MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Jackii Prokop

Director, Program Policy Division
Bureau of Medicaid Policy, Operations, and Actuarial Services

Project Number:	2006-BHDDA	**Comments Due:**	April 16, 2020	**Propose Effective Date:**	October 1, 2020

Mail Comments to: Kelsey Schell
Behavioral Health and Developmental Disabilities Administration
Lewis Cass Building
320 S. Walnut St. 5th Floor
Lansing, Michigan 48909-7979

Telephone Number: 517-284-0202 **Fax Number:** 517-335-5376
E-mail Address: schellk1@michigan.gov

Policy Subject: Opioid Health Home (OHH)

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild

Distribution: All Providers in Michigan's Prepaid Inpatient Health Plan (PIHP) Regions 1, 2, 9, and Calhoun and Kalamazoo Counties within PIHP Region 4

Policy Summary: This policy will implement an OHH in Michigan's PIHP Regions 1, 2, and 9, in addition to Calhoun and Kalamazoo Counties within PIHP Region 4.

Purpose: Opioids were involved in 76.4% of drug overdose deaths (21.4 per 100,000 population) in 2017a 13.8% rate increase from 2016. The availability of treatment resources are limited and geographically disparate. MDHHS has identified PIHP Region 1, 2 and 9 in addition to Calhoun and Kalamazoo Counties in Region 4 as having the greatest need for these resources.

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: All Providers in Michigan's Prepaid Inpatient Health Plan (PIHP) Regions 1, 2, 9, and Calhoun and Kalamazoo Counties within PIHP Region 4

Issued: September 1, 2020 (Proposed)

Subject: Opioid Health Home (OHH)

Effective: October 1, 2020 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

Note: Implementation of this policy is contingent upon approval of a State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS).

Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act/Section 1945 of the Social Security Act, the purpose of this policy is to provide for the coverage and reimbursement of OHH services effective for dates of service on and after October 1, 2020. The policy applies to fee-for-service and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who meet OHH eligibility criteria. In addition, the Michigan Department of Health and Human Services (MDHHS) will create a companion operations guide for providers called the OHH Handbook, which will be available on the MDHHS website at www.michigan.gov/ohh.

I. General Information

MDHHS is seeking approval from CMS to revise the current OHH SPA to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination of services to Medicaid beneficiaries with an opioid use disorder diagnosis. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. The model also elevates the role and importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorder; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's OHH model is comprised of a team of providers, including a Lead Entity (LE) and designated Health Home Partners (HHP). Providers must meet the specific qualifications set forth in the SPA, this policy, and provide the six federally required core health home services. Michigan's OHHs must coordinate with other community-based providers to manage the full breadth of beneficiary needs.

MDHHS will provide a monthly case rate to the LE based on the number of OHH beneficiaries with at least one OHH service during a given month. HHPs must contract or establish a memorandum of understanding (MOU) with an LE in order to be a designated HHP and to receive payment. The LE will reimburse the HHP for delivering health home services. Finally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

II. Eligibility

Section 1945 of the Social Security Act requires states to define beneficiary eligibility for health home services by geographic region and diagnosis. The sections below delineate these criteria for the OHH.

A. Geographic Criteria

OHH services will be available to Medicaid beneficiaries who reside in the following counties and meet all other eligibility criteria:

- Alcona
- Alger
- Alpena
- Antrim
- Baraga
- Benzie
- Calhoun
- Charlevoix
- Cheboygan
- Chippewa
- Crawford
- Delta
- Dickinson
- Emmet
- Gogebic
- Grand Traverse
- Houghton
- Iosco
- Iron

- Kalamazoo
- Kalkaska
- Keweenaw
- Leelanau
- Luce
- Mackinac
- Macomb
- Manistee
- Marquette
- Menominee
- Missaukee
- Montmorency
- Ogemaw
- Ontonagon
- Oscoda
- Otsego
- Presque Isle
- Roscommon
- Schoolcraft
- Wexford

B. Diagnostic Criteria

Medicaid beneficiaries with a specific ICD-10 Code for opioid use disorder, including:

- F11: Opioid related disorders

III. Enrollment

The Michigan OHH uses a two-pronged enrollment approach where the LE will enroll and assign beneficiaries to HHPs on behalf of MDHHS. MDHHS reserves the right to review and verify all enrollments. The two prongs of the enrollment process are as follows:

A. Pre-Enrollment

MDHHS will pre-enroll eligible beneficiaries with the LE using administrative claims data via the Waiver Support Application (WSA). The LE will then work with HHPs to assign and enroll eligible beneficiaries into the OHH benefit plan. MDHHS will update eligible beneficiaries at least monthly via the WSA.

While beneficiary pre-enrollment is automatic, full enrollment into the OHH benefit plan is contingent on beneficiary completion of the Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515), verification of diagnostic eligibility, and the LE electronically enrolling the beneficiary in the WSA. Failure to verify consent or diagnostic eligibility will be considered a de facto opt-out

(disenrollment). The LE shall have six months from the date of pre-enrollment to document the preceding steps in the WSA, after which time the beneficiary will be presumed unresponsive and automatically disenrolled from the benefit. (Note: If a beneficiary in this scenario continues to meet OHH eligibility criteria and wishes to join the OHH at a later date, they are entitled to do so, and a new enrollment must be established via the process in the Provider Recommended Enrollment section below.)

B. Provider Recommended Enrollment

HHPs are permitted to recommend prospective OHH beneficiaries for enrollment into the OHH via the LE. OHH providers must provide documentation that indicates whether a prospective OHH beneficiary meets all eligibility for the benefit, including diagnostic verification, obtaining consent (MDHHS-5515), and establishment of an Individual Plan of Care (IPOC). The LE must review and process all recommended enrollments in the WSA.

IV. Health Home Providers

A. Lead Entity

To qualify as an HHP, the LE must:

- be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
- be an MDHHS-designated community mental health (CMH) entity who may contract for and spend funds for the prevention of substance use disorder (SUD) and for the counseling and treatment of individuals with SUD, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269).
- contract with and pay a negotiated rate to HHPs.
- maintain a network of providers that support the OHHs to service beneficiaries with an opioid use disorder diagnosis.
- have authority to access Michigan Medicaid claims and encounter data for the OHH target population.
- have authority to access Michigan's WSA and CareConnect360.
- provide leadership for implementation and coordination of health home activities.
- serve as a liaison between the health home sites 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 develop prevention and wellness initiatives, and referral tracking.
- have the capacity to evaluate, select, and support providers who meet the standards for OHHs, including:
  - Identification of providers who meet the OHH standards;

- Provision of infrastructure to support OHHs in care coordination;
- Collecting and sharing member-level information regarding health care utilization and medications;
- Providing quality outcome protocols to assess OHH effectiveness; and
- Developing training and technical assistance activities that will support OHH in effective delivery of health home services.

B. Health Home Partners

HHPs must contract or establish memorandums of understanding with a LE to deliver OHH services. Examples of HHPs include the following:

- Community Mental Health Services Programs (CMHSPs)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Tribal Health Centers (THCs)
- Clinical Practices or Clinical Group Practices
- Community/Behavioral Health Agencies

V. Provider Staffing

Below are the provider staffing ratios per 100 consumers:

Title	FTE
Health Home Director	0.25
Behavioral Health Specialist	0.25
Nurse Care Manager	1.00
Peer Recovery Coach, Community Health Worker, Medical Assistant	2.00 – 4.00
Medical Consultant	0.10
Psychiatric Consultant	0.05
TOTAL FTE	**3.65 – 5.65**

VI. Detailed Requirements and Expectations

At a minimum, the following care team is required:

- **Health Home Director** (e.g., LE 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.

- 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 a Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)
  - Screens individuals for mental health and substance use disorders.
  - Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary.
  - Conducts brief intervention for individuals with behavioral health problems.
  - Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.
  - Supports primary care providers in identifying and behaviorally intervening with patients.
  - Focuses on managing a population of patients versus specialty care.
  - Works with patients to identify chronic behavior, discusses impact, and develops improvement strategies and specific goal-directed interventions.
  - Develops and maintains relationships with community based mental health and substance abuse providers.
  - Identifies community resources (i.e., support groups, workshops, etc.) for patient to utilize to maximize wellness.
  - Provides patient education.

- **Nurse Care Manager** (e.g., licensed registered nurse)
  - Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives.
  - Participates in initial care plan development, including specific goals for all enrollees.
  - Communicates with medical providers and subspecialty providers, including mental health and substance abuse service providers, long-term care and hospitals, regarding records (including admission/discharge).
  - Provides education in health conditions, treatment 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.

- 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, Community Health Worker, or Medical Assistant** (with appropriate certification/training)
  - Coordinates and provides access to individual and family supports, including referral to community social supports.
  - 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.
  - Identifies community resources (i.e., social services, workshops, etc.) for patient to utilize to maximize wellness.
  - Conducts referral tracking.
  - 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.

- **Medical Consultant** (e.g., primary care physician, physician's assistant, 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**
  - 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.

VII. Payment Methodology

MDHHS will provide a monthly case rate to the LE based on the number of OHH beneficiaries with at least one OHH service in a month. The LE will reimburse the HHP for delivering health home services. Additionally, MDHHS will employ a P4P incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

A. OHH Case Rates to LE

OHH Case Rate	Case Rate	Case Rate with P4P
Composite	$332.88	$350.40

B. Pay-for-Performance

MDHHS will afford P4P up to 5% of the OHH case rate based on providers meeting defined quality benchmarks in accordance with the timelines and processes delineated below. MDHHS will only claim federal match once it determines a quality improvement benchmark has been met. If quality improvement benchmarks are not met within a given performance year, MDHHS' share of the withhold will be reserved by MDHHS and reinvested for future OHH monthly case rate payments. Subsequent performance years will operate in accordance with this structure. The timelines and P4P metrics are explained in further detail below.

C. Timelines

MDHHS will distribute P4P payments to the LE within one year of the end of the Performance Year (PY). The first year of the OHH SPA being in effect will be the Measurement Year (MY). During the MY, MDHHS will develop process/enrollment metrics to distribute withheld P4P at the end of the MY (essentially deeming the MY as a quasi-PY). The PY will be each subsequent fiscal year the SPA is in effect. Specific timelines are as follows:

- MY: 10/1/2020 through 9/30/2021
- PY1: 10/1/2021 through 9/30/2022
- PY2: 10/1/2022 through 9/30/2023

VIII. Metrics and Allocation

Performance Measure Number	**Measure Name and National Quality Forum (NQF) #** (if applicable)	**Measure Steward**	**State Baseline**	**Allocation % of P4P Budget**
1	Initiation and engagement of alcohol and other drug dependence treatment (0004)	National Committee for Quality Assurance (NCQA)	TBD	50%
2	Reduction in opioid-related hospitalizations per 100,000	Michigan	TBD	30%
3	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Michigan	TBD	20%

IX. Assessment and Distribution

A. Assessment

Within six months of the end of the MY, MDHHS will notify the LE of statistically significant benchmarks for each performance measure. MDHHS will compare data in PY1 to the MY to assess if statistically significant improvements occurred. MDHHS will compare all subsequent PYs to the immediately preceding PY to ascertain statistically significant improvements (e.g., MDHHS will compare PY2 to PY1; PY3 to PY2; etc.).

B. Distribution

Within one year of the end of the PY, MDHHS will determine if quality metrics have been met to trigger P4P payments. If quality metrics have been met, MDHHS will distribute P4P monies to the LE. The LE may retain up to 5% of P4P monies for their role in executing the OHH. The LE will then distribute at least 95% of P4P monies to the HHPs scaled to the volume of OHH services a given HHP renders. The following example illustrates how an LE would distribute the remaining 95% of P4P monies to its HHPs:

Example: The OHH has 100 beneficiaries that are served by three HHPs (HHP A, HHP B, and HHP C) where HHP A has 50 beneficiaries, HHP B has 40, and HHP C has 10. For Measure 1, if HHP A meets the benchmark, they will be awarded P4P by the following formula: ([P4P Budget] * [Measure 1 Allocation] * [50/100]). If HHP A met the benchmarks for Measure 2 and/or 3, then the [Measure 1 Allocation] would be replaced with [Measure 2 Allocation] and/or [Measure 3 Allocation] respectively. MDHHS will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid.