Opioid Health Home (OHH) Handbook

Version 1.11

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration

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The purpose of this manual is to provide Medicaid policy and billing guidance to the providers participating in Michigan's OHH Program.

Note: The information included in this manual is subject to change.

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Preface

The Michigan Department of Health & Human Services (MDHHS) created the OHH Handbook to provide Medicaid policy and billing guidance to providers participating in Michigan's OHH Program which is an optional service under the Michigan Medicaid State Plan Amendment (SPA). Most broadly, this handbook will provide detailed instructions that will help providers complete and submit documentation necessary for policy adherence and billing completion. The handbook will also provide links to additional information where necessary.

MDHHS requires that all providers participating in the OHH Program be familiarized with all Medicaid policies and procedures prior to rendering services to beneficiaries. This includes policies and procedure currently in effect in addition to those issued in the future.

While it is the intent of MDHHS to keep this handbook as updated as possible, the information provided throughout is subject to change. All current and future policies and procedures will be maintained on the MDHHS OHH website listed below. Finally, this handbook should not be construed as policy for the OHH program.

The handbook will be maintained on the OHH website here: michigan.gov/ohh.

Section I: Introduction to the Opioid Health Home Service Model

1.1 Overview of the OHH

The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicaid and Medicare Services (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 services to Medicaid beneficiaries with an opioid use disorder. Michigan's OHH model is comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHPs) that can best serve the needs of each unique beneficiary. HHPs will be comprised of two settings – HHP Opioid Treatment Programs (OTPs) and HHP Office Based Opioid Treatment Providers (OBOTs). The State will provide a monthly case rate to the LE based for OHH beneficiaries with at least one OHH service. The State is requiring the LE to adopt a minimum fee schedule based on state plan OHH Fee for service (FFS) rates to pay in-network HHPs. The LE will pay HHPs directly on behalf of the State. LEs and HHPs must meet the provider qualifications set forth in the SPA, policy and this OHH Handbook and provide the six federally required core health home services. HHPs must contract or establish memorandums of understanding with a LE. The LE and HHPs must be connected to other community-based providers to manage the full breadth of beneficiary needs. 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. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT); 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

1.2 OHH Population Criteria

Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements section include those enrolled in Medicaid, the Healthy Michigan Plan, Freedom to Work, Healthy Kids Expansion or MIChild who have a diagnosis of opioid use disorder.

1.3 OHH Services

OHH services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. These services include the following:

- Comprehensive Care Management, including but not limited to:
  - Assessment of each beneficiary, including behavioral and physical health care needs;
  - Assessment of beneficiary readiness to change;
  - Development of an individualized care/treatment plan;
  - Documentation of assessment and care plan in the Electronic Health Record; and
  - Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.

- Care Coordination, including but not limited to:
  - Organization of all aspects of a beneficiary's care;
  - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;

- Information sharing between providers, patient, authorized representative(s), and family;
- Resource management and advocacy;
- Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries 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;
- Use of patient care team huddles;
- Use of case conferences;
- Tracking of test results;
- Requiring discharge summaries;
- Providing patient and family activation and education;
- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

- Health Promotion, including but not limited to:
  - Providing patient and family activation and education;
  - Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
  - Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.);
  - Promoting healthy lifestyle interventions;
  - Encouraging a routine preventative care such as immunizations and screenings;
  - Assessing the patient and family's understanding of the health condition and motivation to engage in self-management;
  - Using evidence-based practices, to engage and help patient participate in and manage their care.

- Comprehensive Transitional Care, including but not limited to:
  - Connecting the beneficiary to health services;
  - Coordinating and tracking the beneficiary's use of health services through Health Information Technology (HIT) in conjunction with the LE Coordinator;
  - Providing and receiving notification of admissions and discharges;
  - Receiving and reviewing care records, continuity of care documents, and discharge summaries;
  - Post-discharge outreach to ensure appropriate follow-up services for all care in conjunction with the LE Coordinator;
  - Medication reconciliation;
  - Pharmacy coordination;
  - Proactive care (versus reactive care);

- Specialized transitions when necessary (i.e., age, corrections); and
- Home visits to ensure stability through transitions.

- Individual and Family Support (including authorized representatives), including but not limited to:
  - Reducing barriers to the beneficiary's care coordination;
  - Increasing patient and family skills and engagement;
  - Use of community supports (i.e., Community Health Workers, peer supports, peer recovery coaches, support groups, self-care programs, etc.);
  - Facilitating improved adherence to treatment;
  - Advocating for individual and family needs;
  - Assessing and increasing individual and family health literacy;
  - Use of advance directives, including psychiatric advance directives;
  - Contributing assistance with maximizing beneficiary's level of functioning; and
  - Providing assistance with development of social networks.
- Referral to Community and Social Support Services, including but not limited to:
  - Providing beneficiaries with referrals to support services;
  - Collaborating/coordinating with community-based organizations and key community stakeholders;
  - Emphasizing resources closest to the beneficiary's home;
  - Emphasizing resources which present the fewest barriers;
  - Identifying community-based resources;
  - Providing resource materials pertinent to patient needs;
  - Assisting in obtaining other resources, including benefit acquisition;
  - Providing referral to housing resources; and
  - Providing referral tracking and follow-up.

1.4 Health Home Partner (HHP) Qualification Criteria

Eligible HHPs must meet all applicable state and federal licensing requirements, including specifications set forth in this policy. Additionally, eligible providers will sign the MDHHS-5745 (Health Home Partner Application) attesting to meeting the requirements cited in MSA Policy 20-31, the SPA, and other applicable MDHHS policies and procedures. HHPs must contract or have a Memorandum of Understanding (MOU) with the LE.

1.4a Geographic Area

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

1.4b Provider Types

The LE will be responsible for providing health homes in partnership with HHPs. The LE already contracts with the State for Medicaid services. All HHPs must provide Medication Assisted Treatment (MAT). HHP-OTPs must meet all state and federal licensing requirements of an OTP. HHP-OBOT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT.

- Lead Entity (LE)
  - Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
  - Must contract or develop a Memorandum of Understanding (MOU) with and pay a negotiated rate to HHPs (the scope of work established with the health home partners shall be defined by the provisions set forth in the health home handbook).
  - Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as

defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269).Have authority to access Michigan Medicaid claims and encounter data for the OHH target population.
  - Have authority to access Michigan's WSA and CareConnect360.
  - Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including:
    - Identification of providers who meet the HHP standards
    - Provision of infrastructure to support HHPs in care coordination
    - Collecting and sharing member-level information regarding health care utilization and medications
    - Providing quality outcome protocols to assess HHP effectiveness
    - Developing training and technical assistance activities that will support HHPs in effective delivery of HH services
  - Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.
  - Must pay HHPs directly on behalf of the State for the OHH Program at the State defined rate.

- Health Home Partner (HHP) -- Opioid Treatment Program (OTP)
  - 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 an Opioid Treatment Program.

- Health Home Partner (HHP) -- Office Based Opioid Treatment Provider (OBOT)
  - 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:
    - Community Mental Health Services Program (Community Mental Health Center)
    - Federally Qualified Health Center/Primary Care Safety Net Clinic
    - Hospital based Physician Group
    - Physician based Clinic
    - Physician or Physician Practice
    - Rural Health Clinics
    - Substance Use Disorder Provider other than Opioid Treatment Program
    - Tribal Health Center

1.4c Minimum Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

The Michigan OHH Lead Entity (LE) must:

1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
2. Be an MDHHS department-designated community mental health entity who may contract or develop an MOU for and spend funds for the prevention of substance use disorder and

for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269).

3. Have authority to access Michigan Medicaid claims and encounter data for the OHH target population.
4. Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including:
    a. Identification of providers who meet the HHP standards
    b. Provision of infrastructure to support HHPs in care coordination
    c. Collecting and sharing member-level information regarding health care utilization and medications
    d. Providing quality outcome protocols to assess HHP effectiveness
    e. Developing training and technical assistance activities that will support HHPs in effective delivery of health home services
5. Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.
6. Must pay providers directly on behalf of the State for the OHH Program at the State defined rate.
7. The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the OHH with providers; MDHHS will retain overall oversight and direct administration of the LE; The LE will also serve as part of the Health Homes team by providing care management and care coordination services.

The Lead Entity (LE) and the Health Home Partners (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. Attain accreditation from a national recognizing body specific to a health home, patient-centered medical home, or integrated care (e.g., NCQA, AAAHC, JC, CARF, etc.) The LE/HHP may be pursuit of such accreditation at the time of OHH implementation; or,
    b. In the absence of accreditation from a national recognizing body, the LE may certify that an HHP has met standards parallel to those required for accreditation. The LE must establish and utilize a certification template for HHPs. The LE must submit completed certifications to MDHHS for quality assurance and compliance purposes.
4. Provide 24-hour, seven days a week availability of information, screening for services 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, including recovery services, informed by evidence-based clinical practice guidelines.
    c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
    d. Coordinate and provide access to physical, mental health, and substance use disorder 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.

Section II: Provider Requirements for OHH Participation

2.1 OHH General Provider Requirements

LEs must adhere to the OHH contractual and policy requirements with MDHHS. HHPs must meet the requirements indicated in the Health Home Partner Application with MDHHS and the LE requirements. LEs and HHPs must adhere to the requirements of the State Plan Amendment, all Medicaid statutes, policies, procedures, rules, and regulations, and the OHH Handbook.

2.2 Health Home Partner Enrollment

All HHPs must be properly paneled with the LE through contract, memorandum of understanding, or similar mechanism conveying mutual partnership to execute OHH services. Moreover, all HHPs must sign and attest to the requirements set forth in the Health Home Partner Application.

2.3 Health Home Partner Disenrollment

To maximize continuity of care and the patient-provider relationship, MDHHS expects HHPs to establish a lasting relationship with enrolled beneficiaries. However, HHPs wishing to discontinue OHH services must notify the regional LE and MDHHS before ceasing OHH operations. OHH services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

2.4 Health Home Partner Termination

Failure to abide by the terms of the OHH policy and requirements may result in disciplinary action, including placing the provider in a probationary period and, to the fullest degree, termination as an HHP.

2.5 OHH Required Provider Infrastructure

OHHs, through the LE and HHP, will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. Each setting will have its own unique set of requirements commensurate with the scope of their operations to reflect beneficiary needs. Contingent upon MDHHS exceptions, specific minimum requirements for each setting are as follows:

LEs (per 100 beneficiaries)

- Health Home Director (0.5 FTE)

HHPs (per 100 beneficiaries)

- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker, Medical Assistant (2.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

2.6 OHH Provider Requirements and Expectations

- Health Home Director (e.g., Lead Entity Care Coordinator)
    - Provides leadership for implementation and coordination of health home activities
    - Coordinates all enrollment into the health home on behalf of providers
    - Coordinates with LE care management staff and HHPs to identify a beneficiary's optimal setting of care
    - Coordinates and utilizes HIT with the HHP team to maximize care coordination and care management
    - Serves as a liaison between the health homes site and MDHHS staff/contractors
    - Champions practice transformation based on health home principles
    - Coordinates all enrollment into the health home on behalf of providers
    - 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
    - Training and technical assistance
    - Data management and reporting

- Behavioral Health Specialist (e.g., Case Worker, Counselor, or Therapist with related degree)
    - Screens individuals for mental health and substance use disorders

  - Refers beneficiaries to a licensed mental health provider and/or licensed and certified 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, discuss impact, develop 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, 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 recommendation, medications and strategies to implement care plan goals including both clinical and non-clinical needs
  - Monitors assessments and screenings to assure findings are integrated in the care plan
  - Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
  - Monitors and report 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, 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 and recovery capital
  - 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 (i.e., 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, participate in team huddles when appropriate, and monitor 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 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 licensed mental health provider's treatment into patient care plan.

- NOTE: Any provider could be assigned the "lead" for any patient based on their person- centered plan.

- In addition to the above Provider Infrastructure Requirements, eligible HHPs should coordinate care with the following professions:

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

2.7 Training and Technical Assistance

MDHHS is requiring HHPs to actively participate in state and LE sponsored activities related to training and technical assistance and will also impose additional functional provider requirements to optimize care management, coordination, and behavioral health integration. Those requirements are below:

1. Participate in state and LE sponsored activities designed to support HHP in transforming service delivery. This includes a mandatory Health Home orientation for providers and clinical support staff before the program is implemented.
2. Participate in ongoing technical assistance (including but not limited to trainings and webinars).
3. Participate in ongoing individual assistance (including but not limited to audits,

site visits, trainings, etc., provided by State and/or State contractual staff).

4. Support Health Home team participation in all related activities and trainings, including coverage of travel costs associated with attending Health Home activities.
5. Provide each beneficiary, at a minimum, with access to a care team comprised of the providers mentioned in Section 1.4.
6. Assign a personal care team to each beneficiary.
7. Ensure each patient 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 the patient and care team recognize each other as partners.
8. Embed behavioral health care services into primary health care services, with real-time behavioral health consultation available to each primary care provider.
9. Provide behavioral and physical health care to beneficiaries using a whole-person orientation and with an emphasis on quality and safety.
10. Provide care or arrange for care to be provided by other qualified professionals. This includes but is not limited to care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care.
11. Engage in meaningful use of technology for patient communication.
12. Develop a person-centered care plan for each beneficiary that coordinates and integrates all clinical and non-clinical health care related needs and services.
13. Coordinate and integrate each beneficiaries' behavioral health care.
14. Designate for each beneficiary a care coordinator who is responsible for assisting the beneficiary with follow-up, test results, 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.
15. Communicate with each beneficiary (and authorized representative(s), family and caregivers) in a culturally and linguistically appropriate manner.
16. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services and health promotion.
17. Directly provide, or contract to provide, the following services for each beneficiary:
    - Mental health/behavioral health and substance abuse services
    - Oral health services
    - Chronic disease management
    - Coordinated access to long term care supports and services
    - Recovery services and social health services (available in the community)
    - Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco treatment/cessation, and health coaching)
18. Conduct Health Home outreach to local health systems.
19. Provide comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
20. Review and reconcile beneficiary medications.
21. Perform assessment of each beneficiary's social, educational, housing, transportation, and vocational needs that may contribute to disease and/or present barriers to self- management.
22. Maintain a reliable system, including written standards/protocols, for tracking

patient referrals.

23. Adhere to all applicable privacy, consent, and data security statutes.
24. Demonstrate use of clinical decision support within the practice workflow specific to the conditions identified in the Health Home project.
25. Demonstrate use of a population management tool such as a patient registry and the ability to evaluate results and implement interventions that improve outcomes.
26. Implement evidence-based screening tools designated LE.
27. Establish a continuous quality improvement program, and collect and report on data that permit 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.
28. Enhance beneficiary access to behavioral and physical health care.
29. Provide each beneficiary with 24/7 access to the care team including, but not limited to a telephone triage system with after-hours scheduling to avoid unnecessary emergency room visits and hospitalizations.
30. Monitor access outcomes including but not limited to the average 3rd next available appointment and same day scheduling availability.
31. Implement policies and procedures to operate with open access scheduling and available same day appointments.
32. Use HIT, including but not limited to an EHR capable of integrating behavioral and physical health care information.
33. Use HIT to link services, facilitate communication among team members as well as between the health team and individual and family caregivers, and provide feedback to providers.
34. Possess the capacity to electronically report to the State and/or its contracted affiliates information regarding service provision and outcome measures.
35. Work collaboratively with MDHHS and contractors to adapt and adopt program processes for Health Home care team use in the participating sites(s).
36. Engage in Health Home process and outcome achievement activities including ongoing coaching, data feedback and customized improvement plans to meet initiative goals.
37. Practice in accordance with accepted standards and guidelines and comply with all applicable policies published in the Michigan Medicaid Provider Manual.

Section III: Enrollment and Disenrollment

3.1 Enrollee Identification and Assignment

Enrollment Processes

Potential Opioid Health Home (OHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The Lead Entity (LE) will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to fully enroll the Medicaid beneficiary into the OHH benefit. The selection of a health home provider is optional, the beneficiary may have other choices of health home providers, and the beneficiary may disenroll from the benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home

is voluntary and the potential enrollee must agree to receive health home services and provide consent that is maintained in the enrollee's health record.

Lead Entities will provide information about the OHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. LEs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the OHH.

- Lead Entity Identification of Potential Enrollees
  The LE will be responsible for identifying potential enrollees that have a qualifying OHH diagnosis in the WSA to a perspective HHP and provide information regarding OHH services to the Medicaid beneficiary in coordination with the HHP.

- Provider Recommended Identification of Potential Enrollees
  Health Home Partners are permitted to recommend potential enrollees for the OHH benefit via the WSA. OHH providers must provide documentation that indicates whether a potential OHH enrollee meets all eligibility for the health home 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.

3.2 Beneficiary Consent

Potential enrollees must provide HHPs a signed consent to share behavioral health information for care coordination purposes form (MDHHS-5515) to receive the OHH benefit. The MDHHS-5515 must be collected and stored in the beneficiary's health record with attestation in the WSA. The MDHHS-5515 can be found on the MDHHS website at www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Behavioral Health Information Sharing & Privacy. The form will also be available at the designated HHPs office and on the LE's website. HHPs are responsible for verifying receipt of the signed consent form and providing proper documentation to MDHHS via the LE. All documents must be maintained in compliance with MDHHS record-keeping requirements.

3.3 Beneficiary Disenrollment

While identifying potential enrollees 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. Once the Medicaid beneficiary is assigned to a health home, the HHP will work with the beneficiary to complete any further requirements. Failure to verify consent or diagnostic eligibility will prevent the Medicaid beneficiary from enrolling into the OHH benefit.

3.4 Beneficiary Changing Health Home Partner Sites

While the enrollee's stage in recovery and individualized plan of care will be utilized to determine the appropriate setting of care, beneficiaries will have the ability to change HHPs to the extent feasible within the LE's designated OHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting

relationship with their chosen HHP. However, beneficiaries may change HHP, and should notify their current HHP immediately if they intend to do so. The LE and HHP will work together to identify a recommended HHP setting where the potential health home enrollee will likely be most successful. After receiving the recommendation from the LE and HHP, the beneficiary will have the opportunity to choose their preferred HHP. The variety and number of HHPs may vary by region. The current and future HHP must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new HHP appointment availability. Only one HHP may be paid per beneficiary per month for health home services.

Section IV: OHH Payment

4.1 General Provisions for OHH Payment

The MDHHS will provide a monthly case rate to the LE based on attributed OHH beneficiaries with at least one OHH service. MDHHS is the LE to, in turn, pay HHPs a negotiated rate with a state-directed minimum payment. Any savings afforded through the provision of health home services will be shared between the LE and the HHPs based on defined quality metrics. 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 are paid.

4.2 Rate Workup

Staffing Model

OHH payment rates are based on a staffing model per 100 beneficiaries with salary, fringe benefit, and indirect cost information derived from current compensation surveys produced by the Community Mental Health Association of Michigan (i.e., Prepaid Inpatient Health Plans, Substance Use Disorder Providers such as Opioid Treatment Programs [OTPs], and Community Mental Health Services Programs [CMHSPs]) and the Michigan Primary Care Association (i.e., Federally Qualified Health Centers [FQHCs]). Rates reflect the following staffing composition for the OHHs by HHP type, respectively:

Lead Entity (per 100 patients)

- Health Home Director (0.50 FTE)

Health Home Partners (per 100 patients)

- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker, Medical Assistant (2.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

Rate Amounts

The OHH payment rates reflect a monthly case rate per OHH beneficiary with at least one proper and successful OHH service within a given month. The payment for OHH services is subject to recoupment from the PIHP if the beneficiary does not receive an OHH service during the calendar month. Rates will be effective on or after October 1, 2020. Rate information will be maintained on the MDHHS website at www.michigan.gov/OHH. Rates will be evaluated annually and updated as appropriate.

PIHP Payment to Health Home Partners

MDHHS will provide a monthly case rate to the lead entity based on the number of OHH beneficiaries with at least one OHH service during a calendar month. The LE will reimburse the health home partner for delivering health home services. Depending on the current services provided by the health home partner, the lead entity can negotiate a rate with the HHP while following the guidelines below, requirements in the approved SPA, Policy 2006-BHDDA, and the OHH Handbook.

OHH Case Rates to LE

PMPM	PMPM with P4P
$364.48	$383.66

- The LE must provide at least 80% of the OHH case rate to an HHP. The LE can retain up to 20% for health home activities per the LE expectations in the approved SPA, Policy 2006-BHDDA, and the OHH Handbook.

- Of the 80% required to go to the HHP:
  If the lead entity is partnering with an external provider to deliver health home services (FQHC, RHC, CMHSP) and wants to do a value-based payment (VBP):
  - The lead entity must provide at least 90% of the OHH case rate to the health home partner for providing the health home services.
  - The remaining 10% of the approved case rate may be used for value-based payment incentives.
  - The lead entity must have a plan in place to use or reinvest the value-based portion should no health home partner meet the VBP measures

The case rates were developed by utilizing provider compensation surveys from the Community Mental Health Association of Michigan (2019) and the Michigan Primary Care Association (2019), which represent the PIHP and OTP, and OBOT component of the rates, respectively. The State also utilized 2019 fringe rate data from the US Department of Labor's Bureau of Labor and Statistics. Below is a breakdown by each respective category:

- For the LEs, the State utilized salaries and fringe benefits reflecting the Health Home Director and indirect costs for all direct LE and HHP costs.
- For HHPs, the State utilized salaries and fringe benefits reflecting the HHP team structure per 100 patients.

4.3 Pay-for-Performance (P4P) vis a vis 5% Withhold

MDHHS will afford P4P via a 5% performance incentive to the additional per member per month case rate. The LE must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the timelines and processes delineated below. 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 State share of the withhold will be reserved by MDHHS and reinvested for 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:

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). 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: 10/1/2021 through 9/30/2022

NOTE: OHH Cohort 1 (PIHP Region 2) has a timeline two years ahead of the preceding timeline due to the first OHH SPA being effective for Cohort 1 on 10/1/2018; OHH Cohort 1 will remain on that cycle as per contract with MDHHS.

Metrics and Allocation

The metrics and specifications will be maintained on the MDHHS website through the following link: www.michigan.gov/OHH. The table below represents the first set of metrics:

Performance Measure	Description	Numerator	Denominator	Allocation % of P4P Budget
Initiation and engagement of alcohol and other drug dependence treatment NCQA (0004)	Percentage of beneficiaries with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more	Initiation of AOD Treatment: January 1, 2018 – November 28, 2018 (Within 14 days of the IESD) Engagement of AOD Treatment: January 2, 2018 – January 1, 2019 (Day after initiation encounter through 34 days after the initiation date)	Index episode start date (IESD): January 1, 2018 – November 14, 2018 Negative diagnosis history review: November 2, 2017 – September 15, 2018 (60 days prior to IESD)	50%

	additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.			
Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge. 7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge. For both indicators, any of the following meet criteria for a follow-up visit. • An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set) • An outpatient visit (BH	Age 18 and older as of the ED visit. An ED visit (ED Value Set) with a principal diagnosis of AOD (Abuse or Dependence Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was 18 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below. Note: Removal of	30%

		Outpatient Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set) • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set) • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a mental health practitioner • A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set) • Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a	multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusion before removing multiple visits in a 31-day period. If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period.	

		mental health practitioner • A telehealth visit: Visit Setting Unspecified Value Set with Telehealth POS Value Set with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)		
Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	The number of ED visits for SUD during the measurement period	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	20%

Assessment and Distribution

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.).

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 example below illustrates how a LE would distribute the remaining 95% of P4P monies to its HHPs.

In this scenario, the OHH has 100 beneficiaries that are served by three HHPs (HHP A, B, and 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. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid.

4.4 OHH Service Encounter Coding Requirements

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

requirements are as follows:

- OHH Care Management Encounters
  HHPs must provide at least one OHH service (as defined in the "Covered Services" section) within the service month. HHPs must submit the following OHH service encounter code in addition to any pertinent ICD-10 Z-codes (to indicate the any applicable social determinants of health) to the LE:

  - *S0280 with HG Modifier*
    - The initial service must be delivered in-person. The initial service can be delivered non-face-to-face per federal and state guidelines
    - All subsequent services may be delivered
      - Non-face-to-face as appropriate
      - TS Modifier must be used to document non-face-to-face encounters
      - Outside of the HHP physician site
    - The HG Modifier MUST be used for ALL encounters.

  - *Applicable ICD-10 Z diagnosis codes* to be used with the S0280 with HG Modifier code include the following groups:
    - Z55-Z65 (Socio-Economic Conditions) Persons with potential health hazards related to socioeconomic and psychosocial circumstances
    - Z77-Z99 (Environmental Conditions)
    - Z780-Z99 (Persons with potential health hazards related to family and personal history and certain conditions influencing health status)

    (Please note that the Z-code should NOT be used as the primary diagnosis code)

4.5 Encounter Submission

The LE will use the File Transfer Service (FTS) to submit and retrieve encounter related files electronically with MDHHS. Refer to section 6.4 of this handbook for additional information relating to FTS.

The LE will need to use the 'Class ID Filename' for files that are submitted through the FTS to MDHHS, and to recognize files that MDHHS returns to your billing agent "mailbox". When submitting OHH encounters, the Class ID Filename will be 5476. After submission, you will receive a response in the mailbox via a 999-acknowledgment file. The 999 file does not mean that all encounters submitted were accepted. Once the 5476 file is processed by MDHHS, you will receive a 4950-error report which will provide details on accepted and rejected encounters.

OHH organizations are encouraged to review the "Electronic Submissions Manual" (ESM) for additional information and instructions relating to submitting data electronically and the FTS. The ESM can be found at www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual.

The Data Analysis and Quality Specialist in BHDDA and the Encounter Team will handle all electronic questions related to Encounter file submission and FTS issues for OHH

organizations. Questions or issues can be directed to the following email addresses: BerryR3@michigan.gov and MDHHSEncounterData@michigan.gov

4.6 Payment Schedule

The enrollment file for the month will be sent to CHAMPS on the 26th of the month for processing. For illustrative purposes, the July 26th enrollment file would include:

- Payment for newly enrolled beneficiaries added to OHH from July 1 through July 25.
- Retroactive payment for beneficiaries enrolled from June 26 to June 30.
- Prospective payment for the month of August (for all enrolled beneficiaries, as of July 26).

Payment will be made on the second pay cycle (the Thursday after the 2nd Wednesday of the month). The payment will be included with any other scheduled payments associated with the LE's tax identification number.

4.7 Recoupment of Payment

The monthly payment is contingent upon an OHH beneficiary receiving an OHH service during the month at issue. The payment is subject to recoupment if the beneficiary does not receive an OHH service during the calendar month. The recoupment look back will occur six months after the monthly payment is made. Thus, six months after the month a payment is made (for example, in January the State would look back at the month of July's payment), CHAMPS will conduct an automatic recoupment process that will look for an approved encounter code (refer to section 4.3) that documents that the HHP at least one of the five core OHH services (excluding the Health Information Technology core service requirement) during the calendar month in question. If a core OHH service is not provided during a month, that month's payment will be subject to recoupment by the State. Once a recoupment has occurred, there shall be no further opportunity to submit a valid OHH encounter code and/or claim for the month that has a payment recouped.

The recoupment process will run automatically on the 2nd of the month. The LE must submit encounters by the end of the month before the scheduled recoupment. To continue with the example provided above, on January 2nd the recoupment will process for the month of July. July's encounters would need to be submitted no later than December 15th to ensure an accurate recoupment process. This allows over 5 months for the LE to submit encounters.

In addition, a recoupment could also occur if the beneficiary is no longer eligible for the OHH benefit due to a higher priority benefit plan activating. For example, if the beneficiary is admitted to a skilled nursing facility on July 7th and an OHH professional speaks to the beneficiary via phone on July 29th, the month of July's payment would not be maintained due to the higher priority benefit plan being assigned. The beneficiary could be discharged from the nursing facility in August and reenrolled to the OHH benefit.

Section V: OHH and Managed Care

5.1 OHH Enrollment for Health Plan Beneficiaries

The LE and HHPs must work with Medicaid Health Plans to coordinate services for eligible beneficiaries who wish to enroll in the OHH program. The LE has responsibility for SUD services for all enrolled Medicaid beneficiaries within its region and will have a list of all

qualifying beneficiaries including the health plan to which they are assigned. MDHHS will require the LE and health plans to confer to optimize community-based referrals and informational materials regarding the OHH to beneficiaries. The LE will primarily be responsible for conducting outreach to eligible beneficiaries, while health plans will provide support in addressing beneficiary questions. Bi-directional communication is imperative throughout the process so that all parties have current knowledge about a beneficiary.

There are two different scenarios that MDHHS anticipates could manifest with eligible beneficiaries enrolled in a health plan who wish to participate in the OHH Program. Those are detailed below:

A) For health plan beneficiaries whose current primary care provider is a designated HHP, health plans, upon beneficiary request, will direct beneficiaries to setup an appointment with their OHH primary care provider and inform the beneficiary that their provider will help obtain OHH services.

B) For health plan beneficiaries whose current primary care provider is not a designated HHP, health plans, upon beneficiary request, should work with the LE to find an appropriate OHH site. This may or may not include changing the beneficiary's primary care provider to the HHP of the beneficiary's choice that is also within the health plan's provider network. If there is no in-network HHP in the eligible county, then the health plan should work with the LE to establish an MOU between the designated HHP and the beneficiary's primary care provider to facilitate OHH services and continuity of regular care at their primary care provider. The health plan and LE should also help the interested beneficiary find an in-network HHP in the region if the beneficiary is seeking to change primary care providers to a designated OHH site (if applicable).

5.2 OHH Coordination & Health Plans

Health Plans are contractually obligated to provide a certain level of care coordination and care management services to their beneficiaries. However, all SUD services are managed by the LE, but the comorbid physical and mild-to-moderate behavioral health conditions remain under the auspice of the health plan. To minimize confusion and maximize patient outcomes, bi- directional communication between the LE and health plan is essential. MDHHS expects the LE vis a vis the designated HHP to take the lead in the provision of care management, spanning health and social supports. At the same time, health plan coordination in terms of supporting enrollment, facilitating access to beneficiary resources, and maintaining updated information in CareConnect360 and other Health Information Exchange technology will be critical to the success of the OHH and the beneficiary's health status.

Section VI: Health Information Technology

6.1 Waiver Support Application (WSA) and the OHH

The WSA will provide support to the LE in the areas of beneficiary enrollment, including pre- enrollment activities (e.g., maintaining updated list of eligible beneficiaries), enrollment management including beneficiary disenrollment, and report generation. Every month, a new batch of eligible beneficiaries will be uploaded to the WSA.

6.2 CareConnect360 and the OHH

CareConnect360 will help HIT-supported care coordination activities for the OHH Program. Broadly, it is a statewide care management web portal that provides a comprehensive view of individuals in multiple health care programs and settings based on claims information. This will allow the LE and other entities with access to CareConnect360 the ability to analyze health data spanning different settings of care. In turn, this will afford HHP a more robust snapshot of a beneficiary and allow smoother transitions of care. It will also allow the LE to make better and faster decisions for the betterment of the beneficiary. Providers will only have access to individuals that are established as patients of record within their practice. Finally, with appropriate consent, CareConnect360 facilitates the sharing of cross-system information, including behavioral health, physical health, and social support services.

6.3 Electronic Health Records and Health Information Exchanges

The use of electronic health records and HIE is essential to the overarching goals of the OHH Program in the sense that it allows for the maintenance and transmittal of data necessary to optimize care coordination and management activities. MDHHS is also requiring that the LE and all HHPs utilize the same SUD platform to maximize clinical coordination and beneficiary consent to share information management.

Moreover, because CareConnect360 does not have SUD related information, a more robust HIE solution is required to provide the optimal level of care management and coordination required of the OHH program. The LE will secure an HIE with these capabilities and facilitate access, including technical assistance, to the HHPs.

6.4 File Transfer Service (FTS)

Michigan's data-submission portal is the File Transfer Service (FTS). Some documents may still reference the DEG; be aware that a reference to the DEG portal is a reference to the FTS.

Billing agents will use the FTS to submit and retrieve files electronically with MDHHS. MDHHS has established an Internet connection to the FTS, which is a Secure Sockets Layer connection.

This connection is independent of the platform used to transmit data. Every billing agent receives a "mailbox", which is where their files are stored and maintained. Billing agents can access this mailbox to send and retrieve files.

Section VII: OHH Monitoring and Evaluation

7.1 Monitoring & Evaluation Requirements

Both CMS and MDHHS have quality monitoring and evaluation requirements for the Health Home program. To the extent necessary to fulfill these requirements, providers must agree to share all OHH clinical and cost data with MDHHS. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers. The data will be reported annually by MDHHS to CMS.

7.2 Federal (CMS) Monitoring & Evaluation Requirements

CMS has supplied reporting requirements and guidance for health home programs. There are two broad sets of requirements – core utilization and core quality measures. It is essential that HHPs are aware of these measures and how they are calculated for evaluation

purposes and the program's longevity. The specific Core Measures and other federal requirements are laid out below:

1. Core Utilization Measures (reported annually)
    a. Initiation and engagement of alcohol and other drug dependence treatment
    b. Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence
    c. Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries

2. Core Quality Measures (reported annually)
    a. Adult Body Mass Index (BMI) Assessment
    b. Screening for Clinical Depression and Follow-up Plan
    c. Plan All-Cause Readmission Rate
    d. Follow-up After Hospitalization for Mental Illness
    e. Controlling High Blood Pressure
    f. Care Transition – Timely Transmission of Transition Record
    g. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    h. Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

In addition to the CMS Core Measures, CMS also requires participating states to conduct an independent cost-efficiency evaluation to demonstrate cost-savings.

CMS provides a technical specification manual each year for the federal reporting measures, which can be found on this page: CMS Health Homes Quality Reporting.

7.3 State Monitoring & Evaluation Requirements

In addition to the Federal requirements, CMS also requires states to define a separate quality monitoring plan specific to the population their Health Home program will target. MDHHS will monitor and report on the following data annually and utilize some of these measures in the P4P:

- Decrease in Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
- Reduction in County/Regional Opioid Hospitalizations per 100,000 Population
- Increase in the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and Identification of Alcohol and Other Drug Services (IAD)

Appendix A: List of Qualifying ICD-10 Codes

F11 Opioid related disorders:

- F11.1 Opioid abuse
    - F11.10 …… uncomplicated
    - F11.11 …… in remission
    - F11.12 Opioid abuse with intoxication
        - F11.120 …… uncomplicated
        - F11.121 …… delirium

        - F11.122 …… with perceptual disturbance
        - F11.129 …… unspecified
    - F11.14 …… with opioid-induced mood disorder
    - F11.15 Opioid abuse with opioid-induced psychotic disorder
        - F11.150 …… with delusions
        - F11.151 …… with hallucinations
        - F11.159 …… unspecified
    - F11.18 Opioid abuse with other opioid-induced disorder
        - F11.181 Opioid abuse with opioid-induced sexual dysfunction
        - F11.182 Opioid abuse with opioid-induced sleep disorder
        - F11.188 Opioid abuse with other opioid-induced disorder
    - F11.19 …… with unspecified opioid-induced disorder

- F11.2 Opioid dependence
    - F11.20 …… uncomplicated
    - F11.21 …… in remission
    - F11.22 Opioid dependence with intoxication
        - F11.220 …… uncomplicated
        - F11.221 …… delirium
        - F11.222 …… with perceptual disturbance
        - F11.229 …… unspecified
    - F11.23 …… with withdrawal
    - F11.24 …… with opioid-induced mood disorder
    - F11.25 Opioid dependence with opioid-induced psychotic disorder
        - F11.250 …… with delusions
        - F11.251 …… with hallucinations
        - F11.259 …… unspecified
    - F11.28 Opioid dependence with other opioid-induced disorder
        - F11.281 Opioid dependence with opioid-induced sexual dysfunction
        - F11.282 Opioid dependence with opioid-induced sleep disorder
        - F11.288 Opioid dependence with other opioid-induced disorder
    - F11.29 …… with unspecified opioid-induced disorder

- F11.9 Opioid use, unspecified
    - F11.90 …… uncomplicated
    - F11.92 Opioid use, unspecified with intoxication
        - F11.920 …… uncomplicated
        - F11.921 …… delirium
        - F11.922 …… with perceptual disturbance
        - F11.929 …… unspecified
    - F11.93 …… with withdrawal
    - F11.94 …… with opioid-induced mood disorder
    - F11.95 Opioid use, unspecified with opioid-induced psychotic disorder
        - F11.950 …… with delusions
        - F11.951 …… with hallucinations
        - F11.959 …… unspecified
    - F11.98 Opioid use, unspecified with other specified opioid-induced disorder
        - F11.981 Opioid use, unspecified with opioid-induced sexual dysfunction

        - F11.982 Opioid use, unspecified with opioid-induced sleep disorder
        - F11.988 Opioid use, unspecified with other opioid-induced disorder
    - F11.99 …… with unspecified opioid-induced disorder