Opioid Health Home (OHH) Handbook

Version 2.0

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

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

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

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Preface

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

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

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

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

Section I: Introduction to the Opioid Health Home Service Model

1.1 Overview of the OHH

The Michigan Department of Health & Human Services (MDHHS) is seeking approval from the Centers for Medicaid and Medicare Services (CMS) to revise the current OHH SPA to optimize and expand the OHH in select Michigan counties. The OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient centered care across the broader health care system. The model will also elevate 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 complete health and social needs. Participation is voluntary and enrolled beneficiaries may opt-out at any time. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT); 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's OHH 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, MSA policy MMP 22-27, the OHH Handbook and provide the six federally required core health home services. Michigan's OHHs 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 OHH beneficiaries with at least one OHH service during a given month. HHPs must contract or establish a memorandum of understanding (MOU) with an 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 outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

1.2 OHH Population Criteria

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

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

Please note, beneficiaries cannot be enrolled in HHBH (Behavioral Health Home), HHMICare (Health Home MI Care Team), ICO-MC (Integrated Care MI Health Link), NH (Nursing Home), or Hospice during the same month. A beneficiary cannot be in spend down or incarcerated. Lead entities are responsible for checking the beneficiary eligibility in CHAMPS.

1.3 OHH Services

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

- Comprehensive Care Management, including but not limited to:
  - Assessment of each beneficiary, including behavioral and physical health care needs;
  - Assessment of beneficiary readiness to change;
  - 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 OHH.

- Care Coordination, including but not limited to:
  - Organization of all aspects of a beneficiary's care;
  - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;
  - Information sharing between providers, patient, authorized representative(s), and family;
  - Resource management and advocacy;
  - Contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
  - Appointment making assistance, including coordinating transportation;
  - Development and implementation of care plan;
  - Medication adherence and monitoring;
  - Referral tracking;
  - Use of facility liaisons;
  - Use of patient care team huddles;
  - Use of case conferences;
  - Tracking of test results;
  - Requiring discharge summaries;
  - Providing patient and family activation and education;
  - Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
  - Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

- Health Promotion, including but not limited to:
  - Providing patient and family activation and education;
  - Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
  - Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.);

  - Promoting healthy lifestyle interventions;
  - Encouraging routine preventative care such as immunizations and screenings;
  - Assessing the patient and family's understanding of the health condition and motivation to engage in self-management;
  - Using evidence-based practices, to engage and help patient participate in and manage their care.

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

- Individual and Family Support (including authorized representatives), including but not limited to:
  - Reducing barriers to the beneficiary's care coordination;
  - Increasing patient and family skills and engagement;
  - Use of community supports (i.e., Community Health Workers, peer supports, peer recovery coaches, support groups, self-care programs, etc.);
  - Facilitating improved adherence to treatment;
  - Advocating for individual and family needs;
  - Assessing and increasing individual and family health literacy;
  - Use of advance directives, including psychiatric advance directives;
  - Contributing assistance with maximizing beneficiary's level of functioning; and
  - Providing assistance with development of social supports.

- Referral to Community and Social Support Services, including but not limited to:
  - Providing beneficiaries with referrals to support services;
  - Collaborating/coordinating with community-based organizations and key community stakeholders;
  - Emphasizing resources closest to the beneficiary's home;
  - Emphasizing resources which present the fewest barriers;
  - Identifying community-based resources;
  - Providing resource materials pertinent to patient needs;
  - Assisting in obtaining other resources, including benefit acquisition;
  - Providing referral to housing resources; and
  - Providing referral tracking and follow-up.

1.4 Health Home Partner (HHP) Qualification Criteria

Eligible HHPs must meet all applicable state and federal licensing requirements, including specifications set forth in this policy. Additionally, eligible providers will sign the MDHHS-5745 (Health Home Partner Application) attesting to meeting the requirements cited in MSA Policy MMP 22-27, 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 OHH counties.

1.4a Geographic Area

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

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

1.4b Provider Types

The LE will be responsible for providing health homes services in partnership with community based HHPs. The LE already contracts with the State for Medicaid services. All HHPs must provide Medication Assisted Treatment (MAT) or through a contract or MOU with another organization. HHP-OTPs must meet all state and federal licensing and certification requirements of an OTP.

HHP-OBOT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT.

- Lead Entity (LE)
  - Be a regional entity as defined in Michigan's Mental Health Code (330.1204b).
  - Must contract or develop a MOU with and pay a negotiated rate to HHPs (the scope of work established with the health home partners shall be defined by the provisions set forth in the health home handbook).
  - Be an MDHHS department-designated community mental health entity who may contract for and spend funds for the prevention of substance use disorder and for the counseling and treatment of individuals with substance use disorder, as defined in Michigan's Mental Health Code (Michigan Codified Law 330.1269). Have authority to access Michigan Medicaid claims and encounter data for the OHH target population.
  - Have authority to access Michigan's WSA and CareConnect360.
  - Must have the capacity to evaluate, select, and support providers who meet the standards for HHPs, including:
    - Identification of providers who meet the HHP standards
    - Provision of infrastructure to support HHPs in care coordination
    - Collecting and sharing member-level information regarding health care utilization and medications
    - Providing quality outcome protocols to assess HHP effectiveness
    - Developing training and technical assistance activities that will support HHPs in effective delivery of HH services
  - Must maintain a network of providers that support the HHPs to service beneficiaries with an opioid use disorder.
  - Must pay HHPs directly on behalf of the State for the OHH Program at the State defined rate.

- Health Home Partner (HHP) -- Opioid Treatment Program (OTP)
  - Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements.
  - Must meet applicable Federal and State licensing and certification standards in addition to Medicaid provider certification and enrollment requirements as an Opioid Treatment Program.

- Health Home Partner (HHP) -- Office Based Opioid Treatment Provider (OBOT)
  - Enroll or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements.
  - Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as one of the following:
    - Community Mental Health Services Program (Community Mental Health Center)
    - Federally Qualified Health Center/Primary Care Safety Net Clinic
    - Hospital based Physician Group
    - Physician based Clinic

- Physician or Physician Practice
- Rural Health Clinics
- Substance Use Disorder Provider other than Opioid Treatment Program
- Tribal Health Center

1.4c Minimum Standards

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

The Michigan OHH Lead Entity (LE) must:

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

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

1. HHPs must be enrolled in the Michigan Medicaid program and in compliance with all applicable program policies.
2. HHPs must enroll and execute any necessary agreement(s)/contract(s) with the LE; HHPs must also sign the MDHHS-5745 with MDHHS.
3. HHPs must adhere to all federal and state laws regarding Section 2703 Health Homes recognition/certification, including the capacity to perform all core services specified by CMS. Providers shall meet the following recognition/certification standards:
    a. Attain accreditation from a national recognizing body specific to a health home, patient-centered medical home, or integrated care (e.g., NCQA, AAAHC, TJC, CARF, etc.) The LE/HHP may be pursuit of such accreditation at the time of OHH implementation; or,
    b. In the absence of accreditation from a national recognizing body (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 OHH Partner Standards Document, OHH Handbook, SPA, and policy. MDHHS has the right to review all templates created by the LE quality assurance and compliance purposes.

4. Provide 24-hour, seven days a week availability of information, screening for services and emergency consultation services to beneficiaries.
5. Ensure access to timely services for enrollees, including seeing enrollees within seven days and 30 days of discharge from an acute care or psychiatric inpatient stay.
6. Ensure person-centered and integrated care planning that coordinates and integrates all clinical and non-clinical health care related needs and services.
7. Provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy.
8. Utilize the MDHHS-5515 Consent to Share Behavioral Health and Substance Use Disorder Information.
9. Demonstrate the ability to perform each of the following functional requirements. This includes documentation of the processes and methods used to execute these functions.
    a. Coordinate and provide the six core services cited in Section 2703 of the Affordable Care Act.
    b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines.
    c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
    d. Coordinate and provide access to physical, mental health, and substance use disorder services.
    e. Coordinate and provide access to chronic disease management, including self- management support to individuals and their families.
    f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices as appropriate.
    g. Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
10. Demonstrate the ability to report required data for both state and federal monitoring of the program.

Section II: Provider Requirements for OHH Participation

2.1 OHH General Provider Requirements

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

Medicaid statutes, policies, procedures, rules, and regulations, and the OHH Handbook.

2.2 Health Home Partner Enrollment

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

2.3 Health Home Partner Disenrollment

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

2.4 Health Home Partner Termination

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

2.5 OHH Required Provider Infrastructure

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 into the health home. Although 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 OHH.

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

LEs (per 100 beneficiaries)

- Health Home Director (0.5 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, Medical Assistant (2.00-4.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.05 FTE)

2.6 OHH Provider Requirements and Expectations

Health Home Director (e.g., Lead Entity Care Coordinator)

- Provides leadership for implementation and coordination of health home activities
- Coordinates all enrollment into the health home on behalf of providers

  - Coordinates with LE care management staff and HHPs to identify a beneficiary’s optimal setting of care
  - Coordinates and utilizes HIT with the HHP team to maximize care coordination and care management
  - Serves as a liaison between the health homes site and MDHHS staff/contractors
  - Champions practice transformation based on health home principles
  - Coordinates all enrollment into the health home on behalf of providers
  - Develops and maintains working relationships with primary and specialty care providers including Community Mental Health Service Providers and inpatient facilities
  - Collects and reports on data that permits an evaluation of increased coordination of care and chronic disease management
  - Monitors Health Home performance and leads quality improvement efforts
  - Designs and develops prevention and wellness initiatives, and referral tracking
  - Training and technical assistance
  - Data management and reporting

- Behavioral Health Specialist (e.g., Case Worker, Counselor, or Therapist with related degree)
  - Screens individuals for mental health and substance use disorders
  - Refers beneficiaries to a licensed mental health provider and/or licensed and certified SUD therapist as necessary
  - Conducts brief intervention for individuals with behavioral health problems
  - Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic
  - Supports primary care providers in identifying and behaviorally intervening with patients
  - Focuses on managing a population of patients versus specialty care
  - Works with patients to identify chronic behavior, discuss impact, develop improvement strategies and specific goal-directed interventions
  - Develops and maintains relationships with community based mental health and substance abuse providers
  - Identifies community resources (i.e. support groups, workshops, etc.) for patient to utilize to maximize wellness
  - Provides patient education

- Nurse Care Manager (e.g., licensed registered nurse)
  - Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives
  - Participates in initial care plan development including specific goals for all enrollees
  - Communicates with medical providers, subspecialty providers including mental health and substance abuse service providers, long term care and hospitals regarding records including admission/discharge
  - Provides education in health conditions, treatment recommendation, medications, and strategies to implement care plan goals including both clinical and non-clinical needs

  - Monitors assessments and screenings to assure findings are integrated in the care plan
  - Facilitates the use of the EHR and other HIT to link services, facilitate communication among team members and provide feedback
  - Monitors and report performance measures and outcomes
  - Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic

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

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

- Psychiatric Consultant
  - Care team must have access to a licensed mental health service professional (i.e., psychologist, psychiatrist, psychiatric nurse practitioner) providing psychotherapy consult and treatment plan development services. This provider will be responsible for communicating treatment methods and expert advice to Behavioral Health Provider (incorporated into care team).

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

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

  - Dentist
  - Dietician/Nutritionist

- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

2.7 Training and Technical Assistance

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

1. Participate in state and LE sponsored activities designed to support HHP in transforming service delivery. This includes a mandatory Health Home orientation for providers and clinical support staff before the program is implemented.
2. Participate in ongoing technical assistance (including but not limited to trainings and webinars).
3. Participate in ongoing individual assistance (including but not limited to audits, site visits, trainings, etc., provided by State and/or State contractual staff).
4. Support Health Home team participation in all related activities and trainings, including coverage of travel costs associated with attending Health Home activities.
5. Provide each beneficiary, at a minimum, with access to a care team comprised of the providers mentioned in Section 1.4.
6. Assign a personal care team to each beneficiary.
7. Ensure each patient has an ongoing relationship with a personal member of their care team who is trained to provide first contact and support continuous and comprehensive care, where the patient and care team recognize each other as partners.
8. Embed behavioral health care services into primary health care services as applicable, with real-time behavioral health consultation available to each primary care provider.
9. Provide behavioral and physical health care to beneficiaries using a whole-person orientation and with an emphasis on quality and safety.
10. Provide care or arrange for care to be provided by other qualified professionals. This includes but is not limited to care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care.
11. Engage in meaningful use of technology for patient communication.
12. Develop a person-centered care plan for each beneficiary that coordinates and integrates all clinical and non-clinical health care related needs and services.
13. Coordinate and integrate each beneficiaries' behavioral health care.
14. Designate for each beneficiary a care coordinator who is responsible for assisting the beneficiary with follow-up, test results, referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes and communication with external specialists.
15. Communicate with each beneficiary (and authorized representative(s), family and caregivers) in a culturally and linguistically appropriate manner.
16. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-

informed preventive services and health promotion.

17. Directly provide, or contract to provide, the following services for each beneficiary:
    - Mental health/behavioral health and substance abuse services
    - Oral health services
    - Chronic disease management
    - Coordinated access to long term care supports and services
    - Recovery services and social health services (available in the community)
    - Behavior modification interventions aimed at supporting health management (Including but not limited to, obesity counseling, tobacco treatment/cessation, and health coaching)
18. Conduct Health Home outreach to local health systems.
19. Provide comprehensive transitional care from inpatient to other settings, including appropriate follow-up.
20. Review and reconcile beneficiary medications.
21. Perform assessment of each beneficiary's social, educational, housing, transportation, and vocational needs that may contribute to disease and/or present barriers to self- management.
22. Maintain a reliable system, including written standards/protocols, for tracking patient referrals.
23. Adhere to all applicable privacy, consent, and data security statutes.
24. Demonstrate use of clinical decision support within the practice workflow specific to the conditions identified in the Health Home project.
25. Demonstrate use of a population management tool such as a patient registry and the ability to evaluate results and implement interventions that improve outcomes.
26. Implement evidence-based screening tools designated LE.
27. Establish a continuous quality improvement program and collect and report on data that permit an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
28. Enhance beneficiary access to behavioral and physical health care.
29. Provide each beneficiary with 24/7 access to the care team including, but not limited to a telephone triage system with after-hours scheduling to avoid unnecessary emergency room visits and hospitalizations.
30. Monitor access outcomes including but not limited to the average 3rd next available appointment and same day scheduling availability.
31. Implement policies and procedures to operate with open access scheduling and available same day appointments.
32. Use HIT, including but not limited to an EHR capable of integrating behavioral and physical health care information.
33. Use HIT to link services, facilitate communication among team members as well as between the health team and individual and family caregivers, and provide feedback to providers.
34. Possess the capacity to electronically report to the State and/or its contracted affiliates information regarding service provision and outcome measures.
35. Work collaboratively with MDHHS and contractors to adapt and adopt program processes for Health Home care team use in the participating sites(s).

36. Engage in Health Home process and outcome achievement activities including ongoing coaching, data feedback and customized improvement plans to meet initiative goals.
37. Practice in accordance with accepted standards and guidelines and comply with all applicable policies published in the Michigan Medicaid Provider Manual.

Section III: Beneficiary Enrollment and Disenrollment

3.1 Enrollee Identification and Assignment

Enrollment Processes

Potential Opioid Health Home (OHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The Lead Entity (LE) will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to fully enroll the Medicaid beneficiary into the OHH benefit. The beneficiary may have a few choices of health home partners, depending on OHH region. Beneficiary may disenroll from the OHH benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home is voluntary and the potential enrollee must agree to receive health home services and provide consent that is maintained in the enrollee's health record.

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

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

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

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

While identifying potential enrollees is automatic, full enrollment into the OHH benefit plan is contingent on beneficiary completion of the Consent to Share Behavioral Health Information

for Care Coordination Purposes (MDHHS-5515), verification of diagnostic eligibility, and the LE electronically enrolling the beneficiary in the WSA. The LE and HHP will work together to identify a recommended HHP setting where the potential health home enrollee will likely be most successful. After receiving the recommendation from the LE and HHP, the beneficiary will have the opportunity to choose their preferred HHP. The variety and number of HHPs may vary by region. Once the Medicaid beneficiary is assigned to a health home, the HHP will work with the beneficiary to complete the enrollment process.

3.2 Beneficiary Consent

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

3.3 Beneficiary Care Plan

Within 90 days of enrollment, the opioid health home care team must work with the beneficiary to develop and complete an OHH care plan. The OHH care plan must align with the six statutorily, required health home services (as listed in section 1.3) 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 annually but should be reviewed and revised over time based on the beneficiary's progress and changing needs.

The care plan must be developed with the OHH care team, the beneficiary, and can include the beneficiary's support system (family, caregiver, etc.) if appropriate. It is best practice that the OHH care team and the beneficiary agree to and sign off on the care plan before it is implemented. The OHH care plan should be updated at least annually but should be reviewed and revised based on the beneficiary's progress and changing needs. 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 [MDHHS - Opioid Health Home (michigan.gov)](https://www.michigan.gov).

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

- The tasks to be completed by each OHH team member.
- The tasks to be completed by the beneficiary.
- SMART goals and objectives developed by and agreed upon by the beneficiary, and OHH 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 opioid health home care plan progress and update goals.

3.4 Beneficiary Disenrollment

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

Lead Entity Disenrollment Process

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

Provider-Recommended Disenrollment

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

More information on the disenrollment process in WSA can be found in the WSA HHO User Training Manual. Beneficiaries enrolled in the Opioid Health Home can be disenrolled for the following reasons:

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

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

- 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 at least 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 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 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 code should not be billed during the month the beneficiary was incarcerated.

3.5 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 OHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen HHP. However, beneficiaries may change HHP, and should notify their current HHP immediately if they intend to do so. The LE and HHP will work together to identify a recommended HHP setting where the potential health home enrollee will likely be most successful. 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: OHH Payment

4.1 General Provisions for OHH Payment

MDHHS will provide a monthly case rate to the LE based on attributed OHH beneficiaries with

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

4.2 Rate Workup

Staffing Model

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

Lead Entity (per 100 beneficiaries)

- Health Home Director (0.50 FTE)
    - Includes one director and relevant administrative staff (e.g., program coordinators and support staff)

Health Home Partners (per 100 beneficiaries)

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

Rate Amounts

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

The case rates reflect the staffing model per 100 enrollees and developed by utilizing provider compensation surveys from the Community Mental Health Association of Michigan (2019) and the Michigan Primary Care Association (2019), which represent the PIHP and OTP, and OBOT component of the rates, respectively. The State also utilized 2019 fringe rate data from the US Department of Labor's Bureau of Labor and Statistics. Below is a breakdown by each respective category:

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

per 100 patients.

OHH Case Rates to LE

PMPM	PMPM with P4P
$364.48	$382.70

LE Payment to Health Home Partners

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

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

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

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

MDHHS will afford P4P via a 5% performance incentive to the additional per member per month case rate. The LE must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the timelines and processes delineated below. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement benchmarks are not met by any of the HHPs within a given performance year, the State share of the withhold will be reserved by MDHHS and reinvested for OHH monthly case rate payments. Subsequent performance years will operate in accordance with this structure. The timelines and P4P metrics are explained in further detail below:

Timelines

The first year of the OHH 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

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

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	State Baseline	Allocation % of P4P Budget
1.	Initiation and engagement of alcohol and other drug (AOD) dependence treatment (0004), Initiation of AOD Treatment within 14 days	NCQA	TBD	50%
2.	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge	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 of P4P results. MDHHS will compare data in in the PY by juxtaposing the LE's OHH Program metric performance against the performance for the entire state and PIHP Region. If the OHH Program metric performance exceeds the performance at the state and regional level, all P4P will be awarded for that given metric; if, however, the OHH Program metric only exceeds one comparative group but not the other (e.g., OHH 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 OHH. The LE will then distribute at least 95% of P4P monies to the HHPs scaled to the volume of OHH services a given HHP renders based on the LE P4P logic. MDHHS reserves the right to review the LE P4P logic upon request.

4.4 OHH Service Encounter Coding Requirements

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

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

applicable social determinants of health) to the LE:

- *S0280 with HG Modifier*
  The initial service must be delivered in-person. (Note: Pursuant to state and federal policy related to the COVID-19 public health emergency, the initial service may be delivered in a non-face-to-face manner using the TS modifier. This flexibility will be effective with timelines cited in applicable state and federal policy commensurate with the public health emergency.)
  - All subsequent services may be delivered
    - Non-face-to-face as appropriate
    - TS Modifier must be used to document non-face-to-face encounters
    - Outside of the HHP physician site
  - The HG Modifier MUST be used for ALL OHH encounters.

- *Applicable ICD-10-CM Z diagnosis codes* to be used with the S0280 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

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

4.5 Encounter Submission

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

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

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

The Data Analysis and Quality Specialist in BHDDA and the Encounter Team will handle all electronic questions related to Encounter file submission and FTS issues for OHH organizations. Questions or issues can be directed to the following email addresses: MDHHSEncounterData@michigan.gov

4.6 Payment Schedule

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

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

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

4.7 Recoupment of Payment

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

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

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

Section V: OHH and Managed Care

5.1 OHH Enrollment for Health Plan Beneficiaries

The LE and HHPs must work with Medicaid Health Plans to coordinate services for eligible beneficiaries who wish to enroll in the OHH program. The LE has responsibility for SUD services for all enrolled Medicaid beneficiaries within its region and will have a list of all qualifying beneficiaries including the health plan to which they are assigned. MDHHS will require the LE and health plans to confer to optimize community-based referrals and informational materials regarding the OHH to beneficiaries. The LE will primarily be responsible for conducting outreach to eligible beneficiaries, while health plans will provide support in addressing beneficiary questions. Bi-directional communication is imperative throughout the process so that all parties have current knowledge about a beneficiary.

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

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

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

5.2 OHH Coordination & Health Plans

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

Section VI: Health Information Technology

6.1 Waiver Support Application (WSA) and the OHH

The WSA will provide support to the LE in the areas of beneficiary enrollment, including pre-enrollment activities (e.g., maintaining updated list of eligible beneficiaries), enrollment

management including beneficiary disenrollment, and report generation. Every month, a new batch of eligible beneficiaries will be uploaded to the WSA.

6.2 CareConnect360 and the OHH

CareConnect360 will help HIT-supported care coordination activities for the OHH Program. Broadly, it is a statewide care management web portal that provides a comprehensive view of individuals in multiple health care programs and settings based on claims information. This will allow the LE and other entities with access to CareConnect360 the ability to analyze health data spanning different settings of care. 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 OHH 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 OHH Program in the sense that it allows for the maintenance and transmittal of data necessary to optimize care coordination and management activities. MDHHS is also requiring that the LE and all HHPs utilize the same SUD platform to maximize clinical coordination and beneficiary consent to share information management. The LE will secure an HIE with these capabilities and facilitate access, including technical assistance, to the HHPs.

6.4 File Transfer Service (FTS)

Michigan's data-submission portal is the File Transfer Service (FTS). Some documents may still reference the DEG; be aware that a reference to the DEG portal is a reference to the FTS. Billing agents will use the FTS to submit and retrieve files electronically with MDHHS. MDHHS has established an Internet connection to the FTS, which is a Secure Sockets Layer connection. This connection is independent of the platform used to transmit data. Every billing agent receives a "mailbox", which is where their files are stored and maintained. Billing agents can access this mailbox to send and retrieve files.

Section VII: OHH Monitoring and Evaluation

7.1 Monitoring & Evaluation Requirements

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

7.2 Federal (CMS) Monitoring & Evaluation Requirements

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

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

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

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

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

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

7.3 State Monitoring & Evaluation Requirements

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

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

Appendix A: List of Qualifying ICD-10 Codes

F11 Opioid related disorders:

- F11.1 Opioid abuse
    - F11.10 ...... uncomplicated
    - F11.11 ...... in remission
    - F11.12 Opioid abuse with intoxication
        - F11.120 ...... uncomplicated
        - F11.121 ...... delirium
        - F11.122 ...... with perceptual disturbance
        - F11.129 ...... unspecified
    - F11.14 ...... with opioid-induced mood disorder
    - F11.15 Opioid abuse with opioid-induced psychotic disorder
        - F11.150 ...... with delusions
        - F11.151 ...... with hallucinations
        - F11.159 ...... unspecified
    - F11.18 Opioid abuse with other opioid-induced disorder
        - F11.181 Opioid abuse with opioid-induced sexual dysfunction
        - F11.182 Opioid abuse with opioid-induced sleep disorder
        - F11.188 Opioid abuse with other opioid-induced disorder
    - F11.19 ...... with unspecified opioid-induced disorder

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

- F11.9 Opioid use, unspecified
    - F11.90 ...... uncomplicated
    - F11.92 Opioid use, unspecified with intoxication
        - F11.920 ...... uncomplicated
        - F11.921 ...... delirium

    - [F11.922] …… with perceptual disturbance
    - [F11.929] …… unspecified
- [F11.93] …… with withdrawal
- [F11.94] …… with opioid-induced mood disorder
- [F11.95] Opioid use, unspecified with opioid-induced psychotic disorder
    - [F11.950] …… with delusions
    - [F11.951] …… with hallucinations
    - [F11.959] …… unspecified
- [F11.98] Opioid use, unspecified with other specified opioid-induced disorder
    - [F11.981] Opioid use, unspecified with opioid-induced sexual dysfunction
    - [F11.982] Opioid use, unspecified with opioid-induced sleep disorder
    - [F11.988] Opioid use, unspecified with other opioid-induced disorder
- [F11.99] …… with unspecified opioid-induced disorder

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
- 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
- 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
- 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