

MI - Submission Package - MI2025MS0002O - (MI-25-1500) - Health Homes

- Summary
- Reviewable Units
- News
- Related Actions

CMS-10434 OMB 0938-1188

Package Information

Package ID	MI2025MS0002O	Submission Type	Official
Program Name	Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions	State	MI
SPA ID	MI-25-1500	Region	Chicago, IL
Version Number	1	Package Status	Submitted
Submitted By	Erin Black	Submission Date	9/3/2025
		Regulatory Clock	90 days remain
		Review Status	Review 1

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID MI2025MS0002O
Submission Type Official
Approval Date N/A
Superseded SPA ID N/A

SPA ID MI-25-1500
Initial Submission Date 9/3/2025
Effective Date N/A

Reviewable Unit Instructions

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 | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS0002O	SPA ID	MI-25-1500
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Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		
Reviewable Unit Instructions			

SPA ID and Effective Date

SPA ID MI-25-1500

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
1945 Health Home Intro	10/1/2025	MI-24-1500
1945 Health Home Geographic Limitations	10/1/2025	MI-24-1500
1945 Health Home Providers	10/1/2025	MI-24-1500
1945 Health Home Payment Methodologies	10/1/2025	MI-24-1500
1945 Health Home Services	10/1/2025	MI-24-1500

Submission - Summary

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Executive Summary

Summary Description Including Goals and Objectives

The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicare and Medicaid Services to revise the current Behavioral Health Home (BHH) State Plan Amendment (SPA). This revision aims to expand the BHH in three counties within Prepaid Inpatient Health Plan (PIHP) region 10. In addition to this expansion, MDHHS is seeking to add the following staff to the health home staffing structure: SOAR Navigator, Housing Specialist, and Parent Support Partner. This update will also involve revising health services to better reflect current roles and responsibilities.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2026	\$3500000
Second	2027	\$3500000

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

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Governor's Office Review

- ☐ No comment
- ☐ Comments received
- ☐ No response within 45 days
- ☒ Other

Describe Meghan E. Groen
Chief Deputy Director
Health Services

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

CMS-10434 OMB 0938-1188

The submission includes the following:

- ☐ Administration
- ☐ Eligibility
- ☒ Benefits and Payments
- ☒ 1945 Health Home Program

Do not use "Create New 1945 Health Home Program" to amend an existing 1945 Health Home program. Instead, use "Amend existing 1945 Health Home program," below.

- ☐ Create new 1945 Health Home program
- ☒ Amend existing 1945 Health Home program
- ☐ Terminate existing 1945 Health Home program

Chronic Care Management for Individuals with Serious and Persistent ...

1945 Health Home SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

<input type="checkbox"/>	Reviewable Unit Name	Included in Another Source Type Submission Package
<input checked="" type="checkbox"/>	Health Homes Intro	(APPROVED
<input checked="" type="checkbox"/>	Health Homes Geographic Limitations	(APPROVED
<input type="checkbox"/>	Health Homes Population and Enrollment Criteria	(APPROVED
<input checked="" type="checkbox"/>	Health Homes Providers	(APPROVED
<input type="checkbox"/>	Health Homes Service Delivery Systems	(APPROVED
<input checked="" type="checkbox"/>	Health Homes Payment Methodologies	(APPROVED
<input checked="" type="checkbox"/>	Health Homes Services	(APPROVED
<input type="checkbox"/>	Health Homes Monitoring, Quality Measurement and Evaluation	(APPROVED
1 - 8 of 8		

- ☐ 1945A Health Home Program

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Name of 1945 Health Home Program

Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

☒ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
Health-Services-Public-Notice-BHH-Expansion-8-25-25	8/25/2025 4:19 PM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Name of 1945 Health Home Program:

Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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, as described in the state consultation plan.

- ☒ 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, and in accordance with the state consultation plan, 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:
6/25/2025	Letter of Notification to Tribal Chairs and Health Directors

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	
Numbered Letter L 25-34-BHH TN	8/12/2025 9:49 AM EDT	

Indicate the key issues raised (optional)

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

Submission - Other Comment

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SAMHSA Consultation

Name of 1945 Health Home Program

Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

- ☒ 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
3/27/2014

1945 Health Home Intro

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	System-Derived		

Reviewable Unit Instructions

Program Authority

1945 of the Social Security Act

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

Name of 1945 Health Home Program

Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Executive Summary

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

The BHH currently provides comprehensive care management and coordination services to Medicaid beneficiaries with select SMI/SED diagnoses in Michigan's Prepaid Inpatient Health Plan (PIHP) Regions 1, 2, 3, 4, 5, 6, 7, 8 and 9. The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicare and Medicaid Services to revise the current Behavioral Health Home (BHH) State Plan Amendment (SPA). This revision aims to expand the BHH in three counties within Prepaid Inpatient Health Plan (PIHP) region 10. In addition to this expansion, MDHHS is seeking to add the following staff to the health home staffing structure: SOAR Navigator, Housing Specialist, and Parent Support Partner. This update will also involve revising health services to better reflect current roles and responsibilities.

General Assurances

- ✓ The state provides assurance that eligible individuals will be given a free choice of Health Home providers.
- ✓ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home 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 Home providers.
- ✓ The state provides assurance that FMAP for 1945 Health Home 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 home 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.

1945 Health Home Geographic Limitations

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- ☐ Health Home services will be available statewide
- ☒ Health Home services will be limited to the following geographic areas
- ☐ Health Home 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:

- Alcona
- Alger
- Allegan
- Alpena
- Antrim
- Arenac
- Baraga
- Barry
- Bay
- Benzie
- Berrien
- Branch
- Calhoun
- Cass
- Charlevoix
- Cheboygan
- Chippewa
- Clare
- Clinton
- Crawford
- Delta
- Dickinson
- Eaton
- Emmet
- Genesee
- Gladwin
- Gogebic
- Grand Traverse
- Gratiot
- Hillsdale
- Houghton
- Huron
- Ingham
- Ionia
- Iosco
- Iron
- Isabella
- Jackson
- Kalamazoo
- Kalkaska
- Kent
- Keweenaw
- Lake
- Leelanau
- Lenawee
- Livingston
- Luce
- Mackinac
- Macomb
- Manistee
- Marquette
- Mason

53. Mecosta
54. Menominee
55. Midland
56. Missaukee
57. Monroe
58. Montcalm
59. Montmorency
60. Muskegon
61. Newaygo
62. Oakland
63. Oceana
64. Ogemaw
65. Ontonagon
66. Osceola
67. Oscoda
68. Otsego
69. Ottawa
70. Presque Isle
71. Roscommon
72. Saginaw
73. St. Clair
74. St. Joseph
75. Sanilac
76. Schoolcraft
77. Shiawassee
78. Tuscola
79. Van Buren
80. Washtenaw
81. Wayne
82. Wexford

1945 Health Home Providers

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Types of Health Home Providers

☒ Designated Providers

Indicate the Health Home 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)	<p>Provider Qualifications and Standards: The HHP must:</p> <ul style="list-style-type: none">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:<ul style="list-style-type: none">Community Mental Health Services Programs (CMHSPs)Federally Qualified Health Center/Primary Care Safety Net ClinicRural Health ClinicTribal Health CenterClinical Practices or Clinical Group PracticesCommunity/Behavioral Health Agencies
Lead Entity (LE)	<ul style="list-style-type: none">Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).Must contract with and pay a negotiated rate to HHPs,Must maintain a network of providers that support the BHHs to

Provider Type

Description

service beneficiaries with a serious mental illness/serious emotional disturbance diagnosis,

- Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,
- Have authority to access Michigan's Waiver Support Application and CareConnect360,
- Provides leadership for implementation and coordination of health home activities,
- Serves as a liaison between the health homes site and MDHHS staff/contractors,
- Champions practice transformation based on health home principles,
- 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,
- Must have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including:
 - o Identification of providers who meet the BHH standards,
 - o Provision of infrastructure to support BHHs in care coordination,
 - o Collecting and sharing member-level information regarding health care utilization and medications,
 - o Providing quality outcome protocols to assess BHH effectiveness, and
 - o Developing training and technical assistance activities that will support BHH in effective delivery of health home services.

1945 Health Home Providers

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- ☐ Teams of Health Care Professionals
- ☐ Health Teams

1945 Health Home Providers

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Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

MDHHS will utilize designated providers for health homes. Health Home Partners (HHPs), through the Lead Entity (LE), will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The following represents the care team requirements per 100 enrollees:

- Health Home Director (0.25 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SOAR Navigator, Housing Specialist (3.00-5.00 FTE)
- Medical Consultant (.10 FTE)
- Psychiatric Consultant (.10 FTE)

All providers referenced above must meet the following criteria:

Health Home Director

- Provides leadership for implementation and coordination of health home activities

Behavioral Health Specialist

- An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school

Nurse Care Manager

- Must be a licensed registered nurse or licensed practical nurse with relevant experience.

Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SOAR Navigator, Housing Specialist

- Appropriate certification/training

Medical Consultant

- Primary care physician, physician's assistant, pediatrician, or nurse practitioner

Psychiatric Consultant

- Must be a licensed mental health professional (i.e. psychologist, psychiatrist, psychiatric nurse practitioner)

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

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

Supports for Health Home Providers

Describe the methods by which the state will support providers of Health Home services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Home 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 use disorder 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 Home orientation for the designated providers and clinical support staff before the program is officially implemented. The orientation will include all HHPs 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 Home workgroups and listserv forums for Health Home 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 Home beneficiary.

Other Health Home Provider Standards

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

The Michigan BHH Lead Entity (LE) must:


1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
2. Must contract with and pay a negotiated rate to HHPs,
3. Must maintain a network of providers that support the BHHs to service beneficiaries with a serious mental illness/serious emotional disturbance diagnosis,
4. Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,
5. Have authority to access Michigan's Waiver Support Application and CareConnect360,
6. Provides leadership for implementation and coordination of health home activities,
7. Serves as a liaison between the health homes site and MDHHS staff/contractors,
8. Champions practice transformation based on health home principles,
9. Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities,
10. Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management,
11. Monitors Health Home performance and leads quality improvement efforts,
12. Designs and develops prevention and wellness initiatives, and referral tracking,
13. Must have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including:
 - a. Identification of providers who meet the BHH standards,
 - b. Provision of infrastructure to support BHHs in care coordination,
 - c. Collecting and sharing member-level information regarding health care utilization and medications,
 - d. Providing quality outcome protocols to assess BHH effectiveness, and
 - e. Developing training and technical assistance activities that will support BHH in effective delivery of health home services.

The Lead Entity (LE) and the Health Home Partner (HHP) jointly must:

1. HHPs must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies
2. HHPs must enroll and execute any necessary agreement(s)/contract(s) with the LE; HHPs must also sign the MDHHS-5745 with MDHHS
3. HHPs must adhere to all federal and state laws regarding Section 2703 Health Homes recognition/certification, including the capacity to perform all core services specified by CMS. Providers shall meet the following recognition/certification standards:
 - a. Achieve Patient Centered Medical Home (PCMH) from national recognizing body (NCQA, AAAHC, JC, CARF) before the BHH becomes operational. PCMH application can be pending at the time of implementation.
 - b. Achieve CMS Stage 2 Meaningful Use (can be in-progress at the time of implementation).
4. Provide 24-hour, seven days a week availability of information and emergency consultation services to beneficiaries
5. 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
6. Ensure person-centered and integrated recovery action planning that coordinates and integrates all clinical and non-clinical health care related needs and services
7. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy
8. Utilize the MDHHS-5515 Consent to Share Behavioral Health and Substance Use Disorder Information
9. 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 informed by evidence-based clinical practice guidelines
 - c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness.
 - d. Coordinate and provide access to physical and mental health 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
10. 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)

Document is titled "MDHHS Behavioral Health Home Provider Requirements and Expectations- FINAL "

Name	Date Created	
MDHHS Behavioral Health Home Provider Requirements and Expectations- FINAL (8-11-25)	8/12/2025 10:08 AM EDT	

1945 Health Home Payment Methodologies

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Payment Methodology

The State's Health Home 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)

1945 Health Home 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

1945 Health Home Payment Methodologies

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Reviewable Unit Instructions

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 payment methodology attached.

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS0002O	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	N/A	Effective Date	10/1/2025
Superseded SPA ID	MI-24-1500		
	System-Derived		

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Assurances

☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home 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 Behavioral Health Home Payment Methodology -FINAL (8-11-25)	8/12/2025 10:12 AM EDT	

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Reviewable Unit Instructions

Service Definitions

Provide the state's definitions of the following Health Home 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 that appropriate community supports have been secured. Adjustments to the care plan may be necessary as applicable, including moving from one setting of care to another (e.g., FQHC to CMH, 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 to 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

(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- 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

☒ Nurse Practitioner

Description

Nurse Practitioner: Physician, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☒ Nurse Care Coordinators

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in the initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- 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

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☒ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☒ Other (specify)

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Provider Type	Description
Peer Support Specialist	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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
Medical Assistant	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none">• Provide leadership for implementation and coordination of health home activities,• Serve as a liaison between the health homes site and MDHHS staff/contractors,• Champion practice transformation based on health home principles,• Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (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 leads quality improvement efforts,• Design and develops prevention and wellness initiatives, and referral tracking.
Peer Recovery Coach	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,

Provider Type	Description
	<p>Coordinates and provides access to chronic disease management including self-management support,</p> <ul style="list-style-type: none"> • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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.
Youth Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports youth/young adults to identify personal barriers and challenges, • Encourages increased engagement in services, if identified by youth/young adult, • Empowers youth/young adult to identify and connect to additional community supports and resources when this support is requested by youth/young adult, • Supports youth/young adult to advocate for their needs, preferences, and goals, • Collaborates with the agency and care team to ensure information is accessible, youth-friendly and understandable, • Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, and • 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.
Parent Support Partner	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports parent/caregiver to identify barriers to participation or progress • Encourages increased engagement in services, as identified by parent/caregiver • Empowers families to identify and access additional community supports and resource, when this support is requested by parent/caregiver • Supports parent/caregiver to advocate effectively for their family's needs, • Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable, • Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, • Assists in the development of social networks and community connections, when desired by the parent/caregiver, and • 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.
Community Health Worker	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, • Collects medical records and additional information to complete SSI/SSDI applications, • Prepares SOAR medical summaries for SSI/SSDI applications, • Accompanies beneficiaries to appointments at the Social Security Administration,

Provider Type	Description
	<ul style="list-style-type: none"> Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, Coordinates and provides access to individual and family supports, including referrals to community social supports, and 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.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing Collaborates with beneficiaries to develop personalized housing goals and objectives Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, Coordinates and provides access to individual and family supports, including referrals to community social supports, and 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.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Reviewable Unit Instructions

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.

Key support roles include Peer Support Specialists and Peer Recovery Coaches. Peer support services and peer recovery services are provided by an individual with a lived experience and journey in receiving public mental health and/or substance use disorder services and supports. The Peer Support Specialists and Peer Recovery Coaches helps to remove barriers and obstacles and links the beneficiary to resources in the recovery community.

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

Peer Support Specialists must be supervised by a Qualified Mental Health Professional (QMHP). The amount, duration, and scope of supervision can vary depending on the demonstrated competency and experience of the peer support provider, as well as the service array, and may range from direct oversight to periodic care consultation.

Peer Recovery Coaches must be supervised by a Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner.

Community Health Workers are professionals identified by the American Public Health Association. CHWs are frontline public health workers who understand the community they serve. The CHW is 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.

Medical Assistants are multi-skilled health professionals specifically educated to work in ambulatory care settings performing both administrative and clinical duties. MAs help support care coordination for beneficiaries by scheduling appointments, arranging hospital admissions and laboratory services, instructing patient about medication and special diets, preparing and administering medications, and authorizing prescription refills.

Services provided by a Peer Support Specialist, Peer Recovery Coach, CHW, or MA support beneficiaries with health navigation, accessing resources, and supporting a person-centered recovery journey to achieve community inclusion and participation, independence, recovery, and resiliency.

Peer Support Specialists, CHWs, MAs, 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

Lead Entities and Health Home Partners will utilize their EHR to record care coordination activities and adjust these activities as appropriate.

Scope of service

The service can be provided by the following provider types

- ☒ Behavioral Health Professionals or Specialists

Description

Behavioral Health Provider
(An individual who has a minimum of a Bachelor’s Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling,

rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- 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

☒ Nurse Practitioner

Description

Nurse Practitioner: Physician, Nurse Practitioner, Physician's Assistant
Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☒ Nurse Care Coordinators

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in the initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- 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

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☒ Physician's Assistants

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

Provider Type	Description
Medical Assistant	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none">• Provide leadership for implementation and coordination of health home activities,• Serve as a liaison between the health homes site and MDHHS staff/contractors,• Champion practice transformation based on health home principles,• Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (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 leads quality improvement efforts,• Design and develops prevention and wellness initiatives, and referral tracking.
Peer Support Specialist	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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.
Community Health Worker	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• Meets regularly with the care team to plan care and discuss cases, and

Provider Type	Description
	exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, • Collects medical records and additional information to complete SSI/SSDI applications, • Prepares SOAR medical summaries for SSI/SSDI applications, • Accompanies beneficiaries to appointments at the Social Security Administration, • Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • 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.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> • Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, • Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing • Collaborates with beneficiaries to develop personalized housing goals and objectives • Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, • Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, • Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, • Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, • Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • 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.

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Reviewable Unit Instructions

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 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
(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on managing a population of patients versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- 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

- ☒ Nurse Practitioner

Description

Nurse Practitioner: Physician, Nurse Practitioner, Physician's Assistant
Provides medical consultation to assist the care team in the development of

☒ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☒ Physicians

☒ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in the initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- 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.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Provider Type	Description
Peer Support Specialist	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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.
Medical Assistant	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,

Provider Type	Description
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> • Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (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 leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.
Community Health Worker	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS0002O	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	N/A	Effective Date	10/1/2025
Superseded SPA ID	MI-24-1500		
	System-Derived		

Reviewable Unit Instructions

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
(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- 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

Description

Nurse Practitioner: Physician, Nurse Practitioner, Physician's Assistant
Provides medical consultation to assist the care team in the development of

- ☒ Nurse Practitioner

☒ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☒ Physicians

☒ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in the initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- 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.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Provider Type	Description
Community Health Worker	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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.
Peer Support Specialist	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,

Provider Type	Description
	<ul style="list-style-type: none"> Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, Coordinates and provides access to chronic disease management including self-management support, Implements wellness and prevention initiatives, Facilitates health education groups, Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, Accompanies beneficiaries to appointments and support groups, Coordinates and provides access to individual and family supports, including referral to community social supports, and, 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.
Medical Assistant	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> Conducts referral tracking, Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, Coordinates and provides access to chronic disease management including self-management support, Implements wellness and prevention initiatives, Facilitates health education groups, Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, Accompanies beneficiaries to appointments and support groups, Coordinates and provides access to individual and family supports, including referral to community social supports, and, 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.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> Provide leadership for implementation and coordination of health home activities, Serve as a liaison between the health homes site and MDHHS staff/contractors, Champion practice transformation based on health home principles, Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (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 leads quality improvement efforts, Design and develops prevention and wellness initiatives, and referral tracking.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> Conducts referral tracking, Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, Coordinates and provides access to chronic disease management including self-management support, Implements wellness and prevention initiatives, Facilitates health education groups, Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, Accompanies beneficiaries to appointments and support groups, Coordinates and provides access to individual and family supports, including referral to community social supports, and, 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.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, Collects medical records and additional information to complete SSI/SSDI applications, Prepares SOAR medical summaries for SSI/SSDI applications, Accompanies beneficiaries to appointments at the Social Security Administration, Coordinates appointments with medical doctors, psychiatrists, and other

Provider Type	Description
	<p>specialists to obtain evidence for SSI/SSDI applications,</p> <ul style="list-style-type: none"> • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • 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.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> • Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, • Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing • Collaborates with beneficiaries to develop personalized housing goals and objectives • Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, • Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, • Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, • Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, • Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, • Coordinates and provides access to individual and family supports, including referrals to community social supports, and • 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.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

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Reviewable Unit Instructions

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 advanced directives
- *Assistance with maximizing level of functioning in the community

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
(An individual who has a minimum of a Bachelor’s Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor’s Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master’s Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- 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

- ☒ Nurse Practitioner

Description

Nurse Practitioner: Physician, Nurse Practitioner, Physician’s Assistant
Provides medical consultation to assist the care team in the development of the beneficiary’s care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

- ☒ Nurse Care Coordinators

Description

☐ Nurses

☐ Medical Specialists

☒ Physicians

☒ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in the initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- 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.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Provider Type	Description
Community Health Worker	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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.
Peer Support Specialist	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,

Provider Type	Description
Medical Assistant	<ul style="list-style-type: none"> Facilitates health education groups, Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, Accompanies beneficiaries to appointments and support groups, Coordinates and provides access to individual and family supports, including referral to community social supports, and, 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.
Health Home Partners	(Must have appropriate certification/training)
Lead Entity	<ul style="list-style-type: none"> Conducts referral tracking, Screens beneficiaries for Social Determinant of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, Coordinates and provides access to chronic disease management including self-management support, Implements wellness and prevention initiatives, Facilitates health education groups, Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, Accompanies beneficiaries to appointments and support groups, Coordinates and provides access to individual and family supports, including referral to community social supports, and, 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.
Peer Recovery Coach	<ul style="list-style-type: none"> Provide leadership for implementation and coordination of health home activities, Serve as a liaison between the health homes site and MDHHS staff/contractors, Champion practice transformation based on health home principles, Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (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 leads quality improvement efforts, Design and develops prevention and wellness initiatives, and referral tracking.
Youth Peer Support Specialist	<ul style="list-style-type: none"> Conducts referral tracking, Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, Coordinates and provides access to chronic disease management including self-management support, Implements wellness and prevention initiatives, Facilitates health education groups, Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, Accompanies beneficiaries to appointments and support groups, Coordinates and provides access to individual and family supports, including referral to community social supports, and, 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.

Provider Type	Description
	<ul style="list-style-type: none"> 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.
Parent Support Partner	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> Supports parent/caregiver to identify barriers to participation or progress Encourages increased engagement in services, as identified by parent/caregiver Empowers families to identify and access additional community supports and resource, when this support is requested by parent/caregiver Supports parent/caregiver to advocate effectively for their family's needs, Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable, Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, Assists in the development of social networks and community connections, when desired by the parent/caregiver, and 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.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, Collects medical records and additional information to complete SSI/SSDI applications, Prepares SOAR medical summaries for SSI/SSDI applications, Accompanies beneficiaries to appointments at the Social Security Administration, Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, Coordinates and provides access to individual and family supports, including referrals to community social supports, and 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.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing Collaborates with beneficiaries to develop personalized housing goals and objectives Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, Coordinates and provides access to individual and family supports, including referrals to community social supports, and 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.

1945 Health Home Services

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Reviewable Unit Instructions

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
(An individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)

- Screens beneficiaries for mental health and substance use disorders,
- Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and behaviorally intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
- Develops and maintains relationships with community based mental health and substance abuse providers,
- Provides patient education
- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- 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

☒ Nurse Practitioner

Description

Nurse Practitioner: Physician, Nurse Practitioner, Physician's Assistant
Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

☒ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☒ Physicians

☒ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dietitians

☐ Nutritionists

☒ Other (specify)

Description

Nurse Care Manager

(Licensed Registered Nurse, Licensed Practical Nurse)

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
- Participates in the initial care plan development including specific goals for all enrollees,
- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
- Monitors assessments and screenings to ensure findings are integrated in the care plan,
- Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
- Monitors and reports performance measures and outcomes, and
- 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.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Description

Physicians, Nurse Practitioner, Physician's Assistant

Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

Provider Type	Description
Community Health Worker	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management including self-management support,• Implements wellness and prevention initiatives,• Facilitates health education groups,• Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,• Accompanies beneficiaries to appointments and support groups,• Coordinates and provides access to individual and family supports, including referral to community social supports, and,• 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.
Peer Support Specialist	(Must have appropriate certification/training) <ul style="list-style-type: none">• Conducts referral tracking,• Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,• Coordinates and provides access to chronic disease management

Provider Type	Description
Medical Assistant	<p>including self-management support,</p> <ul style="list-style-type: none"> • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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. <p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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.
Health Home Partners	Any of the selected provider types above at the HHP.
Lead Entity	<ul style="list-style-type: none"> • Provide leadership for implementation and coordination of health home activities, • Serve as a liaison between the health homes site and MDHHS staff/contractors, • Champion practice transformation based on health home principles, • Develop and maintain working relationships with primary and specialty care providers including Community Mental Health Services Programs (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 leads quality improvement efforts, • Design and develops prevention and wellness initiatives, and referral tracking.
Peer Recovery Coach	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Conducts referral tracking, • Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management, • Coordinates and provides access to chronic disease management including self-management support, • Implements wellness and prevention initiatives, • Facilitates health education groups, • Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs, • Accompanies beneficiaries to appointments and support groups, • Coordinates and provides access to individual and family supports, including referral to community social supports, and, • 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.
Youth Peer Support Specialist	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> • Supports youth/young adults to identify personal barriers and challenges, • Encourages increased engagement in services, if identified by youth/young adult, • Empowers youth/young adult to identify and connect to additional community supports and resources when this support is requested by youth/young adult, • Supports youth/young adult to advocate for their needs, preferences, and goals, • Collaborates with the agency and care team to ensure information is accessible, youth-friendly and understandable,

Provider Type	Description
	<ul style="list-style-type: none"> Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, and 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.
Parent Support Partner	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> Supports parent/caregiver to identify barriers to participation or progress Encourages increased engagement in services, as identified by parent/caregiver Empowers families to identify and access additional community supports and resource, when this support is requested by parent/caregiver Supports parent/caregiver to advocate effectively for their family's needs, Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable, Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, Assists in the development of social networks and community connections, when desired by the parent/caregiver, and 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.
SOAR Navigator	<p>(Must have appropriate certification/training)</p> <ul style="list-style-type: none"> Interviews beneficiaries to collect information needed for completing SSI/SSDI applications, Collects medical records and additional information to complete SSI/SSDI applications, Prepares SOAR medical summaries for SSI/SSDI applications, Accompanies beneficiaries to appointments at the Social Security Administration, Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications, Coordinates and provides access to individual and family supports, including referrals to community social supports, and 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.
Housing Specialist	<p>(e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience):</p> <ul style="list-style-type: none"> Responds to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations, Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing Collaborates with beneficiaries to develop personalized housing goals and objectives Assists beneficiaries in identifying and securing appropriate housing, including rental units, transitional housing, and shelters, Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing, Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support, Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability, Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries, Coordinates and provides access to individual and family supports, including referrals to community social supports, and 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.

1945 Health Home Services

MEDICAID | Medicaid State Plan | Health Homes | MI2025MS0002O | MI-25-1500 | Chronic Care Management for Individuals with Serious and Persistent Mental Health Conditions

Package Header

Package ID	MI2025MS0002O	SPA ID	MI-25-1500
Submission Type	Official	Initial Submission Date	9/3/2025
Approval Date	N/A	Effective Date	10/1/2025
Superseded SPA ID	MI-24-1500		
	System-Derived		

Reviewable Unit Instructions

Health Home Patient Flow

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

See attached - BHH Patient Flow V3 (6-10-2020).

Name	Date Created	
5. BHH Patient Flow V4 (7-28-2020)	8/27/2020 1:41 PM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 range from 1 hour to 80 hours per response (see below), 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.

This view was generated on 9/3/2025 1:30 PM EDT

BHH Detailed Provider Infrastructure**Detailed Requirements and Expectations**

At a minimum, the following care team is required:

- **Health Home Director** (e.g., lead entity professional):
 - Provides overarching leadership for health home services,
 - Provides coordination of health home activities,
 - 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,
 - Executes enrollment using the MDHHS electronic enrollment system,
 - Provides training and technical assistance, and
 - Provides data management and reporting.
- **Behavioral Health Specialist** (e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school):
 - Screens beneficiaries for mental health and substance use disorders,
 - Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
 - Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
 - Conducts brief intervention for beneficiaries with behavioral health problems,
 - Supports primary care providers in identifying and behaviorally intervening with patients,
 - Focuses on population health management versus specialty care,
 - Works with beneficiaries to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions,
 - Develops and maintains relationships with community based mental health and substance abuse providers,
 - Provides patient education,
 - Coordinates and provides access to individual and family supports, including referral to community social supports, and
 - 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.
- **Nurse Care Manager** (e.g., licensed registered nurse, licensed practical nurse):
 - Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives,
 - Participates in the initial care plan development including specific goals for all enrollees,

- Communicates with medical providers and subspecialty providers including mental health and SUD providers, long term care and hospitals regarding records including admission/discharge,
 - Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
 - Monitors assessments and screenings to ensure findings are integrated in the care plan,
 - Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
 - Monitors and reports performance measures and outcomes, and
 - 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.
- **Peer Support Specialist, Peer Recovery Coach, Community Health Worker, or Medical Assistant** (with appropriate certification/training):
 - Conducts referral tracking,
 - Screens beneficiaries for Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management,
 - Coordinates and provides access to chronic disease management including self-management support,
 - Implements wellness and prevention initiatives,
 - Facilitates health education groups,
 - Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs,
 - Accompanies beneficiaries to appointments and support groups,
 - Coordinates and provides access to individual and family supports, including referral to community social supports, and
 - 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.
- **Youth Peer Support Specialist** (with appropriate certification/training):
 - Supports youth/young adults to identify personal barriers or challenges,
 - Encourages increased engagement in services, if identified by the youth/young adult,
 - Empowers youth/young adult to identify and connect to additional community supports and resources, when this support is requested by the youth/ young adult,
 - Supports and empowers youth/young adults to advocate for their needs, preferences, and goals,
 - Collaborates with the agency and care team to ensure information is accessible, youth-friendly and understandable, and
 - Promotes Family-Driven and Youth-Guided planning and goal setting within the treatment process.

- **Parent Support Partner** (with appropriate certification/training):
 - Supports parent/caregiver to identify barriers to participation or progress,
 - Encourages increased engagement in services, as identified by the parent/caregiver,
 - Empowers families to identify and access additional community supports and resources, when this support is requested by parents/ caregivers,
 - Supports and empowers parents/caregivers to advocate effectively for their family's needs,
 - Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable,
 - Promotes Family-Driven and Youth-Guided planning and goal setting within the care planning process, and
 - Assists in the development of social networks and community connections, when desired by the parent/caregiver.
- **SOAR Navigator** (with appropriate certification/training):
 - Interviews beneficiaries to collect information needed for completing SSI/SSDI applications,
 - Collects medical records and additional information to complete SSI/SSDI applications,
 - Prepares SOAR medical summaries for SSI/SSDI applications,
 - Accompanies beneficiaries to appointments at the Social Security Administration,
 - Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications,
 - Coordinates and provides access to individual and family supports, including referrals to community social supports, and
 - 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.
- **Housing Specialist**
 - Respond to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations,
 - Utilizes a strength-based case management approach to assess beneficiaries' housing needs, and identify and leverage strengths, resources, and support in pursuit of stable housing,
 - Collaborates with beneficiaries to develop personalized housing goals and objectives,
 - Assists beneficiaries in identifying and securing appropriate housing options, including rental units, transitional housing, and shelters,
 - Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing,
 - Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support,
 - Conducts follow-up visits and check-ins to ensure beneficiaries maintain housing stability,
 - Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries,
 - Coordinates and provides access to individual and family supports, including referrals to community social supports, and
 - 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.

- **Medical Consultant** (i.e., primary care physician, physician's assistant, pediatrician, or nurse practitioner):
 - Provides medical consultation to assist the care team in the development of the beneficiary's care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.
- **Psychiatric Consultant:**
 - The care team must have access to a licensed mental health service professional (i.e., psychologist, psychiatrist, psychiatric nurse practitioner) providing psychotherapy consult and treatment plan development services. This provider will be responsible for communicating treatment methods and expert advice to the Behavioral Health Provider (incorporated into care team). It will be the responsibility of the Behavioral Health Provider (and/or other members of care team as assigned), to develop a licensed mental health provider's treatment into a patient's care plan.

Detailed Provider Objectives

Under Michigan's approach to BHH implementation, the primary objective is to foster optimal recovery and/or a decrease in disease burden for all beneficiaries. This requires all providers to deliver 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. BHH providers must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies
- b. Be a Community Mental Health Services Program, Section 330 Health Center program grantee of any type, Federally Qualified Health Center Look-Alike, Tribal 638 facility, Clinical Practice or Clinical Group Practices, Community/Behavioral Health Agency, or Urban Indian organization
- c. HHPs must enroll and execute any necessary agreement(s)/contract(s) with the LE; HHPs must also sign the MDHHS-5745 with MDHHS
- d. MDHHS will contractually charge the LE with executing the enrollment, payment, and administration of the BHH with providers; MDHHS will retain overall oversight and direct administration of the LE. The LE will also serve as part of the Health Home team by providing care management and care coordination services
- e. HHPs must adhere to all federal and state laws regarding Section 2703 Health Homes recognition/certification, including the capacity to perform all core services specified by CMS.
 - a. Attain accreditation from a national recognizing body specific to a health home, patient-centered medical home, or integrated care (e.g., NCQA, AAAHC, Joint Commission, CARF, etc.). The LE/HHP may be in pursuit of such accreditation at the time of BHH implementation; or,
 - b. In the absence of specific accreditation from a national recognizing body (health home, PCMH, or integrated care, etc.), the LE must verify that a HHP meets standards to provide health home services parallel to those required for accreditation. The LE must establish and utilize a template for HHPs that aligns with the BHH Partner Standards Document, BHH Handbook, SPA, and policy. MDHHS has the right to review all templates created by the LE for quality assurance and

compliance purposes.

2. A personal care team will be assigned to each patient

- a. Ensure each beneficiary 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 and vice-versa, with real-time consult available to primary care providers or behavioral health providers

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 everyone 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 beneficiaries 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 beneficiary, 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 a Memorandum of Agreement/Understanding (MOA/U) in place to coordinate or provide:
 - i. Primary care services
 - ii. Mental health/behavioral health and substance use disorder services
 - iii. Chronic disease management
 - iv. Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco treatment/cessation, and health coaching)
 - v. Coordinated access to long-term care supports and services
 - vi. Oral health services
- e. Conduct outreach to local health systems and establish bi-directional referral processes
- f. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- g. Review and reconciliation of medications
- h. Assessment of Social Determinants of Health (SDOH) that may contribute to disease and/or present as barriers to self-management
- i. Maintain a reliable system and written standards/protocols for tracking patient referrals

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 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, STD/STI, 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 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. Must utilize/synchronize to the LE's Health Information Exchange to assure care coordination is seamless within the BHH model
- c. Provider must have achieved or are in the process of achieving Meaningful Use Stage 2 as defined by the Centers for Medicare & Medicaid Services
- d. 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
- e. 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. BHH Team

- a. Support BHH team participation in all related activities and trainings including travel costs associated with Health Home 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 Director) 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.

MDHHS Behavioral Health Home (BHH) Payment Methodology

Overview

MDHHS will provide a monthly case rate to the LE based on the number of BHH beneficiaries with at least one BHH service within the month. The LE will reimburse Health Home Partners (HHP) for delivering health home services.

Additionally, MDHHS will employ a pay-for- performance (P4P) withhold strategy that will reward providers based on outcomes. MDHHS will only claim federal match for P4P payment withholds after P4P qualifications have been met and providers have been paid.

Rate Workup

Staffing Model

BHH payment rates are based on a staffing model per 100 beneficiaries with salary, fringe benefit, and indirect cost information derived from the public SFY 2025 comparison rate analysis. Rates reflect the following staffing model for the BHH per 100 enrollees:

- Health Home Director (0.25 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SOAR Navigator, Housing Specialist (3.00 - 5.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.10 FTE)

Rate Amounts

The case rates are based on the current staffing model per 100 enrollees and were established using the public SFY 2025 comparison rate analysis. Wage data for this analysis was derived from the May 2023 Bureau of Labor Statistics (BLS) for Michigan, along with the 2024 MDHHS Provider Survey for Salary and Expense Reporting. These rates will take effect October 1, 2025. Detailed rate information will be maintained on the MDHHS website at www.michigan.gov/BHH. Rates will be evaluated annually and adjusted as needed, with a minimum rebasing every 3 years.

Behavioral Health Home Case Rates to Lead Entity

The following table depicts the case rate structure:

Monthly Case Rate	Monthly Case Rate with P4P
\$445.18	\$ 468.61

Details regarding this structure are as follows:

The BHH payment rate reflects a monthly case rate per BHH beneficiary who receives at least one eligible services withing a given month. The payment for BHH services is subject to recoupment if an enrolled beneficiary does not receive a BHH service during the calendar month.

HHPs must submit the BHH service encounter code in addition to any pertinent ICD-10 Z-codes (to indicate the many applicable social determinants of health) to the Lead Entity.

Payment for BHH services is dependent on the submission of appropriate service encounter codes. Valid BHH encounters must be submitted by HHPs to the LE within 90 days of providing an BHH service to assure timely service verification.

Pay-for-Performance (P4P) via a 5% Withhold

MDHHS will afford P4P via a 5% performance withhold. The LE must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the approved SPA, policy, and the BHH Handbook. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid.

If quality improvement benchmarks are not met by any of the HHPs within a given performance year, the funding will be distributed equally as outlined in the BHH Handbook. Subsequent performance years will operate in accordance with this structure.

Metrics, Assessment, and Distribution

The methodology for metrics, specifications, and benchmarks will be effective October 1, 2025, and will be maintained on the MDHHS website: www.michigan.gov/BHH.

Public Notice

Michigan Department of Health and Human Services Health Services

Behavioral Health Home (BHH) State Plan Amendment Request

The Michigan Department of Health and Human Services (MDHHS) plans to submit a State Plan Amendment (SPA) request to the Centers for Medicare & Medicaid Services (CMS). The purpose of this SPA is to update Michigan's Behavioral Health Home (BHH) provider requirements, payment methodology, and health home services.

The anticipated effective date for the BHH SPA is October 1, 2025.

MDHHS is seeking approval from CMS to revise the current BHH SPA. This revision will expand the BHH in three counties within Prepaid Inpatient Health Plan (PIHP) region 10 and add the following staff to the health home staffing structure: SOAR Navigator, Housing Specialist, and Parent Support Partner. This update will also involve revising health services to better reflect current roles and responsibilities.

In addition, the SPA will update the current payment methodology by increasing the case rate. The case rate is based on the current staffing model per 100 beneficiaries and was established using the public State Fiscal Year (SFY) 2025 comparison rate analysis. Wage data for this analysis was derived from the May 2023 Bureau of Labor Statistics (BLS) for Michigan, along with the 2024 MDHHS Provider Survey for Salary and Expense Reporting. These rates will take effect October 1, 2025. Detailed rate information will be maintained on the MDHHS website at www.michigan.gov/BHH. Rates will be evaluated annually and adjusted as needed, with a minimum rebasing every 3 years.

The estimated gross cost to the State of Michigan for the SPA is \$5.4 million per year.

There is no public meeting scheduled regarding this notice. Any interested party wishing to request a written copy of the SPA or wishing to submit comments may do so by sending an e-mail to MSADraftPolicy@michigan.gov or submitting a request in writing to: MDHHS/ Health Services Administration, Program Policy Division, PO Box 30479, Lansing MI 48909-7979 by September 24, 2025. A copy of the proposed SPA will also be available for review at: www.michigan.gov/mdhhs/inside-mdhhs/budgetfinance/264/state-plan-amendments.

RELEASED: August 25, 2025



STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

June 25, 2025

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Behavioral Health Home Expansion and Authorization of Additional Staff

This letter, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, serves as notice to all Tribal Chairs and Health Directors of the intent by the Michigan Department of Health and Human Services (MDHHS) to submit a State Plan Amendment (SPA) request to the Centers for Medicare & Medicaid Services (CMS).

The BHH currently provides comprehensive care management and coordination services to Medicaid beneficiaries with select Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) diagnoses in Michigan's Prepaid Inpatient Health Plan (PIHP) Regions 1, 2, 3, 4, 5, 6, 7, 8, and 9.

This SPA will expand access to Behavioral Health Home services in Genesee, Sanilac, and St. Clair Counties within PIHP Region 10 and add the following staff to the health home staffing structure: SOAR Navigator, Housing Specialist, and Parent Support Partner.

The incorporation of a SOAR Navigator and Housing Specialist into the health home staffing structure will significantly enhance support for Native American beneficiaries facing Health Related Social Needs (HRSN) such as lack of housing or income. The addition of Parent Support Partners aims to provide families with essential peer support and guidance, ultimately improving engagement and fostering better outcomes for Native American children and youth.

The anticipated effective date of the SPA is October 1, 2025.

There is no public hearing scheduled for this SPA. Input regarding this SPA 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 517-512-4146, or via email at Elliott-EganL@michigan.gov. **Please provide all input by August 11, 2025.**

In addition, MDHHS is offering to set up group or individual consultation meetings to discuss the SPA, according to the tribes' preference. Consultation meetings 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.

An electronic copy of this letter is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Sincerely,



Meghan E. Groen, Chief Deputy Director
Health Services

CC: Keri Toback, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Asha Petoskey, Acting Area Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 25-34
June 25, 2025

Ms. Whitney Gravelle, President, Bay Mills Indian Community
Ms. Lucy DeWildt, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Ms. Sandra Witherspoon, Chairperson, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Sonya Zotigh, 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. RD Curtis, Tribal President, Keweenaw Bay Indian Community
Ms. Deanna Foucault, 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
Mr. Daryl Wever, Health Director, Little River Band of Ottawa Indians
Ms. Regina Gasco, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Jodi Werner, Health Director, Little Traverse Bay Band of Odawa
Mr. Bob Peters, Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Phyllis Davis, Tribal Council Member, Match-E-Be-Nash-She-Wish Potawatomi
Ms. Mariah Austin, Tribal Council Member, Match-E-Be-Nash-She-Wish Potawatomi
Ms. Dorie Rios, Tribal Chairperson, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Rosalind Johnston, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Mr. Matthew Wesaw, Tribal Chairman, Pokagon Band of Potawatomi Indians
Ms. Priscilla Gatties, Interim Health Director, Pokagon Potawatomi Health Services
Mr. Tim Davis, Tribal Chief, Saginaw Chippewa Indian Tribe
Mrs. Karmen Fox, Executive Health Director, Nimkee Memorial Wellness Center
Mr. Austin Lowes, Tribal Chairperson, Sault Ste. Marie Tribe of Chippewa Indians
Mr. James Benko, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Keri Toback, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Asha Petoskey, Acting Area Director, Indian Health Service - Bemidji Area Office
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