Substance Use Disorder Health Home

(SUDHH) Handbook

Michigan Department of Health and Human Services
Health Services 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 SUDHH Program.

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

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Preface

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

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

The handbook will be maintained on the SUDHH website here: Substance Use Disorder Health Home

Section I: Introduction to the Substance Use Disorder Health Home Service Model

1.1 Overview of the SUDHH

The Substance Use Disorder Health Home (SUDHH) provides comprehensive care management and coordination services to Medicaid beneficiaries with an alcohol use disorder, stimulant use disorder or opioid use disorder. For enrolled beneficiaries, the SUDHH functions as the central point of contact for directing patient centered care across the broader health care system. The model elevates the role and importance of Peer Recovery Coaches and Community Health Workers to foster direct empathy and raise overall health and wellness. In doing so, this will attend to a beneficiary's health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time.

Michigan has five overarching goals for the SUDHH program: 1) improve care management of beneficiaries including MOUD and medications for alcohol use disorder; 2) improve care coordination between physical and behavioral health care services; 3) improve care transitions between primary, specialty, and inpatient settings of care; 4) improve coordination to dental care; 5) educate on fetal alcohol spectrum disorders.

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

MDHHS provides a monthly case rate to the LE based on the number of SUDHH beneficiaries with at least one SUDHH service during a given month. HHPs must contract or establish a memorandum of understanding (MOU) with a LE 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 program outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

1.2 SUDHH Population Criteria

Eligible beneficiaries include those enrolled in Medicaid, the Healthy Michigan Plan, Freedom to Work, Healthy Kids Expansion or MIChild who have a qualifying ICD-10 code diagnosis related to alcohol, stimulant or opioid use disorder.

A list of coexisting benefit plans can be found in Appendix B, all other plans are excluded while a beneficiary is enrolled in SUDHH.

*Please note, beneficiaries cannot be enrolled in HHBH Behavioral Health Home (HHBH), Health Home MI Care Team (HHMICare) or Hospice during the same month. SUDHH services can't be billed while a beneficiary is incarcerated or while receiving the TCM-INCAR benefit. LE are responsible for checking beneficiary eligibility in CHAMPS.

1.3 Diagnostic Criteria

Qualifying ICD-10 codes for alcohol, stimulant and opioid substance use disorders. Please see full

list in appendix A. Qualifying SUD beneficiaries must also be at risk of developing mental health conditions, asthma, diabetes, heart disease, BMI over 25 or COPD.

1.4 SUDHH Services

The SUDHH team is responsible for assuring all individuals enrolled receive the necessary services and supports in accordance with their SUDHH care plan. SUDHH services must be documented by the HHP and reviewed by the LE monthly. HHP documentation must include the health home service provided and by what member(s) of the care team.

SUDHH services are designed to help beneficiaries connect to medically necessary services. However, payment for duplicate 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 HHP can only bill the S0280 HG or S0281 HG code for one of the six core health home services performed by a health home team member.

SUDHH services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. The SUDHH must provide the following six core health home services as appropriate for each beneficiary:

- Comprehensive Care Management

  Comprehensive Care Management services include but not limited to:
  - Assessment of each beneficiary, including behavioral and physical health care needs.
  - Assessment of beneficiary readiness to change.
  - 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 in relation to the SUDHH.

- Care Coordination

  Care Coordination is the implementation of overall individual and family involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Care coordination is designed to be delivered in a flexible manner best suited to the individual's preferences and to support goals that have been identified through the care plan. Services include but are not limited to:
  - 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 representatives, and family.
  - Appointment making assistance, including coordinating transportation.
  - Medication adherence and monitoring.
  - Referral tracking.
  - Use of patient care team huddles.

- Health Promotion

  Health promotion services shall minimally consist of educating and engaging the individual in making decisions that promote independent living skills and lifestyle choices. Services

include but are not limited to:

- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
- Promoting healthy lifestyle interventions.
- Encouraging routine preventive care such as immunizations and screenings.
- Assessing the patient and family's understanding of the health condition and motivation to engage in self-management.
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).
- Using evidence-based practices, to engage and help patients participate in and manage their care.

- Comprehensive Transitional Care

  Comprehensive transitional care services promote health needs by supporting a beneficiary getting back into treatment or facilitating higher levels of care. Services include but not limited to:

  - 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); and
  - Home visits to ensure stability through transitions.

- Individual and Family Support (including authorized representatives)

  Individual and family support services are intended to assist the individual to facilitate and maintain quality of life and explore community options to promote overall quality of life through health stabilization and improved health outcomes. Services include but are not limited to:

  - Increasing patient and family skills and engagement.
  - Use of community support (i.e., Community Health Workers, peer support, 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; and
  - Providing assistance with development of social support.

- Referral to Community and Social Support Services

  Referral to Community and Social Support Services identify the gaps in the overall "whole person" planning and connecting the individual to community-based resources to support the Social Determinants of Health (SDOH). Services include 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 with the fewest barriers.

Section II: Provider Requirements for SUDHH Participation

2.1 SUDHH General Provider Requirements

Lead Entity (LE)

- Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
- Must contract or develop a MOU with HHPs.
- Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269). Have authority to access Michigan Medicaid claims and encounter data for the SUDHH target population.
- Have authority to access Michigan's WSA and CareConnect360.
- Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including:
    - Identification of providers who meet the HHP standards.
    - Provision of infrastructure to support HHPs in care coordination.
    - Collecting and sharing member-level information regarding health care utilization and medications.
    - Providing quality outcome protocols to assess HHP effectiveness.
    - Developing training and technical assistance activities that will support HHPs in effective delivery of HH services.
- Must maintain a network of providers that support the HHPs to service beneficiaries with a substance use disorder.
- Must pay HHPs directly on behalf of the State for the SUDHH Program at the State defined rate.
- The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the SUDHH with providers; MDHHS will retain overall oversight and direct administration of the LE; The LE will also serve as part of the Health Homes team by providing care management and care coordination services.

Health Home Partner (HHP)

- Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements.
- Providers will sign the MDHHS-5745 (Health Home Partner Application) attesting to meeting the requirements cited in MSA Policy, the SPA, and other applicable MDHHS policies and procedures.
- HHPs must contract or have a MOU with the LE. HHPs can reside outside of the LE region but must serve eligible beneficiaries living in the LE identified SUDHH counties.
- Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following:
    - Community Mental Health Services Program (Community Mental Health Center)
    - Federally Qualified Health Center/Primary Care Safety Net Clinic

- Hospital based Physician Group
- Physician based Clinic
- Physician or Physician Practice
- Rural Health Clinics
- Substance Use Disorder Provider
- Opioid Treatment Provider
- Tribal Health Center

The Lead Entity (LE) and the Health Home Partners (HHP) jointly must:

- HHPs must enroll and execute any necessary agreement(s)/contract(s) with the LE.
- 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. Partners shall meet the following recognition/certification standards:
  - Attain accreditation from a national recognizing body specific to a health home, patient-centered medical home, or integrated care (e.g., NCQA, AAAHC, TJC, CARF, etc.) The LE/HHP may be pursuit of such accreditation at the time of SUDHH implementation; or,
  - In the absence of accreditation from a national recognizing body (health home, PCMH, or integrated care), the LE may verify that an 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 SUDHH Partner Standards Document, SUDHH Handbook, SPA, and policy. MDHHS has the right to review all templates created by the LE quality assurance and compliance purposes.
- Provide 24-hour, seven days a week availability of information, screening for services and emergency consultation services to beneficiaries.
- 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.
- Ensure person-centered and integrated care planning that coordinates and integrates all clinical and non-clinical health care related needs and services.
- Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy.
- Utilize the MDHHS-5515 Consent to Share Behavioral Health and Substance Use Disorder Information.
- Demonstrate the ability to perform each of the following functional requirements. This includes documentation of the processes and methods used to execute these functions.
  - Coordinate and provide the six core services cited in Section 2703 of the Affordable Care Act.
  - Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines.
  - Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.

- Coordinate and provide access to physical, mental health, and substance use disorder services.
- Coordinate and provide access to chronic disease management, including self- management support to individuals and their families.
- 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.
- 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.

2.2 Health Home Partner Enrollment

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

2.3 Health Home Partner Disenrollment

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

2.4 Health Home Partner Termination

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

2.5 SUDHH Required Infrastructure

HHPs, through the LE, will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. Each setting will have its own unique set of requirements commensurate with the scope of their operations to reflect beneficiary needs. The staffing structure below is based on 100 beneficiaries enrolled in the health home. Beneficiaries who need less medical intervention are not required to be seen by clinical staff listed below. Determination of beneficiary level of care should be decided by the provider's clinical staff and re-evaluated as appropriate. It is expected that the staffing structure is in place for 100 beneficiaries, it does not mean the 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 SUDHH or reside within the agency. HHPs must have a workflow in place if the required staffing structure below does not reside within the HHP agency, HHPs must have a MOU/Contract with agencies that share care team members. Depending on the SUDHH partner additional staff members with additional roles may be needed.

Contingent upon MDHHS exceptions, specific minimum requirements based on beneficiary need for each setting are as follows:

<u>LEs (per 100 beneficiaries)</u>

Health Home Director (0.25 FTE)

- Includes one director and relevant administrative staff (e.g., program coordinators and support staff)

HHPs (per 100 beneficiaries)
Behavioral Health Specialist (0.25 FTE)
Nurse Care Manager (1.00 FTE)
Peer Recovery Coach, Community Health Worker, (3.00-4.00 FTE)
Medical Consultant (0.10 FTE)
Addictionologist Medical Physician Consultant (0.10 FTE)
Psychiatric Consultant (0.05 FTE)

2.6 SUDHH Staffing Requirements and Expectations

Health Home Director (e.g., Lead Entity Care Coordinator)
The Health Home Director is responsible for but not limited to providing leadership for implementation and coordination of health home activities. Coordinates all enrollment and disenrollments into the health home on behalf of health home partners. Serves as the liaison between the health partners and MDHHS staff. Collects and reports on data evaluating increased coordination of care and chronic disease management for the health home. Monitors Health Home performance and leads quality improvement efforts through training and technical assistance.

Behavioral Health Specialist (e.g., Case Worker, Counselor, or Therapist related degree)
The Behavioral Health Specialist is responsible for but not limited to screening individuals for mental health and substance use disorders. Referring beneficiaries to a licensed mental health provider and/or licensed and certified SUD therapist as necessary. Conducts brief intervention for individuals' behavioral health needs. Focuses on population management. Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions. Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members as part of the daily routine of the clinic.

Nurse Care Manager
The Nurse Care Manager (NCM) is responsible for but not limited to monitoring assessments and screenings to assure findings are integrated in the care plan. Meets regularly with the care team to plan care and discuss cases and exchanges appropriate information with team members. The NCM Communicates with medical providers, subspecialty providers including mental health and substance use service providers, long term care and hospitals regarding records including admission/discharge.
The NCM assists in managing the individual's full array of physical health needs, in addition to behavioral health care needs, taking a "whole person" approach.

- RNs and Licensed Practical Nurses (LPN) are qualified as NCMs.
- Experience working with SUD field is preferred.

Peer Recovery Coach
The Peer Recovery Coaches (PRC) is responsible for but not limited supporting a beneficiary by assisting and advocating for the beneficiaries they serve in achieving their needs, personal pursuits, and self-directed goals. The PRC will share their lived experiences to inspire hope, encourage change and assist to identify resources and supports that promote recovery. The PRC

will meet regularly with the care team to plan care and discuss cases, exchange appropriate information with the care team.

- PRC can be state, CCAR, or MCBAP certified.
    - The state encourages LE/HHPs to assist PRCs to become state certified.

Community Health Worker

The Community Health Workers (CHW) is responsible for but not limited to serve as a liaison/link/intermediary between social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. The CHW will regularly meet with the care team to plan care and discuss cases, exchange appropriate information with the care team.

- CHW can be state certified or certified through another credentialed body.
    - The state encourages LE/HHPs to assist CHWs to become state certified.

Medical Consultant (i.e., primary care physician, physician's assistant, or nurse practitioner)

A Medical Consultant is responsible for but not limited to providing 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

A Psychiatric Consultant is responsible for communicating treatment methods and expert advice to a Behavioral Health Provider. 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.

Addictionologist Medical Physician Consultant

An Addictionologist Medical Physician Consultant is responsible for but not limited to developing comprehensive treatment plans including medical care, behavioral therapies and long-term management strategies. Assist individuals recovering from addiction using evidence-based methods to reduce cravings and withdrawal symptoms. This role should be incompliance with the Administrative Rules for an Opioid Treatment Program.

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

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

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

2.7 Training and Technical Assistance

MDHHS is requiring HHPs to actively participate in state and LE sponsored activities related to

training and technical assistance and will also impose additional functional provider requirements to optimize care management, coordination, and behavioral health integration. Those requirements are below:

- 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.
- Participate in ongoing technical assistance (including but not limited to training and webinars).
- Participate in ongoing individual assistance (including but not limited to audits, site visits, training, etc., provided by State and/or State contractual staff).
- Support Health Home team participation in all related activities and training courses, including coverage of travel costs associated with attending Health Home activities.
- Assign a personal care team to each beneficiary.
- Embed behavioral health care services into primary health care services as applicable, with real-time behavioral health consultation available to each primary care provider.
- Provide behavioral and physical health care to beneficiaries using a whole-person orientation and with an emphasis on quality and safety.
- 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.
- Engage in meaningful use of technology for patient communication.
- Coordinate and integrate each beneficiaries' behavioral health care.
- 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, behavior changes and communication with external specialists.
- Communicate with each beneficiary (and authorized representative(s), family, and caregivers) in a culturally and linguistically appropriate manner.
- Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services and health promotion.
- 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
  - Coordinate access to long term care, support 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)
- Conduct Health Home outreach to local health systems.
- Provide comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
- Review and reconcile beneficiary medications.
- 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.

- Maintain a reliable system, including written standards/protocols, for tracking patient referrals.
- Adhere to all applicable privacy, consent, and data security statutes.
- Demonstrate use of clinical decision support within the practice workflow specific to the conditions identified in the Health Home project.
- Demonstrate use of a population management tool such as a patient registry and the ability to evaluate results and implement interventions that improve outcomes.
- Implement evidence-based screening tools designated by the LE.
- Complete Motivational Interviewing Training.
- 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 individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Enhance beneficiary access to behavioral and physical health care.
- 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.
- Implement policies and procedures to operate with open access scheduling and available same day appointments.
- Use HIT, including but not limited to an EHR capable of integrating behavioral and physical health care information.
- 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.
- Possess the capacity to electronically report to the State and/or its contracted affiliates information regarding service provision and outcome measures.
- Work collaboratively with MDHHS and contractors to adapt and adopt program processes for Health Home care team use in the participating sites(s).
- Engage in Health Home process and outcome achievement activities including ongoing coaching, data feedback and customized improvement plans to meet initiative goals.
- 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 and Disenrollment

3.1 Enrollee Identification and Assignment

Potential Substance Use Disorder Health Home (SUDHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The Lead Entity (LE) will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to identify potential Medicaid beneficiaries that meet eligibility into the SUDHH benefit. Enrolling into the health

home benefit does not restrict access to other providers nor does it limit access to other non-competing Medicaid benefits. Enrollment into a health home is voluntary and the enrollee may disenroll from the SUDHH benefit at any time. Full enrollment into the SUDHH 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.

Lead Entities will provide information about the SUDHH 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 SUDHH.

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

- SUDHH Partner Recommended Identification of Potential Enrollees
  Health Home Partners are permitted to recommend potential enrollees for the SUDHH benefit via the WSA or LE process. SUDHH partners must provide documentation that indicates whether a potential SUDHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of a Substance Use Disorder Health Home care plan. The LE must review and process all 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 thirty days after SUDHH enrollment. HHPs should verify all documentation requirements with the LE.

3.2 Beneficiary Consent

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

3.3 Social Determinants of Health

Upon entering the SUDHH beneficiaries should be screened for Social Determinants of Health (SDOH) and re-screened as appropriate per beneficiary needs. HHP staff completing the screener should have Motivational Interviewing Training completed at least every two years. SDOH should be identified within the Care Plan.

MDHHS recommends the following tools to be used:

- Accountable Health Communities Health Related Social Needs Screening Tool
- The Protocol for Responding to and Assessing Patients' Risks and Experience Tool
- WellRx Questionnaire, or
- American Academy of Family Physicians Screening Tool

ICD 10 Z Codes should be submitted with each appropriate HH encounter that relates to the Care Plan. LE must review HHP screening tool to ensure questions are related to:

- Housing
- Food
- Transportation
- Utility Needs
- Intrapersonal Safety

3.4 Z Code Submission

If a HHP works with a beneficiary on a social determinant of health, that corresponding Z code should be submitted with the claim submitted to the LE. Z codes should only be submitted if a HHP is actively working with the beneficiary during the time of service. More than one Z code may be reported when a person has multiple distinct social, environmental, or economic circumstances affecting their health or care. Each Z code should represent a specific identified circumstance and be supported by documentation in the record. Z codes should only be assigned when there is a documented basis for their use. For SUDHH, up to three Z-codes may be submitted per encounter, following the primary diagnosis

3.5 Beneficiary Care Plan

Within thirty days of enrollment, the Substance Use Disorder Health Home care team must work with the beneficiary to develop and complete an SUDHH care plan. The SUDHH care plan must align with the six statutorily required health home services and act as a plan to guide the care and support services to be provided by the 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 every six months but should be reviewed and revised over time based on the beneficiary's progress and changing needs. If a beneficiary has met all components of their care plan and is no longer in need of SUDHH services, the beneficiary should be disenrolled from the program for completion of SUDHH services.

The care plan must be developed with the SUDHH care team, the beneficiary, and can include the beneficiary's support system (family, caregiver, etc.) if appropriate. It is best practice that the SUDHH care team and the beneficiary agree to and sign off on the care plan before it is implemented. The care plan must have SMART goals that are specific, measurable, achievable, realistic, and timely.

An example of the components to include in the care plan is available on the MDHHS webpage. Substance Use Disorder Health Home

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

- The tasks to be completed by each SUDHH team member.
- The tasks to be completed by the beneficiary.
- SMART goals and objectives developed by and agreed upon by the beneficiary, and SUDHH care team to achieve improved health outcomes.
- Align with the six required health home services.
- Integrate the beneficiary's physical health, behavioral health, and social support needs.
- A plan to monitor the Substance Use Disorder Health Home care plan progress and update goals.

3.6 Beneficiary Disenrollment

Lead Entity Disenrollment Process

The LE will be responsible for disenrolling all SUDHH beneficiaries in WSA. The LE must confirm the confirm the disenrollment reason by checking CHAMPS and WSA. If the LE confirms that a beneficiary should be disenrolled from the SUDHH, they must complete the process in WSA. The disenrollment date should be the last date of SUDHH service. Once a beneficiary is disenrolled their case is closed and can no longer be edited.

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.

More information on the disenrollment process in WSA can be found in the WSA SUDHH User Training Manual. Beneficiaries enrolled in the Substance Use Disorder 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
- Completion of SUDHH Services

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.

Beneficiaries who have moved out of an eligible geographic area, are deceased, or are otherwise no longer eligible for the Medicaid program. Beneficiary eligibility files will be updated per the

standard MI Bridges protocol and can be found in CHAMPS. LE and HHPs will receive updated files accordingly in the WSA.

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 three consecutive months while the beneficiary remains enrolled in the WSA. Attempting to reach a beneficiary unsuccessfully is not a billable encounter. An encounter can only be billed under the S0280 HG or S0281 HG code for one of the six core health home services. If the beneficiary is deemed unresponsive, the beneficiary can be disenrolled from the WSA by the LE. The disenrollment date should be the last date of SUDHH service. The LE must attempt to re-establish contact with the beneficiary at least every six months after the date of disenrollment for one year or until eligibility changes to make the beneficiary ineligible for services. 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.

If a beneficiary becomes incarcerated, the beneficiary should remain enrolled in the WSA for at least 90 days. The HHP should attempt to re-engage the beneficiary for service pending discharge. Incarcerated beneficiaries are not eligible for Medicaid services, the S0280 HG or S0281 HG code should not be billed while the beneficiary was incarcerated.

3.7 Beneficiary Changing Health Home Partner Sites

While the enrollee's stage in recovery, treatment, and care plan will be utilized to determine the appropriate setting of care, beneficiaries will have the ability to change HHPs to the extent feasible within the LE's designated SUDHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen HHP. However, beneficiaries may change HHP and should notify their current HHP immediately if they intend to do so. The LE and HHP will work together to identify a recommended HHP setting where the potential health home enrollee will likely be most successful. The variety and number of HHPs may vary by region. The current and future HHP must discuss the timing of the transfer and communicate transition options for the beneficiary.

The process of transferring a beneficiary to a new HHP site should be completed through the WSA. If a beneficiary wishes to transfer to a HHP within the same LE region, the HHP that is no longer providing services can recommend a beneficiary transfer in the WSA. Only the PIHP will have the authority to make the transfer final. A beneficiary moving LE regions should also be recommended for a transfer in the WSA by the LE. The LE who will no longer be providing services should recommend the transfer of the beneficiary to the new LE region where the beneficiary is eligible. The recommended transfer should include pertinent transfer notes. The new LE should verify eligibility of the beneficiary and either approve, deny, or send back the beneficiary for additional information. The beneficiary will remain in "enrolled" status until determination of the beneficiary's placement is final. The LE should communicate with the new HHP and ensure an updated 5515 consent has been signed with an updated care plan and any other pertinent documents. After the transfer is moved to complete by the new LE, the new HHP will be able to review all the beneficiary's previous information stored in the WSA. The new HHP will be able to bill for services the month following the transfer from the old HHP. This change will most likely occur on the first day of the next month with respect to the new HHP appointment availability. Only one HHP may be paid per beneficiary per month for health home services. Please review the WSA training materials for step-by-step processes.

Section IV: SUDHH Payment

4.1 General Provisions for SUDHH Payment

MDHHS will provide a monthly case rate to the LE based on attributed SUDHH beneficiaries with at least one SUDHH service. MDHHS is the LE to, in turn, pay HHPs a negotiated rate with a state-directed minimum payment. LE must have a monitoring plan to review HH services and ensure HHP appropriate billing. Any savings afforded through the provision of health home services will be shared between the LE and the HHPs based on defined quality metrics. Additionally, MDHHS will employ a P4P incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers are paid.

4.2 Rate Workup

Staffing Model

SUDHH payment rates are based on a staffing model per 100 beneficiaries with salary, fringe benefit, and indirect cost information derived from utilizing provider compensation data evaluation of the staffing required to maintain the model.
SUDHHs by HHP type, respectively:

Lead Entity (per 100 beneficiaries)

- Health Home Director (0.25 FTE)

Health Home Partners (per 100 beneficiaries)

- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Recovery Coach, Community Health Worker, (3.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Addictionologist Medical Physician Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

Rate Amounts

The SUDHH payment rates reflect a monthly case rate per SUDHH beneficiary with at least one proper and successful SUDHH service within a given month. The payment for SUDHH services is subject to recoupment from the PIHP if the beneficiary does not receive an SUDHH service during the calendar month. Rates will be effective on or after October 1, 2025 based on State Plan Amendment approval. Rate information will be maintained on the MDHHS website at www.michigan.gov/SUDHH. Rates will be evaluated annually and updated as appropriate.

The case rates were developed by utilizing provider compensation data evaluation of the staffing required to maintain the model. Case rates are pending based on State Plan Amendment approval.

SUDHH Case Rates to LE

PMPM	PMPM with P4P
$448.01	$471.59

LE Payment to Health Home Partners

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

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

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

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

MDHHS will afford P4P via a 5% performance incentive to the additional per member per month case rate. The LE must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the timelines and processes delineated below. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement benchmarks are not met by any of the HHPs within a given performance year, the funding will be distributed equally among HHPs 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

The first year of the SPA being in effect will be the Measurement Year (MY) for each LE. During the MY LE will be paid P4P payments based on increasing enrollment of beneficiaries each quarter compared to the implementation start date. MDHHS will distribute P4P payments to the LE within one year of the end of either the MY or the Performance Year (PY). The PY will be each subsequent fiscal year the SPA is in effect.

Metrics and Allocation- Pending Changes

The table below represents the first set of metrics:

Performance Measure Number	**Measure Name and NQF #** (if applicable)	**Measure Steward**	**State Baseline**	**Allocation % of P4P Budget**
1.	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge	NCQA	TBD	50%

2.	Access to Preventive/Ambulatory Health Services (AAP)	NCQA	TBD	30%
3.	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	CMS	TBD	20%

Assessment and Distribution

Assessment

Within six months of the end of the PY, MDHHS will notify the LE and HHP associated with the P4P results. MDHHS will compare data in in the PY by juxtaposing HHP performance against the performance for the entire state, PIHP Region and or HH baseline depending on the specific measure. If the SUDHH Program metric performance exceeds the performance at the state, regional level and or HH baseline, all P4P will be awarded for that given metric; if, however, the SUDHH Program metric only exceeds one comparative group but not the other (e.g., SUDHH 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.

Distribution

Within one year of the end of the PY, MDHHS will determine if quality metrics have been met to trigger P4P payments. If quality metrics have been met, MDHHS will distribute P4P monies to the LE. The LE may retain up to 5% of P4P monies for their role in executing the SUDHH. The LE will then distribute at least 95% of P4P monies to the HHPs scaled to the volume of SUDHH services a given HHP renders based on the LE P4P logic. LE must submit logic before MDHHS will distribute funds.

4.4 SUDHH Service Encounter Coding Requirements

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

SUDHH Care Management Encounters

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

S0280 or S0281 with HG Modifier

The initial service must be delivered in person. An in-person encounter must be completed with the beneficiary and provider physically together in the same location. All subsequent services with a beneficiary are expected to be delivered face-to-face. A face-to-face encounter is defined as either in person or telehealth (simultaneous audio and visual technology). HHPs must actively be engaging with the beneficiary or care team staff to initiate a HH service. MDHHS supports the use of simultaneous audio/visual telemedicine service delivery, as a primary method of telemedicine service, but in situations where the beneficiary cannot access services via a simultaneous audio/visual platform, either due to technology constraints or other concerns, MDHHS will allow the provision of audio-only services. HHPs should identify the claim as an audio phone call in their notes along with what HH service was completed with the beneficiary.

S0280 HG
This code should be used at the initiation of service. This code should be used at the first enrollment appointment.

- If a beneficiary moves Health Home Partner locations (Regionally or new provider within the region) this code should be used at the first enrollment appointment.
- At any time, a disenrollment occurs the first encounter back into services should be counted as the first enrollment appointment.

S0281 HG
This code should be used at all subsequent appointments after service initiation/enrollment.

- TS Modifier must be used to document non-face-to-face encounters.
  The TS modifier is required anytime the care team is not physically with the beneficiary, but a Health Home service is provided including, but are not limited to, audio-only calls with or without the beneficiary, care team huddles, calls with other providers or care coordination discussions.

- The HG Modifier MUST be used for ALL SUDHH encounters.

- *Applicable ICD-10-CM Z diagnosis codes* to be used with the S0280 or S0281 with HG Modifier 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
  - Z72 Problems related to lifestyle

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

4.5 Encounter Submission

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

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

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

4.6 Payment Schedule

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

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

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

4.7 Recoupment of Payment

The monthly payment is contingent upon an SUDHH beneficiary receiving an SUDHH service during the month at issue. The payment is subject to recoupment if the beneficiary does not receive an SUDHH service during the calendar month. The recoupment look back will occur six months after the monthly payment is made. Thus, six months after the month a payment is made (for example, in January the State would look back at the month of July's payment), CHAMPS will conduct an automatic recoupment process that will look for the approved encounter code that documents that the HHP conducted at least one of the six core SUDHH services during the calendar month in question. If a core SUDHH 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 SUDHH encounter code and/or claim for the month that a payment was 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 for over 5 months for the LE to submit encounters.

In addition, a recoupment could also occur if the beneficiary is no longer eligible for the SUDHH benefit due to a higher priority benefit plan activating. For example, if the beneficiary is admitted to a skilled nursing facility on July 7th and a SUDHH care team member speaks to the beneficiary via phone on July 29th, the month of July's payment would not be maintained due to the higher

priority benefit plan being assigned. The beneficiary could be discharged from the nursing facility in August and reenrolled to the SUDHH benefit.

Section V: SUDHH and Managed Care

5.1 SUDHH 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 SUDHH program. The LE has responsibility for SUD services for all enrolled Medicaid beneficiaries within its region and will have a list of all qualifying beneficiaries including the health plan to which they are assigned. MDHHS will require the LE and health plans to confer to optimize community-based referrals and informational materials regarding the SUDHH 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 SUDHH 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 SUDHH primary care provider and inform the beneficiary that their provider will help obtain SUDHH 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 SUDHH site. This may or may not include changing the beneficiary's primary care provider to the HHP of the beneficiary's choice that is also within the health plan's provider network. If there is no in-network HHP in the eligible county, then the health plan should work with the LE to establish an MOU between the designated HHP and the beneficiary's primary care provider to facilitate SUDHH 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 SUDHH site (if applicable).

5.2 SUDHH Coordination & Health Plans

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

When a beneficiary is enrolled in both Medicaid Health Home and MICH HIDE D-SNP plan, the Medicaid Health Home care team will collaborate with the MICH HIDE D-SNP plan to support coordination of services and alignment of care management activities in a timely and non-duplicative manner. Coordination will reflect each benefit plan's respective authority and scope. The Medicaid Health Home care team remains responsible for developing and maintaining the Health Home care plan and completing health assessments in accordance with Medicaid Health Home program requirements.

Health Home partners should be aware of dully eligible individuals. HH providers should reach out to the HDE SNP team to share resources and ensure collaboration between the two benefits.

Section VI: Health Information Technology

6.1 Waiver Support Application (WSA) and the SUDHH

The WSA will provide support to the LE in the areas of beneficiary enrollment, including pre-enrollment activities (e.g., maintaining updated list of eligible beneficiaries), enrollment management including beneficiary disenrollment, and report generation. Health Home partners that use the WSA will have 30 days to complete their WSA request; users who fail to finish their applications will be deleted. A detailed reason for access into the WSA is required outlining the job duties and responsibilities for using the application.

6.2 CareConnect360 and the SUDHH

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

6.3 Electronic Health Records and Health Information Exchanges

The use of electronic health records and HIE is essential to the overarching goals of the SUDHH Program in the sense that it allows for the maintenance and transmittal of data necessary to optimize care coordination and management activities. MDHHS is also requiring that the LE and all HHPs utilize the same SUD platform to maximize clinical coordination and beneficiary consent to share information management. The LE will secure an HIE with these capabilities and facilitate access, including technical assistance, to the HHPs.

6.4 File Transfer Service (FTS)

Michigan's data-submission portal is the File Transfer Service (FTS). Some documents may still reference the DEG; be aware that a reference to the DEG portal is a reference to the FTS. Billing agents will use the FTS to submit and retrieve files electronically with MDHHS. MDHHS has established an Internet connection to the FTS, which is a Secure Sockets Layer connection. This

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

Section VII: SUDHH 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 SUDHH clinical and cost data with MDHHS. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers. The data will be reported annually by MDHHS to CMS.

7.2 Federal (CMS) Monitoring & Evaluation Requirements

CMS has supplied reporting requirements and guidance for health home programs. There are two broad sets of requirements – core utilization and core quality measures. It is essential that HHPs are aware of these measures and how they are calculated for evaluation purposes and the program's longevity. The specific Core Measures and other federal requirements CMS provides a technical specification manual each year for the federal reporting measures, which can be found on this page: Health Home Quality Reporting | Medicaid.

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

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. The state will review SUDHH compliance standards with each LE for quality assurance annually.

Appendix A: List of Qualifying ICD-10 Codes

F10 Alcohol related disorders:
F10 Alcohol related disorders
F10.1 Alcohol abuse
F10.10 …… uncomplicated
F10.11 …… in remission
F10.12 Alcohol abuse with intoxication
F10.120 …… uncomplicated
F10.121 …… delirium
F10.129 …… unspecified
F10.13 Alcohol abuse, with withdrawal
F10.130 Alcohol abuse with withdrawal, uncomplicated
F10.131 Alcohol abuse with withdrawal delirium
F10.132 Alcohol abuse with withdrawal with perceptual disturbance
F10.139 Alcohol abuse with withdrawal, unspecified
F10.14 …… with alcohol-induced mood disorder
F10.15 Alcohol abuse with alcohol-induced psychotic disorder
F10.150 …… with delusions
F10.151 …… with hallucinations
F10.159 …… unspecified
F10.18 Alcohol abuse with other alcohol-induced disorders
F10.180 Alcohol abuse with alcohol-induced anxiety disorder
F10.181 Alcohol abuse with alcohol-induced sexual dysfunction
F10.182 Alcohol abuse with alcohol-induced sleep disorder
F10.188 Alcohol abuse with other alcohol-induced disorder
F10.19 …… with unspecified alcohol-induced disorder
F10.2 Alcohol dependence
F10.20 …… uncomplicated
F10.21 …… in remission
F10.22 Alcohol dependence with intoxication
F10.220 …… uncomplicated
F10.221 …… delirium
F10.229 …… unspecified
F10.23 Alcohol dependence with withdrawal
F10.230 …… uncomplicated
F10.231 …… delirium
F10.232 …… with perceptual disturbance
F10.239 …… unspecified
F10.24 …… with alcohol-induced mood disorder
F10.25 Alcohol dependence with alcohol-induced psychotic disorder
F10.250 …… with delusions
F10.251 …… with hallucinations
F10.259 …… unspecified
F10.26 …… with alcohol-induced persisting amnestic disorder
F10.27 …… with alcohol-induced persisting dementia
F10.28 Alcohol dependence with other alcohol-induced disorders

F10.280 Alcohol dependence with alcohol-induced anxiety disorder
F10.281 Alcohol dependence with alcohol-induced sexual dysfunction
F10.282 Alcohol dependence with alcohol-induced sleep disorder
F10.288 Alcohol dependence with other alcohol-induced disorder
F10.29 …… with unspecified alcohol-induced disorder
F10.9 Alcohol use, unspecified
F10.90 …… uncomplicated
F10.91 …… in remission
F10.92 Alcohol use, unspecified with intoxication
F10.920 …… uncomplicated
F10.921 …… delirium
F10.929 …… unspecified
F10.93 Alcohol use, unspecified with withdrawal
F10.930 …… uncomplicated
F10.931 …… delirium
F10.932 …… with perceptual disturbance
F10.939 …… unspecified
F10.94 …… with alcohol-induced mood disorder
F10.95 Alcohol use, unspecified with alcohol-induced psychotic disorder
F10.950 …… with delusions
F10.951 …… with hallucinations
F10.959 …… unspecified
F10.96 …… with alcohol-induced persisting amnestic disorder
F10.97 …… with alcohol-induced persisting dementia
F10.98 Alcohol use, unspecified with other alcohol-induced disorders
F10.980 Alcohol use, unspecified with alcohol-induced anxiety disorder
F10.981 Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10.982 Alcohol use, unspecified with alcohol-induced sleep disorder
F10.988 Alcohol use, unspecified with other alcohol-induced disorder
F10.99 …… with unspecified alcohol-induced disorder

F11 Opioid related disorders:
F11.1 Opioid abuse
F11.10 …… uncomplicated
F11.11 …… in remission
F11.12 Opioid abuse with intoxication
F11.120 …… uncomplicated
F11.121 …… delirium
F11.122 …… with perceptual disturbance
F11.129 …… unspecified
F11.13 …… with withdrawal
F11.14 …… with opioid-induced mood disorder
F11.15 Opioid abuse with opioid-induced psychotic disorder
F11.150 …… with delusions
F11.151 …… with hallucinations
F11.159 …… unspecified
F11.18 Opioid abuse with other opioid-induced disorder
F11.181 Opioid abuse with opioid-induced sexual dysfunction

F11.182 Opioid abuse with opioid-induced sleep disorder
F11.188 Opioid abuse with other opioid-induced disorder
F11.19 …… with unspecified opioid-induced disorder
F11.2 Opioid dependence
F11.20 …… uncomplicated
F11.21 …… in remission
F11.22 Opioid dependence with intoxication
F11.220 …… uncomplicated
F11.221 …… delirium
F11.222 …… with perceptual disturbance
F11.229 …… unspecified
F11.23 …… with withdrawal
F11.24 …… with opioid-induced mood disorder
F11.25 Opioid dependence with opioid-induced psychotic disorder
F11.250 …… with delusions
F11.251 …… with hallucinations
F11.259 …… unspecified
F11.28 Opioid dependence with other opioid-induced disorder
F11.281 Opioid dependence with opioid-induced sexual dysfunction
F11.282 Opioid dependence with opioid-induced sleep disorder
F11.288 Opioid dependence with other opioid-induced disorder
F11.29 …… with unspecified opioid-induced disorder
F11.9 Opioid use, unspecified
F11.90 …… uncomplicated
F11.91 …… in remission
F11.92 Opioid use, unspecified with intoxication
F11.920 …… uncomplicated
F11.921 …… delirium
F11.922 …… with perceptual disturbance
F11.929 …… unspecified
F11.93 …… with withdrawal
F11.94 …… with opioid-induced mood disorder
F11.95 Opioid use, unspecified with opioid-induced psychotic disorder
F11.950 …… with delusions
F11.951 …… with hallucinations
F11.959 …… unspecified
F11.98 Opioid use, unspecified with other specified opioid-induced disorder
F11.981 Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982 Opioid use, unspecified with opioid-induced sleep disorder
F11.988 Opioid use, unspecified with other opioid-induced disorder
F11.99 …… with unspecified opioid-induced disorder
F14 Cocaine related disorders:
F14.1 Cocaine abuse
F14.10 …… uncomplicated
F14.11 …… in remission
F14.12 Cocaine abuse with intoxication
F14.120 …… uncomplicated
F14.121 …… with delirium

F14.122 …… with perceptual disturbance
F14.129 …… unspecified
F14.13 …… unspecified with withdrawal
F14.14 …… with cocaine-induced mood disorder
F14.15 Cocaine abuse with cocaine-induced psychotic disorder
F14.150 …… with delusions
F14.151 …… with hallucinations
F14.159 …… unspecified
F14.18 Cocaine abuse with other cocaine-induced disorder
F14.180 Cocaine abuse with cocaine-induced anxiety disorder
F14.181 Cocaine abuse with cocaine-induced sexual dysfunction
F14.182 Cocaine abuse with cocaine-induced sleep disorder
F14.188 Cocaine abuse with other cocaine-induced disorder
F14.19 …… with unspecified cocaine-induced disorder
F14.2 Cocaine dependence
F14.20 …… uncomplicated
F14.21 …… in remission
F14.22 Cocaine dependence with intoxication
F14.220 …… uncomplicated
F14.221 …… delirium
F14.222 …… with perceptual disturbance
F14.229 …… unspecified
F14.23 …… with withdrawal
F14.24 …… with cocaine-induced mood disorder
F14.25 Cocaine dependence with cocaine-induced psychotic disorder
F14.250 …… with delusions
F14.251 …… with hallucinations
F14.259 …… unspecified
F14.28 Cocaine dependence with other cocaine-induced disorder
F14.280 Cocaine dependence with cocaine-induced anxiety disorder
F14.281 Cocaine dependence with cocaine-induced sexual dysfunction
F14.282 Cocaine dependence with cocaine-induced sleep disorder
F14.288 Cocaine dependence with other cocaine-induced disorder
F14.29 …… with unspecified cocaine-induced disorder
F14.9 Cocaine use, unspecified
F14.90 …… uncomplicated
F14.91 …… in remission
F14.92 Cocaine use, unspecified with intoxication
F14.920 …… uncomplicated
F14.921 …… delirium
F14.922 …… with perceptual disturbance
F14.929 …… unspecified
F14.93 …… with withdrawal
F14.94 …… with cocaine-induced mood disorder
F14.95 Cocaine use, unspecified with cocaine-induced psychotic disorder
F14.950 …… with delusions
F14.951 …… with hallucinations
F14.959 …… unspecified

F14.98 Cocaine use, unspecified with other specified cocaine-induced disorder
F14.980 Cocaine use, unspecified with cocaine-induced anxiety disorder
F14.981 Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14.982 Cocaine use, unspecified with cocaine-induced sleep disorder
F14.988 Cocaine use, unspecified with other cocaine-induced disorder
F14.99 …… with unspecified cocaine-induced disorder

F15 Other stimulant related disorders:
F15.1 Other stimulant abuse
F15.10 …… uncomplicated
F15.11 …… in remission
F15.12 Other stimulant abuse with intoxication
F15.120 …… uncomplicated
F15.121 …… delirium
F15.122 …… with perceptual disturbance
F15.129 …… unspecified
F15.13 …… with withdrawal
F15.14 …… with stimulant-induced mood disorder
F15.15 Other stimulant abuse with stimulant-induced psychotic disorder
F15.150 …… with delusions
F15.151 …… with hallucinations
F15.159 …… unspecified
F15.18 Other stimulant abuse with other stimulant-induced disorder
F15.180 Other stimulant abuse with stimulant-induced anxiety disorder
F15.181 Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182 Other stimulant abuse with stimulant-induced sleep disorder
F15.188 Other stimulant abuse with other stimulant-induced disorder
F15.19 …… with unspecified stimulant-induced disorder
F15.2 Other stimulant dependence
F15.20 …… uncomplicated
F15.21 …… in remission
F15.22 Other stimulant dependence with intoxication
F15.220 …… uncomplicated
F15.221 …… delirium
F15.222 …… with perceptual disturbance
F15.229 …… unspecified
F15.23 …… with withdrawal
F15.24 …… with stimulant-induced mood disorder
F15.25 Other stimulant dependence with stimulant-induced psychotic disorder
F15.250 …… with delusions
F15.251 …… with hallucinations
F15.259 …… unspecified
F15.28 Other stimulant dependence with other stimulant-induced disorder
F15.280 Other stimulant dependence with stimulant-induced anxiety disorder
F15.281 Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282 Other stimulant dependence with stimulant-induced sleep disorder
F15.288 Other stimulant dependence with other stimulant-induced disorder
F15.29 …… with unspecified stimulant-induced disorder

F15.9 Other stimulant use, unspecified
F15.90 …… uncomplicated
F15.91 …… in remission
F15.92 Other stimulant use, unspecified with intoxication
F15.920 …… uncomplicated
F15.921 …… delirium
F15.922 …… with perceptual disturbance
F15.929 …… unspecified
F15.93 …… with withdrawal
F15.94 …… with stimulant-induced mood disorder
F15.95 Other stimulant use, unspecified with stimulant-induced psychotic disorder
F15.950 …… with delusions
F15.951 …… with hallucinations
F15.959 …… unspecified
F15.98 Other stimulant use, unspecified with other stimulant-induced disorder
F15.980 Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15.981 Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15.982 Other stimulant use, unspecified with stimulant-induced sleep disorder
F15.988 Other stimulant use, unspecified with other stimulant-induced disorder
F15.99 …… with unspecified stimulant-induced disorder

Appendix B: List of Coexisting Benefit Plan

- Additional Low Income Medicare Beneficiary
- Ambulatory Prenatal Services
- Autism-Related Services
- Benefits Monitoring Program
- Breast and Cervical Cancer Control Program
- Certified Community Behavioral Health Clinic
- Children's Serious Emotional Disturbance Waiver-DHS
- Children's Home and Community Based Services Waiver
- Children's Serious Emotional Disturbance Waiver Program
- Children's Special Health Care Services
- Children's Special Health Care Services - Managed Care
- Children's Waiver Program Managed Care
- CSHCS Medical Home
- End Stage Renal Disease
- Foster Care and CPS Incentive Payment
- Freedom to Work
- Full Fee-for-Service Healthy Kids – Expansion
- Full Fee-for-Service Medicaid
- Habilitation Supports Waiver Program Managed Care
- Healthy Kids Dental
- Healthy Kids Expansion Emergency Services Only
- Healthy Michigan Plan
- Healthy Michigan Plan Behavioral Health Enrolled in an MHP
- Healthy Michigan Plan Behavioral Health NOT Enrolled in an MHP
- Healthy Michigan Plan Emergency Services Only
- Healthy Michigan Plan-Managed Care
- Home and Community Based Waiver Services-Managed Care
- HSW Habilitation Supports Waiver Program Managed Care
- Intermediate Care Facility for Individuals with Intellectual Disabilities
- Managed Care Exempt
- Maternity Outpatient Medical Services
- Medicaid Behavioral Health Enrolled in an MHP
- Medicaid Behavioral Health NOT Enrolled in an MHP
- Medicaid Managed Care
- Medicaid-Medicare Dually Eligible-Managed Care
- Medical Assistance Emergency Services Only
- Michigan Coordinated Health (MICH)
- MIChild Program (CHIP)
- MIChild Program Emergency Services (CHIP)
- Non-Emergency Medical Transportation
- PIHP Healthy Michigan Plan
- Prepaid Inpatient Health Plan
- Program All-Inclusive Care for Elderly
- Qualified Disabled Working Individual

- Qualified Medicare Beneficiary - All Inclusive
- Serious Emotional Disturbances Managed Care
- Specified Low Income Medicare Beneficiary
- State Psychiatric Hospital
- Targeted Case Management