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State/Territory Name: MI
State Plan Amendment (SPA) #:18-1500-Opioid Health Home

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

March 11, 2019

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

ATTN: Erin Black

Dear Ms. Stiffler:

We are following up on our letter dated October 3, 2018, to provide further clarification on the approval of Michigan State Plan Amendment (SPA) Transmittal Number (TN) 18-1500. As indicated in the earlier letter, the Centers for Medicare & Medicaid Services (CMS) completed its review of SPA 18-1500. This SPA implements Health Homes for Opioid/Substance Use Disorder targeted conditions as authorized under Section 2703 of the Patient Protection and Affordable Care Act. The state plan pages for this SPA were submitted and approved through the Medicaid and CHIP Program System (MACPro). This letter replaces the one issued formally through MACPro on September 28, 2018, and the revised approval letter dated October 3, 2018. CMS will also formally reissue a copy of this version of the approval letter through MACPro.

With this revision, CMS is clarifying that the October 3, 2018 letter, which correctly identified the topic of the SPA as the "Health Homes Benefit to cover treatment for Opioid and Substance Use Disorders," is the official approval letter for this SPA. Consequently, CMS considers the date of the approval to be October 3, 2018. The initial letter issued on September 28, 2018, mistakenly referred to the health home benefit to cover certain physical and behavioral health conditions, and this terminology was not correct with regard to the changes submitted by Michigan, the information contained on the state's 179 form submitted with the SPA, or with what was approved by CMS. Given the significant nature of the discrepancy, CMS issued the revised October 3, 2018 letter to be consistent with the state's stated intent for coverage of health home services, but did not update the approval date accordingly. Now, CMS is updating both this approval package and the state plan pages to reflect that the approval date is October 3, 2018.

Enclosed for your records is an approved copy of the following SPA TN #18-1500 – Authorizes the Medicaid Health Homes Benefit to cover treatment for opioid and substance use disorders as outlined in the approved plan pages.

- Effective Date: October 1, 2018
- Approval Date: October 3, 2018

This approval is based on the state's agreement to collect and report information required for the evaluation of the health home model. States are encouraged to report on CMS' recommended core set of quality measures. In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, October 1, 2018, through September 30, 2020, the federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on October 1, 2020. The Form CMS-64 has a designated category of service Line 43 for states to report health home services expenditures for enrollees with chronic conditions.

Please share with your staff my appreciation for their time and effort throughout the review process. If you have any questions regarding this Health Home SPA, please have a member of your staff contact Keri Toback at 312-353-1754 or via email at keri.toback@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Deputy Director
Division of Medicaid Field Operations North

Enclosures

CMS-10434 OMB 0938-1188

Package Information

Package ID	MI2018MS0003O	**Submission Type**	Official
Program Name	Opioid Health Home	**State**	MI
SPA ID	MI-18-1500	**Region**	Chicago, IL
Version Number	5	**Package Status**	Approved
Submitted By	Erin Black	**Submission Date**	6/18/2018
Package Disposition		**Approval Date**	9/28/2018 10:37 AM EDT
Priority Code	P2		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

Package Header

Package ID MI2018MS0003O

SPA ID MI-18-1500

Submission Type Official

Initial Submission Date 6/18/2018

Approval Date 9/28/2018

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Michigan

Medicaid Agency Name: Michigan Department of Health and Human Services

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Approval Date 9/28/2018

Superseded SPA ID N/A

SPA ID MI-18-1500

Initial Submission Date 6/18/2018

Effective Date N/A

SPA ID and Effective Date

SPA ID MI-18-1500

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	10/1/2018	
Health Homes Geographic Limitations	10/1/2018	
Health Homes Population and Enrollment Criteria	10/1/2018	
Health Homes Providers	10/1/2018	
Health Homes Service Delivery Systems	10/1/2018	
Health Homes Payment Methodologies	10/1/2018	
Health Homes Services	10/1/2018	
Health Homes Monitoring, Quality Measurement and Evaluation	10/1/2018	

Submission - Summary

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Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

The Michigan Department of Health & Human Services (MDHHS) is seeking a State Plan Amendment from the Centers for Medicare & Medicaid Services to implement an Opioid Health Home (OHH) program effective October 1, 2018. The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder who also have or are at risk of developing another chronic condition. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered recovery care plan to best manage their care. The model will also elevate the role and importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and connection to raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders and comorbid chronic conditions, including Medication Assisted Treatment; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's OHH model is comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHPs) that can best serve the needs of each unique beneficiary. HHPs will be comprised of two settings – HHP Opioid Treatment Programs (OTPs) and HHP Office Based Opioid Treatment Providers (OBOTs). The State will provide a monthly case rate to the LE based on OHH beneficiaries with at least one OHH service. The State is requiring the LE to adopt a minimum fee schedule based on state plan OHH FFS rates to pay in-network HHPs. The LE will pay HHPs directly on behalf of the State. LEs and HHPs must meet the provider qualifications set forth in this application and provide the six core health home services. HHPs must be willing to contract with the LEs. The LE and HHPs must be connected to other community-based providers to manage the full breadth of beneficiary needs. Finally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$2560067
Second	2020	$4993765

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Package ID MI2018MS0003O

Submission Type Official

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Initial Submission Date 6/18/2018

Effective Date N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe Kathy Stiffler, Acting Director
Medical Services Administration

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Package ID MI2018MS0003O
SPA ID MI-18-1500
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Effective Date N/A
Superseded SPA ID N/A

Name of Health Homes Program

Opioid Health Home

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

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

Indicate how public comment was solicited:

- ☐ Newspaper Announcement

Name of Paper:	Date of Publication:	Locations covered:
Multiple Newspapers	2/1/2018	Flint, Grand Rapids, Saginaw, Kalamazoo

- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☐ Website Notice
- ☐ Public Hearing or Meeting

Date of meeting: 2/21/2018
Time of meeting: 1:30 PM
Location of meeting: University Center in Gaylord Michigan
Communication Method
- Telephonic Capability Used

Public Forum Used
- Other similar process for public input that afforded interested parties the opportunity to learn about the contents of the Demonstration application and to comment on its contents.

Name of process:	Description of process:
Provider Stakeholder Meeting	A forum to present the Opioid Health Home model in order to solicit feedback.

- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
PN-Clip Kalamazoo	4/16/2018 2:10 PM EDT	
PN-Clip Saginaw	4/16/2018 2:11 PM EDT	
PN-Clip Grand Rapids	4/16/2018 2:12 PM EDT	
PN-Clip Flint	4/16/2018 2:12 PM EDT	

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

Name	Date Created	
No items available		

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

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

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Effective Date N/A
Superseded SPA ID N/A

Name of Health Homes Program

Opioid Health Home

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

- (•) Yes
- ( ) No

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

- (•) Yes
- ( ) No

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

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

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

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

- [ ] All Indian Tribes

Date of consultation:	Method of consultation:
2/16/2018	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 (L18-08)
4/5/2018	Face to Face presentation at the Regional Opioid Symposium in Manistee, Michigan

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

Name	Date Created	
L 18-08	4/16/2018 2:02 PM EDT	PDF

Indicate the key issues raised (optional)

- [ ] Access

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

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Submission Type Official

Approval Date 9/28/2018

Superseded SPA ID N/A

SPA ID MI-18-1500

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Effective Date N/A

SAMHSA Consultation

Name of Health Homes Program

Opioid Health Home

☐ 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
4/26/2018

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Package ID	MI2018MS0003O	**SPA ID**	MI-18-1500
Submission Type	Official	**Initial Submission Date**	6/18/2018
Approval Date	9/28/2018	**Effective Date**	10/1/2018
Superseded SPA ID	N/A		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Opioid Health Home

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The Michigan Department of Health & Human Services (MDHHS) is seeking a State Plan Amendment from the Centers for Medicare & Medicaid Services to implement an Opioid Health Home (OHH) program effective October 1, 2018. The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder who also have or are at risk of developing another chronic condition. Michigan's OHH model is comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHPs) that can best serve the needs of each unique beneficiary. HHPs will be comprised of two settings – HHP Opioid Treatment Programs (OTPs) and HHP Office Based Opioid Treatment Providers (OBOTs). The State will provide a monthly case rate to the LE based on OHH beneficiaries with at least one OHH service. The State is requiring the LE to adopt a minimum fee schedule based on state plan OHH FFS rates to pay in-network HHPs. The LE will pay HHPs directly on behalf of the State. LEs and HHPs must meet the provider qualifications set forth in this application and provide the six core health home services. HHPs must be willing to contract with the LEs. The LE and HHPs must be connected to other community-based providers to manage the full breadth of beneficiary needs. Finally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid. Finally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders and comorbid chronic conditions, including Medication Assisted Treatment; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

General Assurances

- ☐ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☐ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- ☐ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- ☐ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- ☐ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- ☐ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Geographic Limitations

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Superseded SPA ID N/A

- ○ Health Homes services will be available statewide
- ◉ Health Homes services will be limited to the following geographic areas
- ○ Health Homes services will be provided in a geographic phased-in approach

Specify the geographic limitations of the program

- ◉ By county
- ○ By region
- ○ By city/municipality
- ○ Other geographic area

Specify which counties:

1. Alcona
2. Alpena
3. Antrim
4. Benzie
5. Charlevoix
6. Cheboygan
7. Crawford
8. Emmet
9. Grand Traverse
10. Iosco
11. Kalkaska
12. Leelanau
13. Manistee
14. Missaukee
15. Montmorency
16. Ogemaw
17. Oscoda
18. Otsego
19. Presque Isle
20. Roscommon
21. Wexford

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Package ID MI2018MS0003O
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Superseded SPA ID N/A

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

☐ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☐ Medically Needy Eligibility Groups

Mandatory Medically Needy

☐ Medically Needy Pregnant Women

☐ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

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Superseded SPA ID N/A

Population Criteria

The state elects to offer Health Homes services to individuals with

☐ Two or more chronic conditions

☐ One chronic condition and the risk of developing another

Specify the conditions included

☐ Mental Health Condition

☐ Substance Use Disorder

☐ Asthma

☐ Diabetes

☐ Heart Disease

☐ BMI over 25

☐ Other (specify)

Specify the criteria for at risk of developing another chronic condition

Having or Being at Risk of Developing Another Chronic Condition, including comorbid conditions frequently associated with Opioid Use Disorder according to peer-reviewed research and SAMHSA:

a. Depression
b. Anxiety
c. Diabetes
d. Heart disease
e. COPD
f. Hypertension
g. Asthma
h. HIV/AIDS,
i. Hepatitis A, B, and C,
j. PTSD
k. Schizophrenia
l. Bipolar Disorder
m. ADHD
n. Alcohol Use Disorder
o. Tobacco Use Disorder
p. Other Drug Use Disorders

Risk for other chronic conditions will be assessed clinically through review of the patient's electronic health record and through the use of evidence-based screening tools.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home

- ○ Opt-In to Health Homes provider
- ○ Referral and assignment to Health Homes provider with opt-out
- ◉ Other (describe)

Name

Hybrid Autoenrollment Process

Description

Enrollment Processes
The Michigan OHH uses a two-pronged enrollment approach where the LEs will enroll eligible members, using the MDHHS-determined, CMS-approved criteria. The LEs will assign enrolled members to one of the LEs contracted HHPs. The two-prongs of the enrollment process are as follows:

- Autoenrollment:

The MDHHS will identify and enroll eligible beneficiaries using MDHHS administrative claims data. MDHHS will provide a batch list of eligible beneficiaries to the LEs for via the electronic Waiver Support Application system (WSA). The list of eligible beneficiaries will be updated at least monthly. From the list, the LE will identify beneficiaries that are currently receiving Medication Assisted Treatment (MAT). The LE will send current MAT recipients a letter indicating their enrollment in the OHH. The letter will provide the beneficiary with information regarding health home services and indicate that the beneficiary may opt-out (disenroll) from the OHH at any time with no impact on their currently entitled Medicaid services. Beneficiaries not currently in MAT will be made aware of the OHH through community referrals, including through peer recovery coach networks, other providers, courts, health departments, law enforcement, and other community-based settings. MDHHS and the LE will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the OHH.

While beneficiary enrollment is automatic, receipt and full payment of OHH services is contingent on beneficiary consent to share information and verification of diagnostic eligibility. The LE must document these steps within the WSA. Failure to verify consent or diagnostic eligibility will be considered a de facto opt-out (disenrollment). The LE shall have six months from the date of autoenrollment to document the preceding steps in the WSA after which time the beneficiary will be presumed unresponsive and automatically disenrolled from the benefit (note: if a beneficiary in this scenario continues to meet OHH eligibility criteria and wishes to join the OHH at a later date, they are entitled to do so, and a new enrollment must be established via the process in the Recommended Enrollment section below).

- Provider Recommended Enrollment:

HHPs are permitted to recommend potential eligible beneficiaries for enrollment into the OHH via the LE. HHPs must provide documentation that indicates that a prospective OHH beneficiary meets all eligibility for the benefit, including presence of qualifying conditions, consent, and establishment of an individualized care plan. The LE must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

Once enrolled, the LE will work with HHPs and the beneficiary to identify the optimal setting of care (I.e., an Opioid Treatment Program or an Office Based Opioid Treatment Provider). The LE will document the setting of care within the WSA. This decision will be made only after a beneficiary visits an HHP, fills out the behavioral health consent form, and establishes an individualized care plan derived from an evidence-based assessment of need. The beneficiary may opt-out (disenroll) at any time with no impact on other entitled Medicaid services.

Health Homes Providers

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Types of Health Homes Providers

☐ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

☐ Physicians
☐ Clinical Practices or Clinical Group Practices
☐ Rural Health Clinics
☐ Community Health Centers
☐ Community Mental Health Centers
☐ Home Health Agencies
☐ Case Management Agencies
☐ Community/Behavioral Health Agencies
☐ Federally Qualified Health Centers (FQHC)
☐ Other (Specify)

Provider Type	Description
Health Home Partner (HHP)-Opioid Treatment Program (OTP)	• Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. • Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as an Opioid Treatment Program.

Provider Type	Description
Health Home Partner (HHP) -- Office Based Opioid Treatment Provider (OBOT)	Provider Qualifications and Standards: The HHP must: • Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. • Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following: o Community Mental Health Services Program (Community Mental Health Center) o Federally Qualified Health Center/Primary Care Safety Net Clinic o Hospital based Physician Group o Physician based Clinic o Physician or Physician Practice o Rural Health Clinics o Substance Use Disorder Provider other than Opioid Treatment Program o Tribal Health Center
Lead Entity (LE)	• Be a regional entity as defined in Michigan's Mental Health Code (330.1204b). • Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269). • Have authority to access Michigan Medicaid claims and encounter data for the OHH target population. • Have authority to access Michigan's Waiver Support Application and CareConnect360. • Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including: o Identification of providers who meet the HHP standards o Provision of infrastructure to support HHPs in care coordination o Collecting and sharing member-level information regarding health care utilization and medications o Providing quality outcome protocols to assess HHP effectiveness o Developing training and technical assistance activities that will support HHPs in effective delivery of HH services • Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder and having or being at risk of another chronic condition. • Must pay HHPs directly on behalf of the State for the OHH Program at the State defined rates for each HHP type (I.e., HHP-OTP and HHP-OBOT).

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

Health Homes Providers

Package Header

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

MDHHS will utilize designated providers for health homes. The LE will be responsible for providing health homes in partnership with community-based HHPs. The LEs already contract with the State for Medicaid services. All HHPs must provide Medication Assisted Treatment (MAT). HHP-OTPs must meet all state and federal licensing requirements of an OTP. HHP-OBOT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT.

Lead Entity (per 400 patients)
- Health Home Director (0.25 FTE)
- Health Home Coordinator (5 FTE)

HHP-OTPs (per 400 patients; in addition to current staffing requirements required by licensure)
- RN Care Manager (3 FTE)
- Masters-level Clinical Case Manager (1 FTE)
- Masters-level Addiction Counselor (2 FTE)
- Certified Recovery Coach (3 FTE)
- Primary Care Provider (.10 FTE)
- Consulting Psychiatrist (.20 FTE)

HHP-OBOTs (per 400 patients)
- RN Care Manager (3 FTE)
- Masters-level Clinical Case Manager (3 FTE)
- Certified Recovery Coach or Community Health Worker (3 FTE)
- Supervising Primary Care Provider (.15 FTE)
- Consulting Psychiatrist/Psychologist (.10 FTE)

All providers referenced above must meet the following criteria:

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

Clinical Case Manager
- Must be a licensed master's level social worker in Michigan

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

Certified Peer Recovery Coach
- Must obtain requisite peer certification per the Medicaid Policy Provider Manual

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

Health Home Coordinator
- Lead Entity Coordinator responsible for overall care management and coordination activities.

Access to a Psychiatrist/Psychologist/Psychiatric Nurse Practitioner for consultation purposes (can be off-site)
- Must be a licensed psychiatrist, doctoral-level psychologist, or psychiatric nurse practitioner in Michigan

In addition to the above Required Provider Infrastructure Requirements, eligible OHH providers should coordinate care with the following professions:
- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

Health Homes Providers

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Package ID	MI2018MS0003O	**SPA ID**	MI-18-1500
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Approval Date	9/28/2018	**Effective Date**	10/1/2018
Superseded SPA ID	N/A		

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 services 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.

Health Homes Providers

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Other Health Homes Provider Standards

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

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

The Michigan OHH Lead Entity must:
1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
2. Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269).
3. Have authority to access Michigan Medicaid claims and encounter data for the OHH target population.
4. Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including:
   a. Identification of providers who meet the HHP standards
   b. Provision of infrastructure to support HHPs in care coordination
   c. Collecting and sharing member-level information regarding health care utilization and medications
   d. Providing quality outcome protocols to assess HHP effectiveness
   e. Developing training and technical assistance activities that will support HHPs in effective delivery of HH services
5. Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder and having or being at risk of another chronic condition.
6. Must pay providers directly on behalf of the State for the OHH Program at the State defined rates for each HHP type (I.e., HHP-OTP and HHP-OBOT).

The Lead Entity and the Health Home Partner jointly must:

1. Provide 24-hour, seven days a week availability of information and emergency consultation services to beneficiaries
2. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay
3. Ensure person-centered and integrated recovery action planning that coordinates and integrates all clinical and non-clinical health care related needs and services
4. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy
5. Utilize the MDHHS-5515 Consent to Share Behavioral Health and Substance Use Disorder Information
6. Demonstrate the ability to perform each of the following functional requirements. This includes documentation of the processes and methods used to execute these functions.
   a. Coordinate and provide the six core services cited in Section 2703 of the Affordable Care Act
   b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines
   c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
   d. Coordinate and provide access to physical, mental health, and substance use disorder services
   e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
   f. 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 appropriate
   g. 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 clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level
7. Demonstrate the ability to report required data for both state and federal monitoring of the program

(See attached for further requirements of the LE and HHPs)

Name	Date Created	
OHH Provider Requirements and Expectations V7 (9-17-2018)	9/17/2018 5:08 PM EDT	

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Superseded SPA ID N/A

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

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

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

- (•) Yes
- ( ) No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services

The contract amendment describes these requirements for the LEs:
o Providing a network of OHHs in partnership with community based HHPs identified by the State to assure that all six core health home services are provided to OHH beneficiaries and assigning members to HH, including receiving and evaluating referrals from community providers.
o Handling requests to opt-out or opt back into the OHH and requests to change HHPs
o Providing beneficiary assignment lists to HHPs and indicating which HHP setting the OHH member is in
o Recruiting and training HHPs, assuring that they meet the HHP and joint Lead Entity and HHP requirements detailed in the State Plan and OHH Handbook
o Providing bidirectional methods for data sharing between the Lead Entity and HHPs, including clinical care alerts and population management tools
o Collecting quality information and reporting on OHH quality measures to the State
o Paying HHPs for OHH services on behalf of the State
o Dedicating no less than one FTE to OHH management, to serve as a State contact and participate in regular meetings with the State and stakeholders
o Meeting all LE and joint LE and HHP Requirements
o Participating in the OHH Learning Collaborative to promote best practices and process improvement in operating the OHHs
o Submitting encounters documenting OHH service(s) to the State to receive the monthly OHH case rate for each enrolled beneficiary with a service in a given month; the case rate will only be made if a HH service was provided by either the LE or an HHP
o Following all federal and State requirements for HHs described in the Michigan Medicaid State Plan and relevant federal statutes.

- [ ] 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.

Name	Date Created	
No items available		

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

- ( ) Yes
- (•) No

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

- [ ] Fee for Service (describe in Payment Methodology section)
- [ ] Alternative Model of Payment (describe in Payment Methodology section)
- [ ] Other

- [ ] Other Service Delivery System

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

Package Header

Package ID MI2018MS0003O

SPA ID MI-18-1500

Submission Type Official

Initial Submission Date 6/18/2018

Approval Date 9/28/2018

Effective Date 10/1/2018

Superseded SPA ID N/A

Payment Methodology

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

☐ Fee for Service

☐ Individual Rates Per Service

☐ Per Member, Per Month Rates

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

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

☐ Other

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

☐ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

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

☐ Other

Describe below

See P4P section of the payment methodology.

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

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description See the payment methodology attached.

Health Homes Payment Methodologies

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Assurances

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

Describe below how non-duplication of payment will be achieved MDHHS has built into its MMIS, the ability to exclude benefit plans that may duplicate and offer payment for similar services provided under Medicaid. MDHHS will utilize this capability to prevent duplication and payment of services provided under other Medicaid authorities.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
MDHHS Opioid Health Home Payment Methodology V9 (9-19-2018)	9/20/2018 2:31 PM EDT	

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

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Submission Type	Official	**Initial Submission Date**	6/18/2018
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Superseded SPA ID	N/A		

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, including moving from one setting of care to another (e.g., OBOT HHP to OTP HHP, and vice-versa)

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) to participate. LEs and HHPs 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.

HHPs must join the LEs centralized, claims-based health information exchange (HIE). This will assist care coordinators with maintaining a comprehensive care plan for each beneficiary enrolled in the health home.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☐ Physicians

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☐ Physician's Assistants

Description

Physician, Nurse Practitioner, Physician's Assistant
*Serves as the OHH Primary Care Provider (must have appropriate licensure and/or certification from the State)

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Health Home Partners	Any of the selected provider types above at the HHP.

Provider Type	Description
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting

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 Peer Recovery Coach and Community Health Worker (CHW). Peer Recovery Coach services are provided by a person in a journey of recovery from addictions or co-occurring disorders who identifies with a beneficiary based on a shared background and life experience. The Peer Recovery Coach serves as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as everyone determines his or her own way. The Peer Recovery Coach helps to remove barriers and obstacles and links the beneficiary to resources in the recovery community.

Services provided by a Peer Recovery Coach support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery, including outreach for persons who are still active in their addiction, up to and including individuals who have been in recovery for several years.

Peer Recovery Coaches embody a powerful message of hope, helping beneficiaries achieve a full and meaningful life in the community. The Peer Recovery Coach can assist with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery.

The Peer Recovery Coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of their choice to build recovery connections and supports. Utilizing a strength-based perspective and emphasizing assessment of recovery capital, services are designed to include prevention strategies and the integration of physical and behavioral health services to attain and maintain recovery and prevent relapse. Beneficiaries utilizing Peer Recovery Coach services must freely choose the individual who is providing Peer Recovery Coach services.

The Peer Recovery Coach shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.

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 to 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. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Peer Recovery Coaches, 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
*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

LEs and HHPs will utilize their EHR to record care coordination and health promotion activities and adjust these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting

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

LEs and HHPs will utilize their EHR to record care coordination and health promotion activities and adjust these activities, as appropriate. The EHR can provide educational material for the beneficiary to assist with overall health promotion.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary

*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
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*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.

Provider Type	Description
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting.

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

Utilizing the LEs HIE will allow for seamless transitions of care within the region. Moreover, 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. Michigan's LEs have access to CareConnect360 and will leverage the application as appropriate.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize

wellness
*Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☐ Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
Community Health Workers	Must be at least 18 years of age Must possess a high school diploma or equivalent Must be supervised by licensed professional members of the care team MDHHS requires the completion of a CHW Certificate Program or equivalent
Health Home Partners	Any of the selected provider types above at the HHP.

Provider Type	Description
Lead Entity	• Provides leadership for implementation and coordination of health home activities • Coordinates all enrollment into the health home on behalf of providers • Coordinates with LE care management staff and OHH providers to identify a beneficiary's optimal setting of care • Coordinates and utilizes HIT with the OHH provider team to maximize care coordination and care management • Serves as a liaison between the health homes site and MDHHS staff/contractors • Champions practice transformation based on health home principles • Coordinates all enrollment into the health home on behalf of providers • Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities • Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management • Monitors Health Home performance and leads quality improvement efforts • Designs and develops prevention and wellness initiatives, and referral tracking • Training and technical assistance • Data management and reporting.

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 HIE, 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 service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

☐ Nurse Practitioner

☐ Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
*Monitors and report performance measures and outcomes
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

Provider Type	Description
Certified Peer Recovery Coaches	Must obtain requisite peer certification per the Medicaid Provider Manual
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Provider Type	Description
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Referral to Community and Social Support Services

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 HIE, 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 service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider (e.g., Case Worker or Addictions Counselor with MSW or related degree)
*Screening/evaluation of individuals for mental health and substance use disorders
*Referral to licensed mental health provider and/or SUD therapist as necessary
*Brief intervention for individuals with behavioral health problems
*Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
*Supports primary care providers in identifying and behaviorally intervening with patients
*Focuses on managing a population of patients versus specialty care
*Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
*Develops and maintains relationships with community based mental health and substance abuse providers
*Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
*Provides patient education

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators

Description

Nurse Care Manager (Coordinator) (e.g., RN)
*Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
*Participates in initial care plan development including specific goals for all enrollees
*Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
*Provides education in health conditions, treatment recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
*Monitors assessments and screenings to assure findings are integrated in the care plan
*Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
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- [ ] Medical Specialists
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Provider Type	Description
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Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

Package Header

Package ID MI2018MS0003O
SPA ID MI-18-1500
Submission Type Official
Initial Submission Date 6/18/2018
Approval Date 9/28/2018
Effective Date 10/1/2018
Superseded SPA ID N/A

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

See attached.

Name	Date Created	
OHH Patient Flow V6 (9-17-2018)	9/17/2018 5:44 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MI2018MS0003O | MI-18-1500 | Opioid Health Home

Package Header

Package ID	MI2018MS0003O	**SPA ID**	MI-18-1500
Submission Type	Official	**Initial Submission Date**	6/18/2018
Approval Date	9/28/2018	**Effective Date**	10/1/2018
Superseded SPA ID	N/A		

Monitoring

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

MDHHS will contract with an independent evaluator to execute a cost-efficiency analysis for the OHH 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 independent evaluator 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. Michigan will use the MDHHS Data Warehouse which will include 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 cost-efficiency evaluation 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)

Added to the maintenance of their own electronic health records (EHRs), approved Health Homes will utilize available forms of HIT to facilitate HIE necessary for carrying out selected Health Home services. The LE will also 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

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- ☐ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- ☐ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- ☐ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- ☐ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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 0938-1188. The time required to complete this information collection is estimated to average 40 hours 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.

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