MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-23

Distribution: Prepaid Inpatient Health Plans (PIHP), Community Mental Health Service Programs (CMHSP)

Issued: May 30, 2014

Subject: Introduction of Health Homes in Selected Counties of Grand Traverse, Manistee and Washtenaw

Effective: July 1, 2014

Programs Affected: Medicaid, Healthy Michigan Plan

Introduction

The 2014-2015 Michigan Executive Budget committed the state to implement Medicaid Health Homes in up to three pilot counties for individuals with Severe Mental Illness (SMI) beginning July 1, 2014. The Michigan Department of Community Health (MDCH) submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) introducing coverage of Medicaid Health Homes for beneficiaries in the selected pilot counties of Grand Traverse, Manistee, and Washtenaw. Pending approval of this SPA by CMS, the following policy will become effective July 1, 2014.

Michigan will designate Community Mental Health Services Programs (CMHSPs) as Health Homes that will serve as the central point for directing patient-centered care. This will allow more accountability toward reducing avoidable health care costs (specifically preventing hospital admissions/readmissions and avoidable emergency room visits), providing timely post-discharge follow-up. This will also result in improving beneficiary outcomes by addressing whole-person health care needs through provision of comprehensive, integrated behavioral health (mental health and substance use disorder), medical, care coordination and management services. Health Homes meet CMS's and Michigan's shared goals of improving patient experience of care, improving population health, and reducing per capita cost of health care spending.

Michigan's Health Homes for individuals with SMI will provide care management and coordination services centered around the integration of behavioral and physical health objectives, which will involve a transformation in how care teams organize to coordinate care. This change will involve the coordination of data and information in care management and use of evidence-based care management guidelines.

In conducting their work, Health Homes will work with Michigan's existing managed care structures, including Medicaid Health Plans (MHPs), which are responsible for managing networks of providers that deliver contracted services for enrolled members. Health Homes will also collaborate with Prepaid Inpatient Health Plans (PIHPs), Medicaid Fee-For-Service Providers and other Medicaid providers that are responsible for administration of the state's specialty waiver and services for individuals with SMI, substance use disorder or developmental disabilities. CMHSPs in Grand Traverse, Manistee and Washtenaw Counties that desire to become designated providers of Health Home services must obtain approval from MDCH and meet provider eligibility requirements.

TARGET POPULATION

Medicaid Health Home services are intended for beneficiaries with SMI who have experienced high rates of inpatient hospital admissions or high rates of hospital emergency department usage and who may or may not have other chronic physical health conditions that are amenable to care coordination and management by the Health Home (i.e., congestive heart failure, insulin dependent diabetes, chronic obstructive pulmonary disorder, seizure disorder). Individuals to whom these conditions apply may be determined by MDCH to be eligible to receive Health Home services.

Enrollment of Participants

MDCH will use an automatic assignment with an opt-out method to enroll eligible Medicaid beneficiaries into a Health Home.

Description of Assignment Process

Individuals potentially eligible for Health Home services will be identified and attributed to a CMHSP Health Home by MDCH using Medicaid claims and encounter data. MDCH will determine whether, in addition to having a serious and persistent mental health condition, the individual also has high rates of inpatient hospitalization or emergency department use with or without a chronic medical condition.

Individuals assigned to a CMHSP Health Home will be contacted so that the CMHSP Health Home may conduct a face-to-face encounter with the consumer. The purpose of the face-to-face encounter is to allow the Health Home to describe to the beneficiary his or her chronic health status/risk factors, describe the benefits of the new Health Home services and provide the individual with the option of declining Health Home services. Individuals who decline Health Home services must sign a "Health Home Opt-Out Form" and are offered the option to be placed on a do not call/do not contact for Health Home services list maintained by the CMHSP. MDCH may also elect to inform potentially eligible individuals via U.S. mail and other methods as necessary of Health Home services (e.g., names of Health Homes in the beneficiary's county of residence, a brief description of Health Home services, and the process for individuals to opt-out of receiving Health Home services from the assigned Health Home provider).

Individuals who opt out of Health Home services will be permitted to elect to receive Health Home services at any time as long as they continue to meet service eligibility requirements. Individuals who opt out of receiving Health Home program services may do so without jeopardizing their access to other medically necessary services from the Health Home provider. Individuals referred for Health Home services from hospitals or other settings may be determined eligible through processes developed by the state. Individuals new to Medicaid will be assessed for Health Home services eligibility by qualified providers with an approval determination made by MDCH.

PROVIDER ELIGIBILITY

- Health Home providers must be enrolled with MDCH as a CMHSP and agree to comply with all Medicaid program requirements.
- Health Home providers must participate in a readiness assessment to determine initial and ongoing ability of the Health Home provider to meet service delivery requirements.
- Health Home providers must participate in activities sponsored by MDCH to contribute to the successful implementation and sustainability of Health Home services delivery, including: 1) training and other ongoing collaborative leadership and professional development activities to foster the development of Health Home related professional competencies and best practices; 2) monitoring and performance reporting; 3) continuous improvement activities; and 4) evaluation.
- Health Home providers must establish links and appropriate protocols, including data sharing agreements that are compliant with federal and state laws and regulations, with external health care partners (e.g., primary care providers, specialty providers, hospitals, skilled nursing facilities) to assure access to necessary health care services and to assure the provision of efficient transitional care.

- Health Homes must have in place a sufficient number of core team members with the capacity to provide Health Home services to identified eligible beneficiaries. Health Home providers should also maintain all members of the core team as prescribed by MDCH.
- The Health Home will staff each Health Home team with adequate numbers and types of health care professionals that represent the following functions: Health Home Director, Primary Care Liaison, and Registered Nurse Care Manager.
- Health Home providers must agree to utilize Health Information Technology (HIT), Health Information Exchange (HIE), care management tools (i.e., assessment instruments, clinical decision supports) and other such resources made available by MDCH and through partnerships with PIHPs, MHPs or other external healthcare partners to conduct care management and care coordination services.

TEAM COMPOSITION

CMHSPs in Manistee, Grand Traverse, and Washtenaw Counties will serve as Health Homes. Health Homes must maintain teams of healthcare professionals consistent with state-specified staffing and caseload assumptions. The team of healthcare professionals providing care management and care coordination services for the Health Homes will consist of the following: Health Home Director, Registered Nurse Care Manager, and Primary Care Liaison.

Health Home Director (Leadership and Administration Functions)

- Oversees the daily operation of the Health Home team and facilitates routinely-occurring Health Home team meetings with the Primary Care Liaison, Registered Nurse Care Manager and others as appropriate
- Champions Health Home practice transformation and comprehensive person-centered care, with special attention to health and wellness
- Develops Memorandums of Understanding (MOU) with community hospitals and hospital systems to facilitate transitional care for hospital admissions and discharges
- Develops processes to coordinate hospital admission/discharge planning, including processes for medication reconciliation with assistance of the Registered Nurse Care Manager, and develops procedures to ensure that hospital alerts are promptly acted upon by the Health Home team

Registered Nurse Care Manager (Comprehensive Care Management Functions)

- Leads development and implementation of an integrated whole-person-oriented care plan
- Conducts assessment and identification of risk
- Identifies and develops self-management protocols for use by patients
- Makes initial contact with hospitals regarding client admission, conducts a medication reconciliation with input from the client's primary care physician
- Receives, identifies and follows-up treatment and medication alerts reported by HIT tools
- Coordinates care with external healthcare providers, including pharmacies
- Assists Health Home Director in developing and enhancing wellness initiatives
- Champions healthy lifestyle changes
- Consults with the Health Home team about identified health conditions of clients and provides educational training on chronic disease states, health coaching, medications and healthy living

Primary Care Liaison (Physical Healthcare Consultation Functions)

- Champions practice transformation and comprehensive person-centered care with special attention to health and wellness
- Identifies and develops population health management initiatives for the team of healthcare professionals
- Assures that enrollees receive care consistent with appropriate medical standards
- Consults with Registered Nurse Care Managers, Care Coordinators and psychiatrists as appropriate regarding specific health and wellness concerns of individual enrollees
- Participates in team meetings with the Health Home Director, Registered Nurse Care Manager and others as appropriate
- Maintains a monthly log of activities and reports time to Health Home Director or other support staff

COVERED SERVICES

Health Home services consist of six (6) components that are provided by the Health Home based on the unique needs and conditions of eligible beneficiaries: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referrals to community and social support services.

Comprehensive Care Management

Registered Nurse Care Managers, as part of a proactive, prepared health care team, help patients work toward their personal health goals by incorporating self-management principles and providing health education customized to the patient's health literacy level and cultural preferences. Assessment and identification of risk by a Registered Nurse Care Manager leads to the development and implementation of a whole-person-oriented care plan for all eligible consumers of the Health Home. Comprehensive care management consists of:

- Assessment of risk and identification of high risk sub-groups through use of a health risk assessment/patient health questionnaire
- Identification of whole-person service needs and construction of a comprehensive integrated care plan
- Assignment of different care management roles to members of the Health Home team
- Construction of standardized, evidence-based protocols and clinical pathways for management and monitoring of chronic conditions
- Monitoring of the individual and population health status and service use to assure patient adherence and application of clinical pathways by relevant health care practitioners
- Development and dissemination of reports on satisfaction, health status, cost and quality to guide Health Home service delivery and design

Members of the team of healthcare professionals will:

- Use an integrated care management system for population identification and proactive patient management
- Provide facilitated access to care based on evidence-based practice guidelines
- Use collaborative practice models that include the primary care physician and other care team providers
- Provide patient self-management support (may also involve other team members)
- Work with patients to optimize control of their chronic conditions and prevent long-term complications
- Assist in transitions between settings
- Provide patient education with teach-back to ensure understanding

Comprehensive population management must address all stages of health and disease, with the goal of maximizing current functionality and preventing individuals from developing additional chronic conditions and their complications.

Care Coordination

Care coordination is the implementation of the comprehensive treatment and care management plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination may involve:

- Providing telephonic reminders of appointments
- Providing telephonic outreach and follow-up to low-risk Health Home members who do not need face to face contact
- Communication with family members
- Administering risk assessment
- Survey assessments
- Follow-up reminders and assistance with making appointments
- Identifying outstanding items on patient visit summaries
- Assisting with medication reconciliation
- Making appointments
- Providing patient education materials

- Assisting with arrangements such as transportation, directions and completion of Durable Medical Equipment requests
- Obtaining missing records and consultation reports
- Participating in hospital and ED transition care
- Documenting in the integrated care management system

Care coordination is also aimed at assisting individuals to improve self-management of chronic mental and physical conditions and includes:

- Participation in the development and implementation of a member's individualized care plan addressing dimensions of behavioral health recovery and stabilization and improvement in chronic physical conditions
- Assistance and support for the member in stressor situations
- Mental health and physical health education, support and consultation to members' families and their support system, which is directed exclusively to the well-being and benefit of the member
- Individual assistance for the development of interpersonal, community coping and self-management skills, including adapting to home, school, and work environments
- Assisting the member in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric and physical health symptoms that interfere with the consumer's daily living, financial management, personal development, or school or work performance
- Assistance to the consumer in increasing social support skills and networks that ameliorate life stresses resulting from the member's mental illness or physical health conditions and are necessary to enable and maintain the member's independent living
- Developing strategies and supportive mental and physical health intervention for avoiding out-of-home placement for members, and building stronger family support skills and knowledge of the member's strengths and limitations
- Developing mental and physical health relapse prevention strategies and plans

Health Promotion

Health promotion services involve the provision of health education to the individual (and family member/significant other when appropriate) specific to his/her chronic illness or needs as identified in the assessment. The service includes assistance with medication reconciliation and provides assistance for the individual to develop a self-management plan and self-monitoring and management skill promotion of and connection to healthy lifestyle and wellness (nutrition, substance abuse prevention, smoking prevention and cessation, nutrition counseling, increasing physical activity). Health promotion also involves connecting the individual with peer supports including self-help/self-management and advocacy groups, providing support for improving social network and educating the individual about accessing care in appropriate settings. Health promotion services may be provided by any member of the Health Home team, but are driven by protocols and guidelines developed by the Registered Nurse Care Manager and Primary Care Liaison in collaboration with the provider's mental health and substance use disorder practitioners.

Comprehensive Transitional Care from Inpatient to Other Settings, Including Appropriate Follow-Up

Comprehensive transitional care consists of efforts by the Health Home team members to reduce hospital emergency department and inpatient admissions, readmissions and length of stay. The service seeks to interrupt patterns of use of higher than necessary by providing ready and improved access to the Health Home and other lower levels of care through the provision of timely and effective communication between the inpatient setting and Health Home.

Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.

At a minimum, key functions of transitional care include receiving notifications of admissions and discharges from hospitals and other care facilities; outreach to patients to ensure appropriate follow-up after transition; outbound phone call by the care manager or other team member within 48 hours of discharge; scheduled visit for consumers with the PCP and/or specialist within one week of discharge.

Patient contacts during transitions of care include: Review discharge summary and instructions; perform medication reconciliation; ensure that follow-up appointments and tests are scheduled and coordinated; assess the patient's risk status; and arrange for follow-up care management if indicated.

Individual and Family Support Services (Including Authorized Representatives)

Individual and family support services provides:

- Expanded access and availability of services
- Continuity in relationships between the consumer/family and the physician and care manager
- Outreach to the consumer and their family and perform advocacy on their behalf to identify and obtain needed resources such as medical transportation and other benefits to which they may be eligible
- Education to the consumer in self-management of their chronic condition
- Opportunities for the family to participate in assessment and care treatment plan development
- Insurance that Health Home services are delivered in a manner that is culturally and linguistically appropriate
- Referral to support services that are available in the consumer's community
- Assistance with "natural supports"
- Promotion of personal independence
- Empowerment of the consumer to improve their own environment
- Inclusion of the consumer's family in the quality improvement process including surveys to capture experience with Health Home services
- Consumers/families access to electronic health record information or other clinical information

Referral to Community and Social Support Services

Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and achieve overall health. Referrals to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to:

- Wellness programs, including smoking cessation, fitness, weight loss programs
- Specialized support groups (i.e., cancer, diabetes support groups)
- Substance treatment links in addition to treatment, supporting recovery with links to support groups, recovery coaches, 12-step
- Housing resources
- Social integration
- Assistance with the identification and attainment of other benefits
- Supplemental Nutrition Assistance Program
- Connection with the Office of Rehabilitation Services to assist the person in developing work/education goals and then identifying programs/jobs
- Legal assistance resources
- Faith-based organizations
- Access to employment and educational programs or training

Manual Maintenance

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

Questions

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

Approved

Stephen Fitton, Director
Medical Services Administration