MDHHS Michigan Department of Health & Human Services

Medical Services Administration BULLETIN MSA

Bulletin Number: MSA 20-48

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

Issued: July 31, 2020

Subject: Behavioral Health Home (BHH)

Effective: October 1, 2020

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

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

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

I. General Information

MDHHS is expanding the current BHH benefit to select Michigan counties. The BHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with a select serious mental illness/serious emotional disturbance (SMI/SED) diagnosis. For enrolled beneficiaries, the BHH will function as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan, utilizing a person-centered planning process in order to best manage their care. The model will also elevate the role and importance of Peer Support Specialists and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three goals for the BHH program: 1) improve care management of beneficiaries with SMI/SED; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

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

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

II. Eligibility

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

A. Geographic Criteria

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

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

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

B. Diagnostic Criteria

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

- 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
- F41 Other anxiety disorders
- F43 Reaction to severe stress, and adjustment disorders
- F90 Attention-deficit hyperactivity disorders

III. Enrollment

Potential Behavioral Health Home (BHH) enrollees will be identified using a multifaceted approach. MDHHS will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The LE will identify potential enrollees from the WSA and coordinate with a HHP to fully enroll the Medicaid beneficiary into the BHH benefit.

LEs will 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 will strategically provide these

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

A. LE Identification of Potential Enrollees

The LE will be 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

HHPs 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 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.

C. Enrollment and Disenrollment

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 (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.

Failure to verify consent or diagnostic eligibility will prevent the Medicaid beneficiary from enrolling in 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.

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

A. Lead Entity (LE)

To qualify as a HHP, the LE must:

- Be a regional entity as defined in Michigan's Mental Health Code (330.1204b),
- Contract with and pay a negotiated rate to HHPs,
- Maintain a network of providers that support the BHHs to service beneficiaries with a SMI/SED diagnosis,
- Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,
- Have authority to access Michigan's WSA and Careconnect360,

- Provide leadership for implementation and coordination of health home activities,
- Serve as a liaison between the health home-site and MDHHS staff/contractors,
- Champion practice transformation based on health home principles,
- Develop and maintain working relationships with primary and specialty care providers, including Community Mental Health Services Programs (CMHSPs) and inpatient facilities,
- Collect and report on data that permits an evaluation of increased coordination of care and chronic disease management,
- Monitor health home performance and lead quality improvement efforts,
- Design and develop prevention and wellness initiatives, and referral tracking, and
- Have the capacity to evaluate, select, and support providers who meet the standards for BHHs, including:
  - Identification of providers who meet the BHH standards,
  - Provision of infrastructure to support BHHs in care coordination,
  - Collecting and sharing member-level information regarding health care utilization and medications,
  - Providing quality outcome protocols to assess BHH effectiveness, and
  - Developing training and technical assistance activities that will support BHHs in effective delivery of health home services.

B. Health Home Partners

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

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

V. Provider Staffing

Below are the provider staffing ratios per 100 consumers:

Title	FTE
Health Home Director	0.50
Behavioral Health Specialist	0.25
Nurse Care Manager	1.00
Peer Support Specialist, Community Health Worker, Medical Assistant	3.00 – 4.00
Medical Consultant	0.10
Psychiatric Consultant	0.10
TOTAL FTE	**4.95 – 5.95**

VI. Detailed Requirements and Expectations

At a minimum, the following care team is **required**:

- **Health Home Director** (e.g., LE professional):
  - Provides overarching leadership for health home services,
  - Provides coordination of health home activities,
  - Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management,
  - Monitors health home performance and leads quality improvement efforts,
  - Designs and develops prevention and wellness initiatives, and referral tracking,
  - Executes enrollment using the MDHHS electronic enrollment system,
  - Provides training and technical assistance, and
  - Provides data management and reporting.

- **Behavioral Health Specialist** (e.g., shall be an individual who has a minimum of a Bachelor's Degree from an accredited four-year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four-year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR an individual who has a Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school):
  - Screens beneficiaries for mental health and substance use disorders (SUD),
  - Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary,
  - Conducts brief intervention for beneficiaries 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 beneficiaries,
  - Focuses on managing a population of beneficiaries versus specialty care,
  - Works with beneficiaries 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 use providers,
  - Identifies community resources (i.e., support groups, workshops, etc.) for the beneficiary to utilize to maximize wellness, and
  - Provides education to the beneficiary.

- **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 beneficiaries,

  - Communicates with medical providers and subspecialty providers, including mental health and substance use providers, long term care and hospitals, regarding records (including admission/discharge),
  - Provides education in health conditions, treatment recommendations, medications and strategies to implement care plan goals, including both clinical and non-clinical needs,
  - Monitors assessments and screenings to ensure findings are integrated in the care plan,
  - Facilitates the use of the Electronic Health Record (EHR) and other Health Information Technology (HIT) to link services, facilitates communication among team members and provides feedback,
  - Monitors and reports performance measures and outcomes, and
  - Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of care.

- **Peer Support Specialist, Community Health Worker, or Medical Assistant** (with appropriate certification/training):
  - Coordinates and provides access to individual and family supports, including referral to community social supports,
  - Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members in an informal manner as part of the daily routine of care,
  - Identifies community resources (i.e., social services, workshops, etc.) for the beneficiary to utilize to maximize wellness,
  - Conducts referral tracking,
  - Coordinates and provides access to chronic disease management including self-management support,
  - Implements wellness and prevention initiatives,
  - Facilitates health education groups, and
  - Provides education on health conditions and strategies to implement care plan goals, including both clinical and non-clinical needs.

- **Medical Consultant** (i.e., primary care physician, physician assistant, pediatrician, or nurse practitioner):
  - Provides medical consultation to assist the care team in the development of the beneficiary’s care plan, participates in team huddles when appropriate, and monitors the ongoing physical aspects of care as needed.

- **Psychiatric Consultant:**
  - The care team must have access to a licensed mental health service professional (i.e., psychologist, psychiatrist, psychiatric nurse practitioner) providing psychotherapy consult and treatment plan development services. This provider will be responsible for communicating treatment methods and expert advice to the behavioral health provider (incorporated into care team). It will be the responsibility of the behavioral health provider (and/or other members of the care team as assigned) to develop a licensed mental health provider's treatment into a beneficiary's care plan.

VII. Payment Methodology

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

A. BHH Case Rates to the LE

MDHHS will maintain a fee schedule of the BHH case rate on the MDHHS BHH website, in the BHH Handbook, and in the Behavioral Health Developmental Disabilities Administration (BHDDA) Service Encounter Coding chart. MDHHS will review the case rates at least annually and make updates as appropriate.

B. Pay-for-Performance (P4P)

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 approved SPA, policy, and the BHH Handbook. MDHHS 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 withhold will be reserved by MDHHS and reinvested for BHH monthly case rate payments. Subsequent performance years will operate in accordance with this structure.

Metrics, Assessment, and Distribution
The methodology for metrics, specifications, and distribution will be effective October 1, 2020, and will be maintained on the MDHHS BHH website and in the BHH Handbook.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kate Massey, Director
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