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.

Jackie Prokop

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

Project Number:	2007-BHDDA	**Comments Due:**	April 14, 2020	**Proposed Effective Date:**	October 1, 2020

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Policy Subject: Behavioral Health Home (BHH)

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild

Distribution: All Providers in Michigan's Prepaid Inpatient Health Plan (PIHP) Regions 1, 2, and 8.

Policy Summary: This policy will implement a BHH in Michigan's PIHP Regions 1, 2, and 8.

Purpose: BHH models increase access to essential integrated physical and behavioral health services, which is critical given the number of unserved Michigan residents with behavioral health needs. This policy will recalibrate the diagnoses to serve the highest-need beneficiaries with a Serious Mental Illness/Serious Emotional Disturbances (SMI/SED) and expand the initiative to more regions.

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, and 8

Issued: September 1, 2020 (Proposed)

Subject: Behavioral Health Home (BHH)

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 BHH services. This policy is 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 BHH eligibility criteria. In addition, MDHHS will create a companion operation guide for providers called the Behavioral Health Home Handbook.

I. General Information

The Michigan Department of Health & Human Services (MDHHS) is seeking approval from CMS to revise the current BHH SPA to optimize and expand the BHH in select Michigan counties. The BHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with a select serious mental illness/serious emotional disturbance (SMI/SED) diagnosis. For enrolled beneficiaries, the BHH 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 will also elevate the role and importance of Peer Support Specialists 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 BHH program: 1) improve care management of beneficiaries with SMI/SED; 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 BHH 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 BHHs 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 BHH beneficiaries with at least one BHH 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 BHH.

A. Geographic Criteria

BHH 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
- Charlevoix
- Cheboygan
- Chippewa
- Crawford
- Delta
- Dickinson
- Emmet
- Gogebic
- Grand Traverse
- Houghton
- Iosco
- Iron
- Kalkaska
- Keweenaw

- Leelanau
- Luce
- Mackinac
- Manistee
- Marquette
- Menominee
- Missaukee
- Montmorency
- Oakland
- Ogemaw
- Ontonagon
- Oscoda
- Otsego
- Presque Isle
- Roscommon
- Schoolcraft
- Wexford

B. Diagnostic Criteria

Medicaid beneficiaries with a specific ICD-10 Code for Serious Mental Illness or Serious Emotional Disturbance, including the following:

- F41 Other anxiety disorders
- F32 Major depressive disorder, single episode
- F43 Reaction to severe stress, and adjustment disorders
- F33 Major depressive disorder, recurrent
- F31 Bipolar disorder
- F06 Other mental disorders due to known physiological condition
- F25 Schizoaffective disorders
- F90 Attention-deficit hyperactivity disorders
- F20 Schizophrenia

III. Enrollment

The Michigan BHH uses a two-pronged enrollment approach where the LEs enroll and assign eligible beneficiaries to an HHP using the Waiver Support Application (WSA). The two prongs of the enrollment process include pre-enrollment from administrative claims data and provider-recommended enrollment. Details on the two processes are as follows:

A. Pre-Enrollment

MDHHS will identify and pre-enroll eligible beneficiaries using MDHHS administrative claims data. MDHHS will provide a batch list of eligible beneficiaries to the LEs in which they are enrolled via the WSA. The list of eligible beneficiaries will be updated at least

monthly. From the list, the LE will identify beneficiaries who are currently receiving services from the LE and provide them with information regarding BHH services. The LE will indicate that the beneficiary may opt-out (disenroll) from the BHH at any time with no impact on their eligibility for other Medicaid services. All prospective BHH beneficiaries will be made aware of the BHH through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. MDHHS and the LE will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the BHH.

While beneficiary pre-enrollment is automatic, full enrollment into the BHH 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 BHH eligibility criteria and wishes to join the BHH 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 potential eligible beneficiaries for enrollment into the BHH via the LE. BHH providers must provide documentation that indicates whether a prospective BHH beneficiary meets all eligibility for the benefit, including diagnostic verification, obtaining consent, and establishment of an individualized care plan. The LE must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

IV. <u>Health Home Providers</u>

A. Lead Entity (LE)

To qualify as an HHP, the LE must:

- Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
- Contract with and pay a negotiated rate to HHPs,
- Maintain a network of providers that support the BHHs to service beneficiaries with a SMI/SED diagnosis,
- Have authority to access Michigan Medicaid claims and encounter data for the BHH 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 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,
- Have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including:
  - Identification of providers who meet the BHH standards,
  - Provision of infrastructure to support BHHs in care coordination,
  - Collecting and sharing member-level information regarding health care utilization and medications,
  - Providing quality outcome protocols to assess BHH effectiveness, and
  - Developing training and technical assistance activities that will support BHH in effective delivery of health home services.

B. Health Home Partners

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

- CMHSPs
- Federally Qualified Health Centers/Primary Care Safety Net Clinic
- 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 Support Specialist, Community Health Worker, Medical Assistant	3.00 – 4.00
Medical Consultant	0.10
Psychiatric Consultant	0.10
TOTAL FTE	**4.70 – 5.70**

VI. 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 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 the patient to utilize to maximize wellness, and
  - 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 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, 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, and
  - Provides education on health conditions and strategies to implement care plan goals including both clinical and non-clinical needs.

- **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.

VII. Payment Methodology

MDHHS will provide a monthly case rate to the LE based on the number of BHH beneficiaries with at least one BHH service in a month. The LE will reimburse the HHP for delivering health home services. Additionally, 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.

A. BHH Case Rates to LE

BHH Case Rate	Case Rate	Case Rate with P4P
Composite	$358.37	$377.23

B. Pay-for-Performance (P4P)

MDHHS will afford P4P up to 5% of each tiered 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 quality improvement benchmarks have 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 BHH 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 BHH 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. 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	Reduction in Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	National Committee for Quality Assurance (NCQA)	TBD	50%
2	Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	TBD	20%
3	Access to Preventative/Ambulatory Health Services (AAP)	NCQA	TBD	30%

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 BHH. The LE will then distribute at least 95% of P4P monies to the HHPs scaled to the volume of BHH services a given HHP renders. The example below illustrates how a LE would distribute the remaining 95% of P4P monies to its HHPs:

Example: The BHH 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 measures 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.