with the same three care team providers she has interacted with previously (the BHC, NCM, and PCP).

The care team had reviewed Lori's initial questionnaires and determined:

- Lori does not have an ongoing relationship with a PCP
- Lori uses the local emergency room most often for her medical care
- Lori has little desire to change her health at this time and feels hopeless
- Lori's PAM scores are low, indicating a low level of activation
- Lori has no support system at home
- Lori's HbA1c levels are dangerously high

Wendy (NCM) explained to Lori that based on the answers Lori submitted, the care team has created an initial health action plan for Lori. Wendy and Dr. Rose (PCP) reviewed the plan and solicited feedback from Lori. Lori learned that she would need to visit CSCHC twice a month for the next few months, to help her get her symptoms under control and improve her health. Melissa (CHW) talked about how important it was for Lori to attend all of these appointments and offered assistance with transportation. Dr. Rose explained that she will be Lori's primary care provider and will be overseeing her medical conditions. As a reminder from her examination, Dr. Rose instructed Lori to follow her newly prescribed insulin level dosage to help maintain Lori's HbA1c levels. Melissa then informed Lori of some assistance programs available within the community that will be able to assist with reliable transportation to or delivery of her insulin prescription. Dr. Rose also described how she will work closely with Mary (BHC) and other specialists, as needed, to ensure Lori's care is well coordinated. Wendy reminded Lori that Melissa would contact Lori once a week to check in, offer encouragement, and if there was anything Lori needed, Melissa would notify the care team and remain in touch with Lori. Lori was already comfortable with Melissa and indicated that no one had ever shown that kind of interest in her and she seemed eager to begin. Together, she worked with Wendy to establish goals within the health action plan that she felt she could achieve in the next couple of months.

Continued Success:
Melissa (CHW) continues to work with Lori to promote self-efficacy, review her strengths and successes, and to help her achieve her health related goals. Melissa provides regular updates to Wendy (NCM) who then reports this information back to Dr. Rose and the rest of the care team assigned to Lori's care. Additionally, Mary (BHC) has connected Lori with a local support group for those dealing with loss. Lori attends the group meeting weekly. Lori is slowly meeting goals, managing her HbA1c, and her PHQ-9 score at her last visit was down to 13. She reports feeling more energy and more of a sense of self-worth now that she is playing an active role in her own health advocacy. She has also adopted a dog from the local shelter, and reports that she doesn't feel as lonely and feels needed. She has been walking the dog every evening, and has now (five months into enrollment) lost 21 lbs. Wendy (NCM) has referred Lori to a local dietician who will help Lori plan meals that help her control her diabetes and weight. Lori is now on a monthly visit plan to CSCHC, with bi-weekly check in calls from Melissa.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

September 2, 2015

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Primary Care Health Homes Project

This letter is an update to Letter L 15-19 dated March 18, 2015, and is intended to provide additional information regarding the health homes benefit that will be available for Tribal and Urban Health Centers.

In compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, this letter serves as additional notice of intent to all Tribal Chairs and Health Directors of the request by the Michigan Department of Health and Human Services (MDHHS) to submit State Plan Amendments (SPAs) to add the health homes benefit to the Medicaid State Plan and to the Alternate Benefit Plan benefit package for the Healthy Michigan Plan.

The health homes benefit is for Medicaid and Healthy Michigan Plan beneficiaries served in the primary care setting within selected geographic areas. Beneficiaries must have at least one targeted behavioral health condition and the presence of another program defined chronic health condition. MDHHS intends to solicit applications from qualifying entities that would like to be designated as health homes by the end of the year. Tribal and Urban Health Centers that meet health homes provider qualifications and standards may be eligible to apply. The anticipated effective date for this new benefit is April 1, 2016.

As a reminder, participating health homes sites must maintain a robust care coordination program and will function as the central point of contact for directing patient-centered care across all elements of the broader health care system. Native American beneficiaries with a qualifying health condition will be eligible to enroll in the program if they wish. Participation is voluntary and enrolled beneficiaries may opt-out at any time. MDHHS will notify eligible beneficiaries of the opportunity to enroll and provide them with the name and location of the nearest health homes provider.

Additional face-to-face consultation regarding these amendments will occur at the next scheduled Michigan Tribal Health Directors Association's Quarterly Tribal Health Directors meeting on October 14, 2015 in Sault Ste. Marie, MI. The consultation will provide a project status update and discussion of the amendments.

Input regarding these amendments is highly encouraged, and comments regarding this Notice of Intent may be submitted to Lorna Elliott-Egan, MDHHS Liaison to the Michigan Tribes. Lorna can be reached at 517-373-4963 or via email at Elliott-EganL@michigan.gov. **Please provide all input regarding this notice by October 19, 2015.**

In addition, MDHHS is offering to set up group or individual meetings for the purposes of consultation in order to discuss these amendments, according to the tribes' preference. This consultation meeting will allow tribes the opportunity to address any concerns and voice any suggestions, revisions, or objections to be relayed to the author of the proposal. If you would like additional information or wish to schedule a consultation meeting, please contact Lorna Elliott-Egan at the telephone number or email address provided above.

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

Sincerely,

Kathy Stiffler, Acting Director
Medical Services Administration

cc: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Jenny Jenkins, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 15-56
September 2, 2015

Mr. Levi Carrick, Sr., Tribal Chairman, Bay Mills Indian Community
Ms. Audrey Breakie, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. Alvin Pedwaydon, Tribal Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Loi Chambers, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. Warren C. Swartz, Jr., President, Keweenaw Bay Indian Community
Ms. Carole LaPointe, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Mr. James Williams, Jr., Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Ms. Sadie Valliere, Health & Human Services Director, Lac Vieux Desert Band
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Ms. Jessica Burger, Acting Health Director, Little River Band of Ottawa Indians
Mr. Fred Kiogima, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Sharon Sierzputowski, Health Director, Little Traverse Bay Band of Odawa
Mr. DK Sprague, Tribal Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Phyllis Davis, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Mr. Homer Mandoka, Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Mr. Travis Parashonts, Chief Executive Officer, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Rosalind Johnston, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Mr. John Warren, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Matt Clay, Health Director, Pokagon Potawatomi Health Services
Mr. Steve Pego, Tribal Chief, Saginaw Chippewa Indian Tribe
Mrs. Karmen Fox, Executive Health Director, Nimkee Memorial Wellness Center
Mr. Aaron Payment, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Ms. Bonnie Culfa, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Jenny Jenkins, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

March 18, 2015

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Primary Care Health Homes Pilot

This letter, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, serves as notice of intent to all Tribal Chairs and Health Directors of the request by the Michigan Department of Community Health (MDCH) to submit a State Plan Amendment (SPA).

The State of Michigan appropriated funds to implement a primary care health homes pilot project in Michigan's Federally Qualified Health Centers (FQHCs), in accordance with Section 2703 of the Affordable Care Act. The pilot project will be focused on beneficiaries served in the primary care setting who have at least one behavioral health condition and either the presence or risk of another chronic health condition. MDCH will solicit applications from qualifying entities that would like to be designated as health homes. Tribal and Urban Health Centers that meet health homes provider qualifications and standards may be eligible to apply.

Health homes will function as the central point of contact for directing patient-centered care across all elements of the broader health care system. They will be required to maintain a robust care coordination program in an effort to reduce avoidable health care costs and improve the overall quality of life for the beneficiary. This may include referrals to appropriate community and support services as needed. Native American beneficiaries with a qualifying health condition will be eligible to enroll in the pilot program if they wish. Participation is voluntary and enrolled beneficiaries may opt-out at any time. MDCH will notify eligible beneficiaries of the opportunity to enroll and provide them with the name and location of the nearest health homes provider.

There is no public hearing scheduled for this SPA. Input regarding this Amendment is highly encouraged and comments regarding this Notice of Intent may be submitted to Lorna Elliott-Egan, MDCH Liaison to the Michigan Tribes. Lorna can be reached at 517-373-4963 or via e-mail at Elliott-EganL@michigan.gov. **Please provide all input by April 19, 2015.**

In addition, MDCH is offering to set up group or individual meetings for the purposes of consultation in order to discuss this Amendment, according to the tribes' preference. This consultation meeting will allow tribes the opportunity to address any concerns and voice any suggestions, revisions, or objections to be relayed to the author of the proposal. If you would like additional information or wish to schedule a consultation meeting, please contact Lorna Elliott-Egan at the telephone number or email address provided above.

MDCH appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

Sincerely,

Stephen Fitton, Director
Medical Services Administration

cc: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Ashley Tuomi, MHPA, Executive Director, American Indian Health and Family Services of Southeastern Michigan
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Jenny Jenkins, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDCH

Distribution List for L 15-19
March 18, 2015

Mr. Levi Carrick, Sr., Tribal Chairman, Bay Mills Indian Community
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