Behavioral Health Home (BHH) Handbook

Version 2.0

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 BHH Program.

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

Table of Contents

Preface **3**
Section I: Introduction to the Health Home Service Model **4**
1.1 Overview of the BHH 4
1.2 BHH Population Criteria 4
1.3 Diagnostic Criteria 5
1.4 BHH Services 5
1.5 Health Home Partner (HHP) Qualification Criteria 7
1.5 a Geographic Area 7
1.5 b Provider Types 8
1.5 c Minimum Standards 9
Section II: Provider Requirements for BHH Participation **11**
2.1 BHH General Provider Requirements 11
2.2 Health Home Partner Enrollment 11
2.3 Health Home Partner Termination 11
2.4 Behavioral Health Home Provider Infrastructure 11
2.5 Health Home Partner Requirements and Expectations 12
2.6 Training and Technical Assistance 14
Section III: Beneficiary Enrollment, Transfers, and Disenrollment **16**
3.1 Beneficiary Identification and Assignment 16
3.2 Behavioral Health Home Care Plan Requirements 17
3.3 Behavioral Health Home and Targeted Case Management 18
3.4 Beneficiary Consent 19
3.5 Beneficiary Transfer Process 19
3.6 Beneficiary Disenrollment 20
3.7 Beneficiary Changing BHH Providers 21
Section IV: BHH Payment **21**
4.1 General Provisions for BHH Payment 21
4.2 Rate Workup 21
4.3 BHH Service Encounter Codes 23
4.4 Encounter Submission 24
4.5 Payment Schedule 24
4.6 Recoupment of Payment 24
4.7 Pay-for-Performance (P4P) vis a vis 5% Withhold 25
Section V: BHH and Managed Care **27**
5.1 BHH Enrollment for Health Plan Beneficiaries 27
5.2 BHH Coordination & Health Plans 27
Section VI: Health Information Technology **28**
6.1 Waiver Support Application (WSA) and the BHH 28
6.2 CareConnect360 and the BHH 28
6.3 Electronic Health Records (EHRs) and Health Information Exchanges (HIEs) 28
6.4 File Transfer Service (FTS) 28
Section VII: BHH Monitoring and Evaluation **28**
7.1 Monitoring & Evaluation Requirements 28
7.2 Federal (CMS) Monitoring & Evaluation Requirements 29
7.3 State Monitoring & Evaluation Requirements 29
Appendix A: List of Qualifying ICD-10 Codes **30**
Serious Mental Illness and Serious Emotional Disturbance: 30
Appendix B: Coexisting Benefit Plan List **34**

Preface

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

MDHHS requires that all providers participating in the BHH 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 BHH website listed below. Finally, this handbook should not be construed as policy for the BHH program.

The handbook is maintained on the BHH website here: www.michigan.gov/bhh

Section I: Introduction to the Health Home Service Model

1.1 Overview of the BHH

The Michigan Department of Health & Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) to amend the current Behavioral Health Home (BHH) State Plan to optimize and expand the BHH in select Michigan counties. The BHH provides 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 functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered Behavioral Health Home care plan (also known as, care plan, throughout this document) to best manage their care. The model also elevates 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 attends 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 its contracted designated Health Home Partners (HHPs). 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 within a calendar month. HHPs must contract with a LE to be a designated HHP and to receive payment. The LE will reimburse the Health Home Partner 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.

1.2 BHH Population Criteria

Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements section include those enrolled in Medicaid, the Healthy Michigan Plan, MIChild, Freedom to Work, Full Fee-for-Service Medicaid, and Full Fee-for-Service Healthy Kids - Expansion who have a select serious mental illness/serious emotional disturbance (SMI/SED) diagnosis.

Individuals eligible for behavioral health home services are eligible for all Medicaid covered services. Behavioral health home services were designed to help beneficiaries connect to medically necessary services. However, payment for duplicative services in the same calendar month is prohibited. The health home team must choose which available Medicaid covered service best meets the person's needs.

A list of coexisting benefit plans can be found in Appendix B*, all others are excluded benefit plans.

*Please note, beneficiaries cannot be enrolled in SUD HH (Substance Use Disorder Health Home), HMICare (Health Home MI Care Team), ICO-MC (Integrated Care MI Health Link), or Hospice during the same month.

A beneficiary cannot be in spend down. Lead entities are responsible for checking the beneficiary benefit status in CHAMPS.

1.3 Diagnostic Criteria

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

- F06 Other mental disorders due to known physiological condition
- F20 Schizophrenia
- F25 Schizoaffective disorders
- F31 Bipolar disorder
- F32 Major depressive disorder, single episode
- F33 Major depressive disorder, recurrent
- F43 Reaction to severe stress, and adjustment disorders
- F41 Other anxiety disorders
- F90 Attention-deficit hyperactivity disorders
- F91 Conduct Disorders
- F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence

1.4 BHH Services

BHH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. BHH must provide the following six core services, linked as appropriate by health information technology (HIT):

- 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 the Behavioral Health Home care plan (see requirements in section 3.2);
  - 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 Behavioral Health Home 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.);
  - 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; and
  - 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.

1.5 Health Home Partner (HHP) Qualification Criteria

Eligible BHH providers must meet all applicable state and federal licensing requirements, including specifications set forth in this handbook. Additionally, eligible providers will sign the MDHHS-5745 (Health Home Provider Application) attesting to meeting the requirements cited in MSA Policy 20-48, the State Plan Amendment, and other applicable MDHHS policies and procedures. HHPs must establish a contract or MOU with the LE.

1.5 a Geographic Area

BHH services are available to Medicaid beneficiaries who reside in the following counties and meet all other eligibility criteria:

Alcona	Delta	Keweenaw	Oakland
Alger	Dickinson	Lake	Oceana
Allegan	Eaton	Leelanau	Ogemaw
Alpena	Emmett	Lenawee	Ontonagon
Antrim	Gladwin	Livingston	Osceola
Arenac	Gogebic	Luce	Oscoda
Baraga	Grand Traverse	Mackinac	Otsego
Barry	Gratiot	Macomb	Ottawa
Bay	Hillsdale	Manistee	Presque Isle
Benzie	Houghton	Marquette	Roscommon
Berrien	Huron	Mason	Saginaw
Branch	Ingham	Mecosta	Schoolcraft
Calhoun	Ionia	Menominee	Shiawassee
Cass	Iosco	Midland	St. Joseph
Charlevoix	Iron	Missaukee	Tuscola
Cheboygan	Isabella	Monroe	Van Buren
Chippewa	Jackson	Montcalm	Washtenaw
Clare	Kalamazoo	Montmorency	Wayne
Clinton	Kalkaska	Muskegon	Wexford
Crawford	Kent	Newaygo	

1.5 b Provider Types

The LE is responsible for providing health home services in partnership with community based HHPs. The LEs currently contract with the State of Michigan for Medicaid services. HHPs are permitted to recommend prospective BHH 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 (MDHHS-5515), and establishment of the Behavioral Health Home care plan. The LE must review and process all recommended enrollments in the WSA.

- BHH 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 with and pay a negotiated rate to HHPs (the scope of work established with the health home partners shall be defined by the HHP requirements set forth in the health home handbook, SPA, and Policy),
  - Must maintain a network of providers that support the BHHs to service beneficiaries with a serious mental illness/serious emotional disturbance diagnosis,
  - Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,
  - Have authority to access Michigan's Waiver Support Application and CareConnect360,
  - Provides leadership for implementation and coordination of health home activities,
  - Serves as a liaison between the health homes site and MDHHS staff/contractors,
  - Champions practice transformation based on health home principles,
  - 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,
  - Must 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 support BHH in effective delivery of health home services.

- Health Home Partners (HHPs)

  HHPs must contract or establish memorandums of understanding with a LE to deliver BHH services. Additionally, HHPs must enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. Examples of HHPs include the following:

  - Community Mental Health Services Programs (CMHSPs)

- Federally Qualified Health Center/Primary Care Safety Net Clinic
- Rural Health Clinic
- Tribal Health Center
- Clinical Practices or Clinical Group Practices
- Community/Behavioral Health Agencies

1.5 c Minimum Standards

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

Michigan BHH Lead Entity (LE) must:

1. Be a regional entity as defined in Michigan's Mental Health Code (330.1204b),
2. Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,
3. 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 service,
4. Must maintain a network of providers that support the HHPs to service beneficiaries with a serious mental illness and serious emotional disturbance,
5. Must reimburse HHPs for providing health home services,
6. The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the BHH with providers; MDHHS retains overall oversight and direct administration of the LE; The LE also serves 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:
   a. Attain accreditation from a national recognizing body specific to a health home, patient-centered medical home, or integrated care (e.g., NCQA, AAAHC, Joint Commission, CARF, etc.). The LE/HHP may be in pursuit of such accreditation at the time of BHH implementation; or,
   b. In the absence of specific accreditation from a national recognizing body (health home, PCMH, or integrated care, etc.), the LE must verify that a HHP meets standards to provide health home services parallel to those required for accreditation. The LE must establish and utilize a template for HHPs that aligns with the BHH Partner Standards Document, BHH Handbook, SPA, and policy. MDHHS

has the right to review all templates created by the LE for quality assurance and compliance purposes.

4. Provide 24-hour, seven days a week availability of information 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 care 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 informed by evidence-based clinical practice guidelines
    c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness.
    d. Coordinate and provide access to physical and mental health 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

<u>Conflict of Interest</u>

The requirements in this section are intended to mitigate conflicts of interest that may occur when a Lead Entity also serves as a Health Home Partner.

Staffing

- Lead Entity staff must be separate and distinct from Health Home Partner staff. Lead Entity staff should not be serving as part of the Health Home care team or in a supervisory role to any Health Home partner staff.
- Lead Entity staff must conduct oversight of health home partners as described under Minimum Standards within this section. Lead Entities cannot delegate health home oversight responsibilities to a CMHSP.

Guardrails for Referrals and Assignment to Health Homes

- If a Lead Entity is referring a beneficiary to a Health Home, the Lead Entity must determine what Health Home Partner is best positioned to serve the beneficiary according to the factors described below:
    - Choice: If the individual served has expressed a choice/preference for a specific Health Home, the Lead Entity must honor that choice to the maximum extent possible.
    - Existing Provider Relationship: The Lead Entity must consider whether the beneficiary has an existing relationship with a Health Home and give preference to that provider when making a referral unless there is a specific reason not to do so.
    - Geographic Location: The Lead Entity must consider the individual's geographic location to ensure reasonable accessibility to the Health Home.
    - Capacity: The Contractor must ensure they refer/assign individuals to Health Homes that have the capacity to serve new individuals in a timely manner.

Section II: Provider Requirements for BHH Participation

2.1 BHH General Provider Requirements

LEs must adhere to the BHH contractual and policy requirements with MDHHS. HHPs must meet the requirements indicated in the Health Home Provider 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 BHH Handbook.

2.2 Health Home Partner Enrollment

All HHPs must be properly paneled with the LE through contract, memorandum of understanding, or a similar mechanism conveying mutual partnership to execute BHH services. Moreover, all HHPs must sign and attest to the requirements set forth in the Health Home Provider Application (MDHHS-5745).

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 BHH services must notify the regional LE and MDHHS at least six months in advance of ceasing BHH operations. BHH services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

2.3 Health Home Partner Termination

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

2.4 Behavioral Health Home Provider Infrastructure

HHPs, through the LE, ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The requirements span two settings – the LE and the HHP providers. Each setting has its own unique set of requirements commensurate with the scope of their operations to reflect beneficiary needs.

The staffing structure below is based on 100 consumers enrolled into the health home. Although it is expected that the staffing structure is in place for 100 beneficiaries, it does not mean that this structure needs to be in place prior to enrolling 100 beneficiaries. This also means that each staff person's FTE does not need to be solely dedicated to BHH.

Contingent upon MDHHS exceptions, specific minimum requirements for each setting are as follows:

Lead Entities (per 100 beneficiaries)

- Health Home Director (0.25 FTE)
  - Includes one director and relevant administrative staff (e.g., program coordinators and support staff)

Health Home Partners (per 100 beneficiaries),

- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Community Health Worker, Medical Assistant (3.00-4.00 FTE)
- Medical Consultant (.10 FTE)
- Psychiatric Consultant (.10 FTE)

2.5 Health Home Partner Requirements and Expectations

- Health Home Director (e.g., Lead Entity Professional)
  - 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 BHH providers to identify a beneficiary's optimal setting of care,
  - Coordinates and utilizes HIT with the BHH provider 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,
  - 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 behavioral health, behavioral sciences, counseling, human development, mental health and human services, psychology, rehabilitation, social work, sociology, special education, 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

counseling, education, nursing, psychology, social work, 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., shall be a licensed registered nurse [RN] or licensed practical nurse [LPN].)
  - LPNs must meet the following requirements to fill this role:
    - Minimum of one year experience in a managed care setting preferred, and
    - A minimum of three to five years medical nursing, surgical nursing and/or nursing in the acute care setting.
    - LPNs can perform all functions of the role, including the administration of assessments and participation in initial care plan development, however, a portion of the Nurse Care Manager FTE must be designated to hire an RN. The RN nurse case manager will be responsible for the ongoing review of all assessments and care plans, coordination for complex patients, and providing high-level education as needed.
  - 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 Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitate communication among team members and provide feedback,
  - Monitors and report 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, Peer Recovery Coach, Youth Peer Support Specialist, 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 (social services, workshops, etc.) for patients to utilize and 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 assistant, pediatrician, 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 is responsible for communicating treatment methods and expert advice to Behavioral Health Provider (incorporated into care team). It is 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 the 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 BHH providers should coordinate care with the following professions:
    - Dentist
    - Dietician/Nutritionist
    - Pharmacist
    - Diabetes educator
    - School personnel
    - Others as appropriate

2.6 Training and Technical Assistance

MDHHS requires HHPs to actively participate in state and LE sponsored activities related to training and technical assistance and impose additional functional provider requirements to optimize care management, coordination, and behavioral health integration. Requirements are listed 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 1.5,
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, as applicable, 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 such as SBIRT, PHQ9, GAD, diabetes and asthma risk tests to assess treatment needs,
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 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, and
37. Practice in accordance with accepted standards and guidelines and comply with all applicable policies published in the Michigan Medicaid Provider Manual.

Section III: Beneficiary Enrollment, Transfers, and Disenrollment

3.1 Beneficiary Identification and Assignment

Enrollment Process

Potential Behavioral Health Home (BHH) enrollees are identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) provides a generated list that pulls 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 BHH benefit.

Lead Entities provide information about the BHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. LEs strategically

provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the BHH.

A. Lead Entity Identification of Potential Enrollees
The LE is responsible for identifying potential enrollees that have a qualifying BHH diagnosis in the WSA to a prospective HHP and provide information regarding BHH services to the Medicaid beneficiary in coordination with the HHP.

B. Provider-Recommended Identification of Potential Enrollees
Health Home Partners are permitted to recommend potential enrollees for the BHH benefit via the WSA. BHH providers must provide documentation that indicates whether a potential BHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of a care plan*. The LE must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

*Please note, the establishment of a care plan can take place after the beneficiary is enrolled in the benefit. The care plan must be submitted and approved by the LE within the required timeframe set by the LE, which should not exceed three months.

While identifying potential enrollees 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. 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. Once the Medicaid beneficiary is assigned to a health home, the HHP will work with the beneficiary to complete the enrollment process.

3.2 Behavioral Health Home Care Plan Requirements

Within 30 days of enrollment, the behavioral health home care team must work with the beneficiary to develop and complete a behavioral health home care plan. The BHH care plan must align with the six statutorily, required health home services (as listed in section 1.4) and act as a plan to guide the care and support services to be provided by the behavioral health home care team. The care plan must integrate the beneficiary's physical health, behavioral health, and social support needs. The care plan must be updated annually but should be reviewed and revised over time based on the beneficiary's progress and changing needs.

The care plan must be developed with the BHH care team, the beneficiary, and the beneficiary's support system (family, caregiver, etc.) when available. It is best practice that all parties agree to and sign off on the care plan before it is implemented. Crisis needs should be assessed monthly and crisis response plans should be added as necessary.

An example of the components to include in the care plan is available on the MDHHS webpage www.michigan.gov/BHH.

At a minimum, the care plan should include the following:

I. The tasks to be completed by each BHH team member.

II. The tasks to be completed by the beneficiary and the beneficiary's support system (family, caregiver, etc.) when available.
III. SMART* goals and objectives developed by and agreed upon by the beneficiary, beneficiary's support system, and BHH care team to achieve improved health outcomes. Improved health outcomes are defined with the beneficiary and beneficiary support system.
IV. Align with the six required health home services.
V. Integrate the beneficiary's physical health, behavioral health, and social support needs.
VI. A plan to monitor the behavioral health home care plan progress and update goals.**

*SMART goals are specific, measurable, achievable, realistic, and timely.
**Health Home goals should be updated at least annually but should be reviewed and revised based on the beneficiary's progress and changing needs.

3.2.1 Behavioral Health Home Care Plan and Existing IPOS/Treatment Plan
Health Home Partners should bill the S0280 for development of the BHH care plan and related activities. The BHH care plan goals and objectives can also be added to an existing Individualized Plan of Service/Treatment Plan developed for a Medicaid beneficiary. In this scenario, HHPs can bill the S0280 code when a member of the Behavioral Health Home care team adds health home specific goals and objectives to an existing IPOS/treatment plan. HHPs and LEs must ensure that billing for care plan/treatment plan development and/or modification is not duplicative (see Section 1.2).

Please reference Care Plan Training materials housed in Microsoft Teams for examples of health home goals and objectives.

3.3 Behavioral Health Home and Targeted Case Management

For beneficiaries enrolled in Behavioral Health Home and Targeted Case Management (TCM), special consideration must take place to avoid billing for duplicative services within a calendar month. The following chart identifies service overlap between BHH and TCM. HHPs and LEs can bill for BHH and TCM in the same calendar month but must ensure that the following activities are not billed by both programs in the same month. For the services below, the HHP and/or LE must choose which program they are going to bill the service to (BHH or TCM).

Behavioral Health Home Service Definition	Included as Part of TCM
Comprehensive Care Management	
• *Conducting outreach and engagement activities to gather information from the enrollee, the enrollee's support member(s), and other primary and specialty care providers.*	Yes
• *Completing a comprehensive needs assessment.*	Yes
• *Developing a comprehensive person-centered care plan.*	Yes
Care Coordination	

• *Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with enrollee, enrollee's support member(s) and primary and specialty care providers.*	Yes
• *Participating in hospital discharge processes to support the enrollee's transition to a non-hospital setting.*	Yes
• *Communicating and consulting with other providers and the enrollee and enrollee's support member, as appropriate.*	Yes
Referrals to Community/Social Support Services	
• *Providing referral and information assistance to individuals in obtaining community-based resources and social support services;*	Yes
• *Identifying resources to reduce barriers to help individuals in achieving their highest level of function and independence.*	Yes
• *Monitoring and follow up with referral sources, enrollee, and enrollee's support member, to ensure appointments and other activities, including employment and other social community integration activities, were established and enrollees were engaged in services.*	Yes

3.4 Beneficiary Consent

Beneficiaries must provide BHH providers a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form (MDHHS-5515) to receive the BHH 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 should 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.

3.5 Beneficiary Transfer Process

A beneficiary who is enrolled in the BHH can be transferred to another health home partner via the WSA within the same PIHP region or to a different PIHP region. HHPs are permitted to recommend a transfer to the LE via the WSA. The transfer recommendation will automatically be moved to the PIHP work queue as an "Enrolled (Transfer Recommended)" case status. The LE will review the HHP transfer recommendation and approve, send back for more information, or deny the transfer. LE's can also initiate a transfer without receiving a HHP recommendation.

The "new" LE region will receive the transfer request and either approve, send back the request for more information, or deny the transfer. If the transfer is denied, the beneficiary will remain in "Enrolled" status. The existing HHP/LE will discuss next steps and possibly disenroll the individual from the BHH if they are no longer receiving services.

A new MDHHS-5515 must be obtained to complete a transfer to a new health home partner. In addition to the MDHHS-5515, a new care plan must be developed by the new health home partner care team. After the transfer is complete, the previous HHP will have access to the information obtained while the beneficiary was enrolled in their service. This includes the following information which is stored within the WSA:

- Documents
  - Care Plan
  - Consent to Share Behavioral Health Information
- Enrollment History
- Transfer History

Detailed information on the transfer process can be found in the Waiver Support Application under the training tab.

3.6 Beneficiary Disenrollment

Failure to verify consent or diagnostic eligibility will prevent the Medicaid beneficiary from enrolling into the BHH benefit. Medicaid beneficiaries may opt-out (disenroll) from the BHH at any time with no impact on their eligibility for other Medicaid services.

Disenrollment Process

Lead Entity Disenrollment

The LE is responsible for disenrolling all BHH beneficiaries in WSA. The LE must confirm the disenrollment reason by checking CHAMPS and WSA. If the LE confirms that a beneficiary should be disenrolled from the BHH, they must complete the process in WSA.

Provider-Recommended Disenrollment

HHPs are permitted to recommend beneficiary disenrollment via the WSA. The HHP must select the recommended disenrollment reason and disenrollment date before submitting the recommendation to the LE. The LE must review and process all recommended disenrollment's in the WSA. MDHHS reserves the right to review and verify all disenrollment's from BHH.

More information on the disenrollment process in WSA can be found in the WSA HHBH User Training Manual.

Beneficiaries enrolled in the Behavioral Health Home can be disenrolled for the following reasons:

- Loss of Medicaid eligibility
- Moved out of the eligible geographic region
- Deceased
- No longer in required benefit plan or enrolled in excluded benefit plan
- Unresponsive
- Voluntarily Opt-out
- Administrative removal

Beneficiaries that are involuntarily disenrolled from the Health Home may appeal such decision through the State Fair Hearing process under 42 CFR Part 431 Subpart E. Information regarding Michigan's State Fair Hearing process and related forms can be found at the following link: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-16825--,00.html.

Other than beneficiary-initiated disenrollment, disengaged beneficiaries will be categorized into one of the following two groups, which have unique disenrollment processes:

- Beneficiaries who have moved out of an eligible geographic area, are deceased, or are otherwise no longer eligible for the Medicaid program. These beneficiaries will have their eligibility files updated per the standard MI Bridges protocol. Providers will receive updated files accordingly.

- Beneficiaries who are unresponsive for reasons other than moving or death. The LE or HHP must make at least three unsuccessful beneficiary contact attempts within at least three consecutive months for MDHHS to deem a beneficiary as unresponsive. During this time, the beneficiary must remain enrolled in BHH. If the beneficiary is deemed unresponsive, the beneficiary can be disenrolled from the BHH by the LE. The LE and MDHHS must maintain a list of disenrolled beneficiaries. The LE must attempt to re- establish contact with these beneficiaries at least every six months after disenrollment for one year or until eligibility changes to make the beneficiary ineligible for services*.

  *Please note: The LE can delegate this task to the HHP if the HHP has an existing relationship with the beneficiary. The HHP must provide documentation of the contact attempts to the LE.

3.7 Beneficiary Changing BHH Providers

While the beneficiary's care plan will be utilized to determine the appropriate setting and BHH provider of care, beneficiaries will have the ability to change BHH providers to the extent feasible within the LE's designated BHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen BHH provider. However, if a beneficiary decides to change BHH providers, they should notify their current BHH provider immediately if they intend to do so.
The current and future BHH providers 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 BHH provider's appointment availability. Only one BHH provider may be paid per beneficiary per month for health home services (please see section 4.5 for payment schedule).

Section IV: BHH Payment

4.1 General Provisions for BHH Payment

MDHHS will provide a monthly case rate to the LE based on the number of enrolled BHH beneficiaries with at least one BHH service within the month. The LE will reimburse the Health Home Partner for delivering health home services following the guidelines below.

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 (please see section 4.7 for more information).

4.2 Rate Workup

Staffing Model

BHH 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, Community Mental Health Services Programs) and the Michigan Primary Care Association (i.e., Federally Qualified Health Centers). Rates reflect the following staffing model for the BHH per 100 enrollees:

- Health Home Director (0.25 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Community Health Worker, Medical Assistant (3.00 - 4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.10 FTE)

Rate Amounts

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

The case rates reflect the preceding staffing model per 100 enrollees and were developed by utilizing provider compensation surveys from the Community Mental Health Association of Michigan (2019) and the Michigan Primary Care Association (2019). The State also utilized 2018 fringe rate data from the US Department of Labor's Bureau of Labor and Statistics. MDHHS will continue to use this methodology to evaluate case rates annually.

BHH Case Rates to LE

BHH Case Rate	PMPM	PMPM with P4P
Composite	$389.97	$ 410.49

PIHP Payment to Health Home Partners

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 calendar month. The LE will reimburse the HHP for delivering health home services. LE must have a monitoring plan in place to review HH services and ensure appropriate billing. Depending on the current services provided by the HHP, the LE may negotiate a rate with the HHP for value-based payment (VBP) while following the guidelines below, requirements in the approved SPA, Policy, and the BHH Handbook.

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

- Of the 80% monthly case rate required to go to the HHP, the LE has the following options:

  1. Pay the HHP the full case rate
     a. Preferred for HHPs whose case rate will be used to support health home required staff and where the LE does not wish to engage in a VBP.

OR

2. Pay on a VBP arrangement whereby outcome metrics are established with the HHPs in concert with MDHHS access and quality goals. If VBP is pursued, the LE must pay the HHP pursuant to one or both of the following options (note that the options reflect the staffing readiness within a given HHP):

    a. Option 1 (for HHPs with greater staffing infrastructure needs):
        - Pay at least 90% of the case rate to the HHP and;
        - Reserve 10% for VBP and if outcomes are met, distribute as appropriate
        - Preferred for HHPs whose case rate will mainly be used to support health home required staff.

    b. Option 2 (for HHPs with less staffing infrastructure needs):
        - Pay at least 25% of the case rate to the HHP and;
        - Reserve 75% for VBP and if outcomes are met, distribute as appropriate
        - Preferred for HHPs who already have staff to provide core health home services and want to engage in a VBP arrangement to focus on outcomes.

    NOTE: If the VBP goals set forth by the LE and the HHPs are not met, the LE should utilize those funds for the Health Home program.

4.3 BHH Service Encounter Codes

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

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

    - *S0280*
        - The initial service must be delivered in-person.
        - All subsequent services may be delivered in the following ways:
            - Face to face (simultaneous audio and visual technology)
            - Non-face-to-face
                - TS modifier must be used to document non-face-to-face encounters
            - Outside of the HHP provider site

    - *Applicable ICD-10-CM Z diagnosis codes* to be used with the S0280 code include the following groups:

        - Z55 Problems related to education and literacy
        - Z56 Problems related to employment and unemployment
        - Z57 Occupational exposure to risk factors
        - Z59 Problems related to housing and economic circumstances

- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

4.4 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 submit 837 HIPAA Encounter Files through the FTS to MDHHS, and to recognize files that MDHHS returns to your billing agent "mailbox". When submitting BHH encounters, you will use Class ID/file number 5476 for encounter files. 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 file, also known as the Encounter Transaction Results Report (ETRR), which will provide details on accepted and rejected encounters.

BHH 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 BHH organizations.

Questions or issues can be directed to MDHHSEncounterData@michigan.gov

4.5 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 BHH 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.

4.6 Recoupment of Payment

The monthly payment is contingent upon a BHH beneficiary receiving a BHH service during the month at issue. The payment is subject to recoupment if the beneficiary does not receive a BHH service during the calendar month. The recoupment lookback 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 provided at least one of the six core BHH services during the

calendar month in question. If a core BHH 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 BHH 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 their encounters.

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

MDHHS will afford P4P via a 5% performance withhold. 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 LEs within a given performance year, the funding will be distributed equally among regions that maintain a recoupment rate less than 45% during the performance year. 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 PIHP within one year of the end of the Performance Year (PY). The Measurement Year (MY) is the first year the BHH SPA is in effect. During the Measurement Year, MDHHS will identify baseline values for the performance metrics to be measured against during the subsequent payment years. P4P will still be available during the MY after meeting agreed upon process measures between MDHHS and the LE. The PY will be each subsequent fiscal year the SPA is in effect.

Metrics and Allocation

The metrics and specifications will be maintained in the BHH Handbook and on the MDHHS website: www.michigan.gov/BHH.

- Measurement Year (MY) Metric
  MDHHS will identify P4P based on an increase in the number of BHH beneficiaries enrolled per quarter.

- Performance Year (PY) Metrics
  The table below represents the PY metrics:

Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward**	**Allocation % of P4P Budget**
1.	Follow Up After Hospitalization (FUH-7)	NCQA	50%

2.	Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	20%
3.	Access to Preventive/Ambulatory Health Services (AAP)	NCQA	30%

Technical Specifications for PY Metrics

Performance Measure	Source
Follow Up After Hospitalization (FUH-7)	Technical Specifications will be identified based on HEDIS for the performance year in question.
Increase in Controlling High Blood Pressure (CBP-HH)	Technical Specifications will be identified based on the Health Home Core Set of Quality Measures for the performance year in question.
Access to Preventive/Ambulatory Health Services (AAP)	Technical Specifications will be identified based on HEDIS for the performance year in question.

Assessment and Distribution

Assessment

Within six months of the end of the PY, MDHHS will notify the LE of P4P results. MDHHS will compare the LE's BHH Program metric performance against the performance for the entire state and PIHP Region. If the BHH Program metric performance exceeds the performance at the state and regional level, all P4P will be awarded for that given metric; if, however, the BHH metric exceeds one comparative group but not the other (e.g., BHH Program metric performance exceeds the state performance, but not the regional performance), 75% of the P4P will be awarded for that given metric. MDHHS will utilize this methodology for all subsequent PYs unless otherwise noted.

Threshold numerator and denominator requirements must be met (N=5 D=30) for a measure to be included in the P4P budget and award. If threshold numbers are not met, the allocation for that measure will be equally redistributed to the other eligible performance measures. For example, if FUH-7 does not meet the numerator and/or denominator thresholds, the FUH-7 P4P allocation is 50% and that would be equally distributed to CBP-HH and AAP. The P4P allocation for CBP-HH would be 45% and the allocation for AAP would be 55%.

Distribution

If performance benchmarks are met, MDHHS will provide P4P monies to the LE for distribution. The LE may retain up to 5 percent of the P4P allotment. The LE must distribute the remainder of the P4P allotment to HHPs. Lead entities must inform MDHHS of their distribution plan prior to receiving pay-for-performance monies. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid.

Section V: BHH and Managed Care

5.1 BHH 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 BHH program. The LE has responsibility for SMI/SED services for all enrolled Medicaid beneficiaries (Michigan Mental Health Code) 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 BHH 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 BHH 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 BHH primary care provider and inform the beneficiary that their provider will help them obtain BHH 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 BHH 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 BHH and the beneficiary's primary care provider to facilitate BHH 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 BHH site (if applicable). See section 3.4 for guidance on Beneficiary Transfer of a HHP.

5.2 BHH 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 SMI/SED 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 BHH and the beneficiary's health status.

Section VI: Health Information Technology

6.1 Waiver Support Application (WSA) and the BHH

The WSA provides support to the LE in the areas of beneficiary enrollment, including pre-enrollment activities (e.g., maintaining updated list of potential 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 BHH

CareConnect360 helps HIT-supported care coordination activities for the BHH 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 allows the LE and other entities with access to CareConnect360 the ability to analyze health data spanning different settings of care. In turn, affording HHPs 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 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 (EHRs) and Health Information Exchanges (HIEs)

The use of electronic health records and health information exchanges is essential to the overarching goals of the BHH Program in the sense that it allows for the maintenance and transmittal of data necessary to optimize care coordination and management activities. It is the intent of MDHHS that the EHR will reflect the CMS Promoting Interoperability Program.

6.4 File Transfer Service (FTS)

Michigan's data-submission portal is the File Transfer Service (FTS); however, it has previously been referred to as the Data Exchange Gateway (DEG). 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.

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

Section VII: BHH 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 BHH 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 BHH providers 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 can be found on this page: CMS Health Homes Quality Reporting.

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 monitors and reports on the core utilization measures and core quality measures (section 7.2) along with the following P4P measures:

- Controlling High Blood Pressure (CBP-HH)
- Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)
- Access to Preventive/Ambulatory Health Services (AAP)

Appendix A: List of Qualifying ICD-10 Codes

Serious Mental Illness and Serious Emotional Disturbance:

- F06 Other mental disorders due to known physiological condition
  - F06.0 Psychotic disorder with hallucinations due to known physiological condition
  - F06.1 Catatonic disorder due to known physiological condition
  - F06.2 Psychotic disorder with delusions due to known physiological condition
  - F06.3 Mood disorder due to known physiological condition
    - F06.30 …… unspecified
    - F06.31 …… with depressive features
    - F06.32 …… with major depressive-like episode
    - F06.33 …… with manic features
    - F06.34 …… with mixed features
  - F06.4 Anxiety disorder due to known physiological condition
  - F06.7 Mild neurocognitive disorder due to known physiological condition
  - F06.8 Other specified mental disorders due to known physiological condition

- F20 Schizophrenia
  - F20.0 Paranoid schizophrenia
  - F20.1 Disorganized schizophrenia
  - F20.2 Catatonic schizophrenia
  - F20.3 Undifferentiated schizophrenia
  - F20.5 Residual schizophrenia
  - F20.8 Other schizophrenia
    - F20.81 …… Schizophreniform disorder
    - F20.89 …… Other schizophrenia
  - F20.9 Schizophrenia, unspecified

- F25 Schizoaffective disorders
  - F25.0 Schizoaffective disorder, bipolar type
  - F25.1 Schizoaffective disorder, depressive type
  - F25.8 Other schizoaffective disorders
  - F25.9 Schizoaffective disorder, unspecified

- F31 Bipolar disorder
  - F31.0 Bipolar disorder, current episode hypomanic
  - F31.1 Bipolar disorder, current episode manic without psychotic features
    - F31.10 …… unspecified
    - F31.11 …… mild

        - F31.12 …… moderate
        - F31.13 …… severe
    - F31.2 Bipolar disorder, current episode manic severe with psychotic features
    - F31.3 Bipolar disorder, current episode depressed, mild or moderate severity
        - F31.30 …… unspecified
        - F31.31 Bipolar disorder, current episode depressed, mild
        - F31.32 Bipolar disorder, current episode depressed, moderate
    - F31.4 Bipolar disorder, current episode depressed, severe, without psychotic features
    - F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features
    - F31.6 Bipolar disorder, current episode mixed
        - F31.60 …… unspecified
        - F31.61 …… mild
        - F31.62 …… moderate
        - F31.63 …… severe, without psychotic features
        - F31.64 …… severe, with psychotic features
    - F31.7 Bipolar disorder, currently in remission
        - F31.70 …… most recent episode unspecified
        - F31.71 Bipolar disorder, in partial remission, most recent episode hypomanic
        - F31.72 Bipolar disorder, in full remission, most recent episode hypomanic
        - F31.73 Bipolar disorder, in partial remission, most recent episode manic
        - F31.74 Bipolar disorder, in full remission, most recent episode manic
        - F31.75 Bipolar disorder, in partial remission, most recent episode depressed
        - F31.76 Bipolar disorder, in full remission, most recent episode depressed
        - F31.77 Bipolar disorder, in partial remission, most recent episode mixed
        - F31.78 Bipolar disorder, in full remission, most recent episode mixed
    - F31.8 Other bipolar disorders
        - F31.81 Bipolar II disorder
        - F31.89 Other bipolar disorder
    - F31.9 Bipolar disorder, unspecified

- F32 Major depressive disorder, single episode
    - F32.0 Major depressive disorder, single episode, mild
    - F32.1 Major depressive disorder, single episode, moderate
    - F32.2 Major depressive disorder, single episode, severe without psychotic features
    - F32.3 Major depressive disorder, single episode, severe with psychotic features
    - F32.4 Major depressive disorder, single episode, in partial remission
    - F32.5 Major depressive disorder, single episode, in full remission

- F32.8 Other depressive episodes
  - F32.81 Premenstrual dysphoric disorder
  - F32.89 Other specified depressive episodes
- F32.9 Major depressive disorder, single episode, unspecified
- F32.A Depression, unspecified

- F33 Major depressive disorder, recurrent
  - F33.0 Major depressive disorder, recurrent, mild
  - F33.1 Major depressive disorder, recurrent, moderate
  - F33.2 Major depressive disorder, recurrent severe without psychotic features
  - F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms
  - F33.4 Major depressive disorder, recurrent, in remission
    - F33.40 …… unspecified
    - F33.41 Major depressive disorder, recurrent, in partial remission
    - F33.42 Major depressive disorder, recurrent, in full remission
  - F33.8 Other recurrent depressive disorders
  - F33.9 Major depressive disorder, recurrent, unspecified

- F41 Other anxiety disorders
  - F41.0 Panic disorder [episodic paroxysmal anxiety]
  - F41.1 Generalized anxiety disorder
  - F41.3 Other mixed anxiety disorders
  - F41.8 Other specified anxiety disorders
  - F41.9 Anxiety disorder, unspecified

- F43 Reaction to severe stress, and adjustment disorders
  - F43.0 Acute stress reaction
  - F43.1 Post-traumatic stress disorder (PTSD)
    - F43.10 Post-traumatic stress disorder, unspecified
    - F43.11 Post-traumatic stress disorder, acute
    - F43.12 Post-traumatic stress disorder, chronic
  - F43.2 Adjustment disorders
    - F43.20 Adjustment disorder, unspecified
    - F43.21 Adjustment disorder with depressed mood
    - F43.22 Adjustment disorder with anxiety
    - F43.23 Adjustment disorder with mixed anxiety and depressed mood
    - F43.24 Adjustment disorder with disturbance of conduct
    - F43.25 Adjustment disorder with mixed disturbance of emotions and conduct
    - F43.29 Adjustment disorder with other symptoms
  - F43.8 Other reactions to severe stress
    - F43.81 Prolonged grief disorder

        - F43.89 Other reactions to severe stress
    - F43.9 Reaction to severe stress, unspecified

- F90 Attention-deficit hyperactivity disorders
    - F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type
    - F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type
    - F90.2 Attention-deficit hyperactivity disorder, combined type
    - F90.8 Attention-deficit hyperactivity disorder, other type
    - F90.9 Attention-deficit hyperactivity disorder, unspecified type

- F91 Conduct Disorders
    - F91.0 Conduct disorder confined to family context
    - F91.1 Conduct disorder, childhood-onset type
    - F91.2 Conduct disorder, adolescent-onset type
    - F91.3 Oppositional defiant disorder
    - F91.8 Other conduct disorders
    - F91.9 Conduct disorder, unspecified

- F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence
    - F98.0 Enuresis not due to a substance or known physiological condition
    - F98.1 Encopresis not due to a substance or known physiological condition
    - F98.2 Other feeding disorders of infancy and childhood
        - F98.21 Rumination disorder of infancy
        - F98.29 Other feeding disorders of infancy and early childhood
    - F98.3 Pica of infancy and childhood
    - F98.4 Stereotyped movement disorders
    - F98.5 Adult-onset fluency disorder
    - F98.8 Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
    - F98.9 Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

Appendix B: Coexisting Benefit Plan List

- Autism-Related Services (AUT)
- Benefits Monitoring Program (BMP)
- Breast and Cervical Cancer Control Program (BCCCP)
- Certified Community Behavioral Health Clinic Demonstration (CCBHC)
- Children's Special Health Care Services (CSHCS)
- CSHCS Medical Home (CSHCS-MH)
- Children’s Home and Community Based Services Waiver (CWP)
- Children’s Waiver Program Managed Care (CWP-MC)
- Freedom to Work (MA-FTW)
- Full Fee-for-Service Medicaid (MA)
- Full Fee-for-Service Healthy Kids – Expansion (HK-EXP)
- Habilitation Supports Waiver Program (HSW)
- Habilitation Supports Waiver Program Managed Care (HSW-MC)
- Healthy Kids Dental (HK-Dental)
- Healthy Michigan Plan Emergency Services Only (MA-HMP-ESO)
- Healthy Kids Expansion Emergency Services Only (HK-HMP-ESO)
- Healthy Michigan Plan (MA-HMP)
- Healthy Michigan Plan Behavioral Health NOT Enrolled in an MHP (BHHMP)
- Healthy Michigan Plan-Managed Care (MA-HMP-MC)
- Home and Community Based Waiver Services-Managed Care (MICHOICEMC)
- Managed Care Exempt (MC-EXEMPT)
- Maternity Outpatient Medical Services (MOMS)
- Medical Assistance Emergency Services Only (MA-ESO)
- MIChild Program (CHIP) (MA-MICHILD)
- MIChild Program Emergency Services (CHIP) (MICHILDESO)
- Non-Emergency Medical Transportation (NEMT)