MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Jackie Prokop

Director, Program Policy Division
Bureau of Medicaid Policy and Health System Innovation

Project Number:	1807-BHDDA	**Comments Due:**	June 26, 2018	**Proposed Effective Date:**	October 1, 2018

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Policy Subject: Opioid Health Home Pilot Program

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild

Distribution: All Providers in Michigan's Prepaid Inpatient Health Plan (PIHP) Region 2

Policy Summary: This policy will implement an Opioid Health Home (OHH) pilot program in Michigan's PIHP Region 2.

Purpose: Deaths from drug overdose in Michigan have more than tripled from 1999 to 2016, and the availability of treatment and recovery-oriented resources is limited and geographically disparate. The Michigan Department of Health and Human Services (MDHHS) has identified several counties in PIHP Region 2 as having the greatest need for these resources.

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: All Providers in Michigan's Prepaid Inpatient Health Plan (PIHP) Region 2

Issued: September 1, 2018 (Proposed)

Subject: Opioid Health Home Pilot Program

Effective: October 1, 2018 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

Note: Implementation of this policy is contingent upon State Plan Amendment Approval from the Centers for Medicare & Medicaid Services (CMS). Continuation of the Opioid Health Home policy/benefit after eight (8) quarters of the effective date is subject to Michigan Department of Health and Human Services (MDHHS) review and approval.

Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act and the State Plan Amendment, the purpose of this policy is to provide for the coverage and reimbursement of Opioid Health Home services. This policy is effective for dates of service on and after October 1, 2018. The policy applies to fee-for-service and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who meet Opioid Health Home eligibility criteria. In addition, this policy will have an operations guide for providers called the Opioid Health Home Handbook.

I. General Information

Effective October 1, 2018, MDHHS will implement a new care management and care coordination primary care Health Home benefit called the Opioid Health Home (OHH). The goals of the program are to ensure seamless transitions of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting.

II. Beneficiary Eligibility

Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements section of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who have a diagnosis of opioid use disorder and have or are at risk of another chronic condition.

III. Beneficiary Enrollment

A. Enrollment Processes

The Michigan OHH uses a two-pronged enrollment approach where MDHHS, the regional PIHP, and the Health Home providers participate. The process is as follows:

- Autoenrollment:
  MDHHS will identify and enroll eligible beneficiaries using administrative claims data and provide a batch list of these beneficiaries to the regional PIHP for which they are assigned via the electronic Waiver Support Application (WSA) system. The list of eligible beneficiaries will be updated at least monthly. From the list, the PIHP will identify beneficiaries that are currently receiving Medication Assisted Treatment (MAT). The PIHP will send current MAT recipients a letter indicating their enrollment in the OHH. The letter will provide the beneficiary with information regarding health home services and indicate that the beneficiary may opt-out (disenroll) from the OHH at any time with no impact on their currently entitled Medicaid services. Beneficiaries not currently in MAT will be made aware of the OHH through community referrals, including through peer recovery coach networks, other providers, courts, health departments, law enforcement, and other community-based settings. MDHHS and the PIHP will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the OHH.

  While beneficiary enrollment is automatic, receipt and full payment of OHH services is contingent on beneficiary consent to share information (see Beneficiary Consent below) and verification of diagnostic eligibility. The PIHP must document these steps within the WSA. Failure to verify consent or diagnostic eligibility will be considered a de facto opt-out (disenrollment). The PIHP shall have six months from the date of autoenrollment to document the preceding steps in the WSA after which time the beneficiary will be presumed unresponsive and automatically disenrolled from the benefit (note: if a beneficiary in this scenario continues to meet OHH eligibility criteria and wishes to join the OHH at a later date, they are entitled to do so, and a new enrollment must be established via the process in the Recommended Enrollment section below).

- Recommended Enrollment:
  OHH providers are permitted to recommend potential eligible beneficiaries for enrollment to MDHHS via the regional PIHP. OHH providers must provide documentation that indicates that a prospective OHH beneficiary meets all eligibility for the benefit, including presence of qualifying conditions, consent, and establishment of an individualized care plan. The regional PIHP must review and process all recommended enrollments. MDHHS reserves the right to review and verify all enrollments.

Once enrolled, the PIHP will work with designated OHH providers and the beneficiary to identify the optimal setting of care. The PIHP will document the setting of care within the WSA. This decision will be made only after a beneficiary visits an OHH provider,

fills out the behavioral health consent form (see Beneficiary Consent below) and establishes an individualized care plan derived from an evidence-based assessment of need. The beneficiary may opt-out (disenroll) at any time with no impact on other entitled Medicaid services.

B. Beneficiary Consent

Beneficiaries must provide OHH providers 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 Disabilities Administration >> Behavioral and Physical Health Care Integration. The form will also be available at the designated OHH provider office. OHH providers are responsible for verifying receipt of the signed consent form and providing proper documentation to MDHHS via the regional PIHP. All documents must be maintained in compliance with MDHHS record-keeping requirements.

C. OHH Benefit Plan Assignment

Once enrolled, the beneficiary will be assigned to the OHH benefit plan associated with their Medicaid member ID in the Community Health Automated Medicaid Processing System (CHAMPS). It is incumbent upon OHH providers to verify a beneficiary's OHH benefit plan assignment prior to rendering services. Beneficiaries without the OHH benefit plan assignment will not be eligible for OHH payment.

D. Beneficiary Disenrollment

Beneficiaries may opt-out or disenroll from the OHH benefit at any time. Beneficiaries who opt-out of enrollment initially may elect to enroll later contingent on meeting eligibility requirements. Beneficiaries who decline services or disenroll may do so without jeopardizing their access to other entitled medically necessary Medicaid services.

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

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

- Beneficiaries who are unresponsive for reasons other than moving or death. The PIHP must make at least three unsuccessful beneficiary contact attempts within six consecutive months for MDHHS to deem a beneficiary as unresponsive. For autoenrolled beneficiaries, if no activity occurs after six months from the date of enrollment, the beneficiary will be auto-disenrolled; for provider recommended

enrolled beneficiaries, if the beneficiary is unresponsive for six months, the PIHP must mark the beneficiary as disenrolled via the Waiver Support Application. The PIHP and MDHHS must maintain a list of disenrolled beneficiaries in the Waiver Support Application. The PIHP must attempt to re-establish contact with these beneficiaries at least every six months after disenrollment, as applicable.

E. Beneficiary Changing OHH Providers

While the beneficiary's stage in recovery and individualized plan of care will be utilized to determine the appropriate setting and OHH provider of care (i.e., providers within Opioid Treatment Program versus Office Based Opioid Treatment), beneficiaries will have the ability to change OHH providers to the extent feasible within the regional PIHP'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 OHH provider. However, beneficiaries may change OHH providers, and should notify their current OHH provider immediately if they intend to do so. The current and future OHH providers must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new OHH provider's appointment availability. Only one OHH provider may be paid per beneficiary per month for health home services. The new OHH provider will also not be eligible for the initial "Recovery Action Plan" payment if that one-time payment was already made to another OHH provider.

IV. Covered Services

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

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

- Care Coordination and Health Promotion, including but not limited to:
  - Organization of all aspects of a beneficiary's care;
  - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;
  - Information sharing between providers, patient, authorized representative(s), and family;
  - Resource management and advocacy;

  - Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
  - Appointment making assistance, including coordinating transportation;
  - Development and implementation of care plan;
  - Medication adherence and monitoring;
  - Referral tracking;
  - Use of facility liaisons;
  - Use of patient care team huddles;
  - Use of case conferences;
  - Tracking of test results;
  - Requiring discharge summaries;
  - Providing patient and family activation and education;
  - Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
  - Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

- Comprehensive Transitional Care, including but not limited to:
  - Connecting the beneficiary to health services;
  - Coordinating and tracking the beneficiary's use of health services;
  - 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;
  - Medication reconciliation;
  - Pharmacy coordination;
  - Proactive care (versus reactive care);
  - Specialized transitions when necessary (i.e., age, corrections); and
  - Home visits.

- Patient 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;
  - Providing assistance with maximizing beneficiary's level of functioning; and
  - Providing assistance with development of social networks.

- Referral to Community and Social Support Services, including but not limited to:
  - Providing beneficiaries with referrals to support services;

- Collaborating/coordinating with community-based organizations and key community stakeholders;
- Emphasizing resources closest to the beneficiary's home;
- Emphasizing resources which present the fewest barriers;
- Identifying community-based resources;
- Providing resource materials pertinent to patient needs;
- Assisting in obtaining other resources, including benefit acquisition;
- Providing referral to housing resources; and
- Providing referral tracking and follow-up.

- Use of Health Information Technology to link services, including but not limited to:
  - Using an Electronic Health Record with meaningful use attainment;
  - Using an Integrated Health Information System to share critical data in real-time;
  - Using CareConnect360 for care coordination, transition and planning; and
  - Using telemedicine as needed.

V. Provider Eligibility Requirements

Eligible OHH providers must meet all applicable state and federal licensing requirements, including specifications set forth in this policy. Additionally, eligible providers will sign a Memorandum of Understanding with MDHHS attesting to meeting the requirements cited in this policy, the State Plan Amendment, and other applicable MDHHS policies and procedures. Designated OHH providers must be formally part of the regional PIHP's provider panel.

A. Geographic Area

Eligible providers must implement the MI Care Team in Michigan PIHP Region 2, which spans the following 21 counties:

- Alcona
- Alpena
- Antrim
- Benzie
- Charlevoix
- Cheboygan
- Crawford
- Emmet
- Grand Traverse
- Iosco
- Kalkaska
- Leelanau
- Manistee
- Missaukee
- Montmorency
- Ogemaw
- Oscoda

- Otsego
- Presque Isle
- Roscommon
- Wexford

B. Provider Types

Eligible provider types for the OHH include Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) providers. All OTPs and OBOT providers must provide Medication Assisted Treatment (MAT). OTPs must meet all state and federal licensing requirements. 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. OBOT providers may include Community Mental Health Services Programs (CMHSPs), Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, Tribal Health Centers (THCs), and individual provider practices.

C. Provider Requirements

PIHPs must adhere to the OHH contractual requirements with MDHHS. Designated OHH providers must meet the requirements indicated in the OHH Memorandum of Understanding with MDHHS. PIHPs and Providers must adhere to the requirements of the State Plan Amendment, all Medicaid statutes, policies, procedures, rules, and regulations, and the OHH Handbook.

D. Provider Infrastructure Requirements

OHH providers will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The requirements will span three settings – the regional PIHP, the OTPs, and the OBOT providers. Each setting will have its own unique set of requirements commensurate with the scope of their operations. The specific minimum requirements for each setting are as follows:

1. <u>Regional PIHP</u>

   - Health Home Director (0.25 FTE)
   - Administrative Support Staff (5 FTE)

2. <u>OTPs (per 400 patients; in addition to current staffing requirements required by licensure)</u>

   - RN Care Manager (3 FTE)
   - Masters-level Clinical Case Manager (1 FTE)
   - Masters-level Addiction Counselor (2 FTE)
   - Certified Recovery Coach (3 FTE)
   - Primary Care Provider (.10 FTE)
   - Consulting Psychiatrist (.20 FTE)

3. OBOTs (per 400 patients)

- RN Care Manager (3 FTE)
- Masters-level Clinical Case Manager (3 FTE)
- Certified Recovery Coach or Community Health Worker (3 FTE)
- Supervising Primary Care Provider (.15 FTE)
- Consulting Psychiatrist/Psychologist (.10 FTE)

All providers referenced above must meet the following criteria:

- Primary Care Provider
  - Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan (i.e., full licensure and certification, as applicable)

- Clinical Case Manager
  - Must be a licensed master's level social worker in Michigan

- Nurse Care Manager
  - Must be a licensed registered nurse in Michigan

- Certified Peer Recovery Coach
  - Must obtain requisite peer certification per the Medicaid Provider Manual

- Community Health Worker (CHW)
  - Must be at least 18 years of age
  - Must possess a high school diploma or equivalent
  - Must be supervised by licensed professional members of the care team
  - Must complete a CHW Certificate Program or equivalent

- Health Home Coordinator
  - Must be an administrative staff person employed by the PIHP

- Access to a Psychiatrist/Psychologist for consultation purposes (can be off-site)
  - Must be a licensed psychiatrist or doctoral-level psychologist in Michigan

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

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

VI. Provider Enrollment and OHH Designation

The PIHP must contractually adhere to the terms of this policy and the State Plan Amendment. Prospective OHH providers meeting the requirements in the Provider Eligibility Requirements section of this policy and the State Plan Amendment will be allowed to enroll as a designated OHH provider contingent upon adherence to this policy, enrolling in the PIHP's provider panel, and signing the MOU with MDHHS. The fully executed MOU will serve as the formal MDHHS recognition of OHH provider designation.

A. Training and Technical Assistance

MDHHS requires provider participation in state-sponsored training and technical assistance as a standard condition for continued OHH designation. A readiness assessment will be completed for each designated OHH site which will provide a basis for training and technical assistance needs.

B. Use of Applicable Health Information Technology (HIT)

MDHHS requires OHH providers to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources will be provided by MDHHS.

VII. Provider Disenrollment

To maximize continuity of care and the patient-provider relationship, MDHHS expects OHH providers to establish a lasting relationship with enrolled beneficiaries. However, designated OHH providers wishing to discontinue OHH services must notify the regional PIHP and MDHHS at least six months in advance of ceasing OHH operations. OHH services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

VIII. OHH Payment

Payment for OHH services is contingent on designated OHH providers meeting the requirements laid out in this policy, the OHH provider application, and as determined by MDHHS. Failure to meet these requirements may result in loss of OHH provider designation.

A. General Provisions for OHH Payment

1. MDHHS to Regional PIHP

MDHHS will distribute monies monthly to the regional PIHP based on the enrolled population (auto-enrolled or provider-enrolled). MDHHS will periodically reconcile payments made to actual service delivered except for a 5 percent overage variance, which will be reserved for an alternative payment methodology in the form of pay-for-performance (P4P) regarding a withhold. If the PIHP meets MDHHS-identified

quality improvement benchmarks, it will let the PIHP keep some or all the 5 percent withhold. The PIHP will distribute at least 85 percent of the P4P monies to designated OHH providers based on their meeting individual benchmarks. If quality improvement benchmarks are not met by either the PIHP or the designated OHH provider(s), the withhold will be reserved by MDHHS. Details and guidance regarding the P4P methodology and selected metrics can be found in the SPA and the OHH Handbook.

Payments will depend on enrollment status pursuant to the enrollment section. MDHHS will provide monies to the PIHP based on the methodology below:

- Baseline Payments (Auto-enrolled but pending consent)
  For auto-enrolled beneficiaries not yet assigned to a designated OHH provider and who have yet to have consent and diagnostic eligibility verified in the WSA, the PIHP will receive a baseline payment (the lower of the two ongoing care management rates) until the PIHP completes the aforementioned steps.

- Fully Enrolled Payments
  For all beneficiaries for which the PIHP has completed the requisite steps in the WSA, the payment will be commensurate with the setting of care (i.e., OTP or OBOT), encounter type (i.e., “recovery action plan” or “ongoing care management”), and in accordance with the approved rate schedule.

2. Regional PIHP to OHH Providers

   Designated OHH providers must bill through their regional PIHP to receive OHH payment. Designated OHH providers will be paid one of two monthly case rates which are as follows:

   - Recovery Action Plan Rate
     The OHH uses a once-in-a-lifetime-per-beneficiary "Recovery Action Plan" rate to be paid only for the first month that a beneficiary participates in the OHH program. This once-in-a-lifetime-per-beneficiary rate represents reimbursement for certain actions and services including, but not limited to, initial care plan development. This service must be delivered in person. Rates vary by setting (i.e., OTPs vs. OBOT providers).

   - Ongoing Care Management Rate
     For all subsequent months following the Recovery Action Plan payment, the "Ongoing Care Management" rate will be paid for eligible OHH beneficiaries. Rates vary by setting (i.e., OTPs vs. OBOT providers).

Details and guidance regarding applicable service encounter and diagnosis codes can be found in the OHH Handbook.

Please note that payment for OHH services is in addition to the existing fee-for-service payments, encounters, or daily rate payments for direct clinical services. The MDHHS payment methodology is designed to only reimburse for the cost of the OHH provider staff for the delivery of Health Home services that are not covered by any other currently available Medicaid reimbursement mechanism.