Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

Maryland Medicaid Health Home Provider Application

1. Applicant Information:

Base Medicaid Provider #: NPI:

Organization Name: _____

Primary Location Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Telephone Number: _____ Fax Number: _____

County Code: _____ Website: _____

Provider Type (check all that apply): ☐ Adult PRP ☐ Child PRP ☐ MTS ☐ OTP

For child PRPs, list years of experience providing PRP services to children: _____

Organization Contact Person: _____

Title: _____ Telephone Number: _____

Fax Number: _____ Email Address: _____

*Attach a current copy of the BHA license **for each site**.

Additional Sites: List all sites that will offer Health Home services. If no additional sites, skip to Section 2. If you will have additional sites, provide Section 4 Health Home Staffing information for each site. Attach additional sheets as necessary for each site. If sites plan to share Health Home staff members, explain your staffing plan in detail.

Site Address #2: _____

City: _____ State: _____ Zip Code: _____ County Code: _____

Telephone Number: _____ Fax Number: _____

Medicaid Provider #: NPI:

☐ Adult PRP ☐ Child PRP ☐ MTS ☐ OTP

Site Address #3: _____

City: _____ State: _____ Zip Code: _____ County Code: _____

Telephone Number: _____ Fax Number: _____

Medicaid Provider #: NPI:

☐ Adult PRP ☐ Child PRP ☐ MTS ☐ OTP

2. Health Home Accreditation

Please check the appropriate box regarding the status of your organization's Health Home accreditation. All Health Home sites must obtain accreditation.

☐ Provider currently has the Commission on Accreditation of Rehabilitation Facilities' (CARF) Health Home accreditation for all sites offering Health Home services. Please attach a copy of the CARF certificate documenting all programs and sites accredited.

Date Issued: _____ Expiration Date: _____

☐ Provider is in the process of obtaining CARF Health Home certification. Please attach the Letter of Intent to Survey received from CARF.

☐ Provider has The Joint Commission Behavioral Health Home certification for all sites offering Health Home services. Please attach a copy of The Joint Commission certificate documenting all programs and sites accredited.

Date Issued: _____ Expiration Date: _____

☐ Provider is in the process of obtaining The Joint Commission Behavioral Health Home certification. Please attach the Letter of Intent to Survey received from The Joint Commission.

3. Consortium:

Will this application include a consortium agreement with another agency?

☐ Yes ☐ No

If yes, sections 4b through 5 may be submitted jointly, with an additional Consortium Addendum submitted as well

4. Health Home Staffing:

A. What is your organization's current number of Medicaid enrollees engaged in PRP, MT, or OTP services?

_____

B. Based on this Medicaid enrollment number, please provide the required staffing levels your organization will maintain for the following Health Home positions. Review the attached application instructions for an explanation of how to determine staff levels required for a given enrollment number.

1) Health Home Director: _____

2) Health Home Care Manager: _____

3) Physician or Nurse Practitioner Consultant: _____

4) Administrative support staff: _____

C. Provide the job descriptions that will be used to recruit the Health Home staff, including the qualifications and responsibilities of each position:

1) Health Home Director:

2) Health Home Care Manager:

3) Physician or Nurse Practitioner Consultant:

4) Administrative support staff:

5. **Health Home Provider Standards:**

Describe the systems and protocols your Health Home will use to meet each of the core service requirements and functional components. The detailed description should include the staff performing the tasks, process, procedure, and outcome evaluation.

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 abuse services:

5) Coordinate and provide access to comprehensive care management:

6) Coordinate and provide access to care coordination:

7) Coordinate and provide access to 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 care):

8) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families:

9) Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services:

10) Coordinate and provide access to long-term care supports and services:

11) Develop a person-centered care plan for each enrollee that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:

12) Demonstrate a capacity to use HIT 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:

13) 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. **Health Information Technology:**

A. Please answer the following questions regarding your organization's health information technology (HIT) capabilities:

1) Please describe your HIT capacity, if any, including but not limited to EHR and electronic care management tools.

2) Your organization is required to enroll with the Chesapeake Regional Information System for our Patients (CRISP) Encounter Notification System to receive alerts of patient admissions, discharges, or transfers in a hospital or emergency department setting?

Attach a copy of the email received from CRISP confirming you have initiated the registration process.

7. **Attestations:**

Health Home applicants must attest to the following:

1) Health Home services will include coordination of care and services post critical events (such as emergency department use, hospital inpatient admission, and hospital inpatient discharge).
   - ☐ YES
   - ☐ NO

2) Health Home services will include links to acute and outpatient medical, mental health, and substance abuse services.
   - ☐ YES
   - ☐ NO
3) Health Home services will include links to community-based social support services (including housing services).
   - ☐ YES
   - ☐ NO
4) Health Home services will include beneficiary consent for program enrollment and for sharing of patient information and treatment.
   - ☐ YES
   - ☐ NO
5) The Health Home will not bill the State until staffing requirements are met and service provision begins.
   - ☐ YES
   - ☐ NO
6) The Health Home will notify the State of any changes in Health Home staff.
   - ☐ YES
   - ☐ NO
7) The Health Home agrees to participate in CMS required evaluation activities.
   - ☐ YES
   - ☐ NO
8) The Health Home will engage in periodic reporting as required by the State including submitting monthly online eMedicaid reports documenting Health Home service delivery and enrollees' health and social outcomes.
   - ☐ YES
   - ☐ NO

8. **Rights of the State:**

A. The State reserves all rights generally afforded to the State in contracting with Medicaid providers, pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder.

B. The State reserves the following rights specifically regarding the Health Home program:

1) The State reserves the right to assign beneficiaries to a specific Health Home.

2) The State reserves the right to cancel a Health Home provider's approved status based on failure of the provider to provide Health Home services in accordance with Maryland Health Home regulations (COMAR 10.09.33) provide quality Health Home services to its clients, or on other significant findings determined by the State.

3) The State reserves the right to cancel the Health Home program at any time for lack of funding, and/or if, after evaluation of the program, desired results in quality, efficiency, and decreased costs are not shown, or any other reason determined by the State.

9. **Signature:**

By signing below, the signatory confirms that he or she has read and understands all information included in this application, and affirms that all information entered is true and accurate. The signatory should be an authorized representative of the applicant organization.

Authorized Signature	Title	Date