



MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

Michigan's Behavioral Health Home

Overview and Requirements

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Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Agenda

- Overview
- Expansion
- Criteria
- Structure
- Services
- Enrollment
- Care Plan
- Payment
- Monitoring and Reporting
- Resources

BHH Overview



Medicaid Health Homes Defined

Medicaid “Health Homes” are an optional State Plan benefit authorized under Section 1945 of the US Social Security Act

Purpose:

- Coordinate care for Medicaid beneficiaries with serious and complex chronic conditions
- Serve the “whole-person” by integrating and coordinating physical, behavioral, and social services
- Provide state flexibility to create innovative delivery and payment models
- Afford sustainable reimbursement to affect the social determinants of health

Requirements:

- Target populations by condition(s), geography, and provide the following core services:
 - Comprehensive care management
 - Care coordination
 - Health promotion
 - Comprehensive transitional care and follow-up
 - Individual and family support
 - Referral to community and social support services

Michigan Behavioral Health Home

Began in 2014, revamped in October 2020

Target Population

- Medicaid beneficiaries with a diagnosis of a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED)

Geography

- PIHP Regions- NorthCare Network (upper peninsula), Northern MI Regional Entity (northern-lower peninsula), CMH Partnership of Southeast MI (Southeast MI, Detroit Wayne Integrated Health Network (Wayne), and Oakland Community Health Network (Oakland County)
- 42 counties
- 39 BHH provider sites

Goals

- Improve care management of beneficiaries with SMI/SED
- Improve care coordination between physical and behavioral health care services
- Improve care transitions between primary, specialty, and inpatient settings of care

Enrollment

- 2,240 enrolled as of March 2023
- Age range: 6-84 years old
- Race: 25% African American, 69% Caucasian, 2% or less American Indian, Hispanic, Native Hawaiian and Other Pacific Islander

Behavioral Health Home Expansion

Expansion (May 1, 2023)

- PIHP Region 5 – Midstate Health Network

Projected Expansion Impact

- 63 counties
- 60 provider sites

BHH Population Criteria

Medicaid Requirements

Medicaid beneficiaries enrolled in:

- Full Fee-for-Service Medicaid
- Full Fee-for-Service Healthy Kids-Expansion
- Health Michigan Plan
- MICHild Program (CHIP)
- Freedom to Work

Must not be in the following benefit plans:

- Opioid Health Home
- Health Home MI Care Team
- Integrated Care MI Health Link
- Nursing Home
- Hospice
- Spenddown

A full list of coexisting benefit plans can be found in Appendix B of the Behavioral Health Home Handbook.

Geographic Area

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

- Alcona
- Alger
- Alpena
- Antrim
- Arenac
- Baraga
- Bay
- Benzie
- Charlevoix
- Cheboygan
- Chippewa
- Clare
- Clinton
- Crawford
- Delta
- Dickinson
- Eaton
- Emmet
- Gladwin
- Gogebic
- Grand Traverse
- Gratiot
- Hillsdale
- Houghton
- Huron
- Ingham
- Ionia
- Iosco
- Iron
- Isabella
- Jackson
- Kalkaska
- Leelanau
- Lenawee
- Livingston
- Luce
- Mackinac
- Manistee
- Marquette
- Mecosta
- Menominee
- Midland
- Missaukee
- Monroe
- Montcalm
- Montmorency
- Newaygo
- Oakland
- Ogemaw
- Ontonagon
- Osceola
- Oscoda
- Otsego
- Presque Isle
- Saginaw
- Schoolcraft
- Shiawassee
- Tuscola
- Washtenaw
- Wayne
- Wexford

Diagnostic Criteria

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

- F06 Other mental disorders due to known physiological condition
- F20 Schizophrenia
- F25 Schizoaffective disorders
- F31 Bipolar disorder
- F32 Major depressive disorder, single episode
- F33 Major depressive disorder, recurrent
- F41 Other anxiety disorders
- F43 Reaction to severe stress, and adjustment disorders
- F90 Attention-deficit hyperactivity disorders

BHH Provider Structure



Michigan's BHH Structure

- Team of providers including a Lead Entity (LE) and its designated health home partners (HHPs)
- Comply with the State Plan Amendment, Policy, and Behavioral Health Home Handbook
- Enroll as a HHP with the LE
- Submit valid encounters to the LE for payment for BHH services
- Utilize current Medicaid reimbursement for other services
- Collect and store the signed MDHHS-5515 form (beneficiary consent to share behavioral health/SUD information)
- Meet specific staffing requirements outlined in the handbook, policy, and State Plan Amendment.

BHH Structure and Delivery System

BHH is comprised of a Lead Entity (LE) and their contracted Health Home Partners (HHPs)

- Lead Entity (Prepaid Inpatient Health Plan [PIHP])
 - Managed care entity
 - High-level care coordination
 - Enrollment
 - Payment
- Health Home Partners (HHPs)
 - Community Mental Health Services Programs (CMHSPs)
 - Federally Qualified Health Centers/Primary Safety Net Clinic
 - Rural Health Clinics (RHCs)
 - Tribal Health Centers (THCs)
 - Clinical Practices or Clinical Group Practices
 - Community/Behavioral Health Agencies
- LEs and HHPs must meet robust requirements specified by MDHHS in the federally approved State Plan Amendment, Policy, and Handbook

Lead Entity Key Roles

1. Evaluate, select, and support providers that are HHPs or meet HHP standards
2. Reimburse HHPs for services
3. Enroll, disenroll, and transfer health home beneficiaries
4. Verify MDHHS-5515 consent form and diagnostic criteria
5. Provide overall oversight and administration of BHH
6. Utilize the Waiver Support Application

Please see section 1.5 in the Behavioral Health Home Handbook for a full list of requirements.

Health Home Partner Key Roles

1. Provide six required health home services utilizing interdisciplinary care team
2. Contract or have a Memorandum of Understanding with the LE
3. Identify beneficiary eligibility
 - Obtain consent to share behavioral health information (MDHHS-5515)
 - Verify diagnosis criteria
 - Establish health home care plan
4. Recommend enrollment, disenrollment, and transfers to LE
5. Utilize the Waiver Support Application

Please see section 1.5 in the Behavioral Health Home Handbook for a full list of requirements.

Michigan's BHH Staffing Structure - Handbook Sections 2.5 and 2.6

Must directly provide or contract to provide a multidisciplinary care team comprised of physical and behavioral health providers, including the following staffing structure per 100 beneficiaries:

The Lead Entity

- Health Home Director (.50 FTE)

The Health Home Partners

- Nurse Care Manager (1.00 FTE)
- Behavioral Health Specialist (.25 FTE)
- Peer Support Specialist or Community Health Worker or Medical Assistant (3.00-4.00 FTE)
- Consulting Primary Care Provider (.10 FTE)
- Consulting Psychiatrist/Psychologist (.10 FTE)
- Other Providers or Support Professionals as Required



Health Home Director

- Lead Entity Staff
- 0.50 FTE per 100 enrolled beneficiaries
- Includes one director and relevant administrative staff

Core Responsibilities

- Provides leadership for implementation and coordination of health home activities
- Coordinates all enrollment into the health home on behalf of providers
- Coordinates with LE care management staff and BHH providers to identify a beneficiary's optimal setting of care
- Serves as a liaison between the health homes site and MDHHS staff/contractors
- Monitors Health Home performance and leads quality improvement efforts
- Provides training and technical assistance

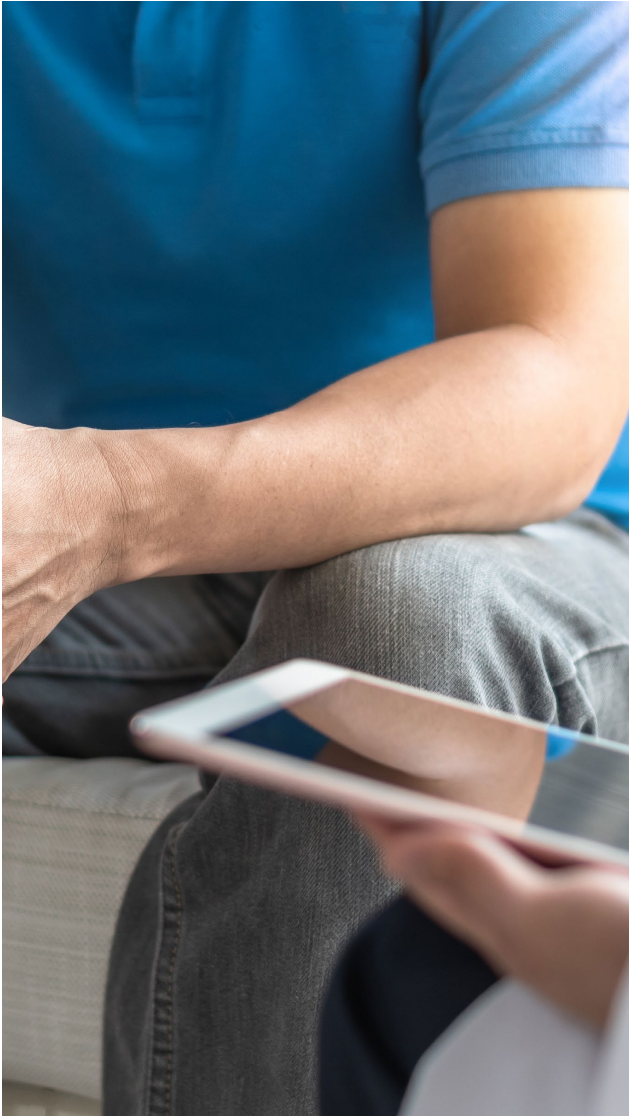


Nurse Care Manager

- Health Home Partner staff
- 1.0 FTE per 100 enrolled beneficiaries
- Licensed registered nurse

Core Responsibilities

- 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



Behavioral Health Specialist

- Health Home Partner staff
- 0.25 FTE per 100 enrolled beneficiaries
- Minimum Bachelor's Degree

Core Responsibilities

- Screens individuals for mental health and substance use disorders
- Refers beneficiaries to a licensed mental health provider and/or SUD therapist as necessary
- Conducts brief interventions
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members
- Supports primary care providers in identifying and behaviorally intervening with patients
- Focuses on managing a population of patients versus specialty care



Peer Support, Community Health Worker, Medical Assistant

- Health Home Partner staff
- 3.00-4.00 FTE per 100 enrolled beneficiaries
- Appropriate certification or training

Core Responsibilities

- 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 patients to utilize and maximize wellness
- 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

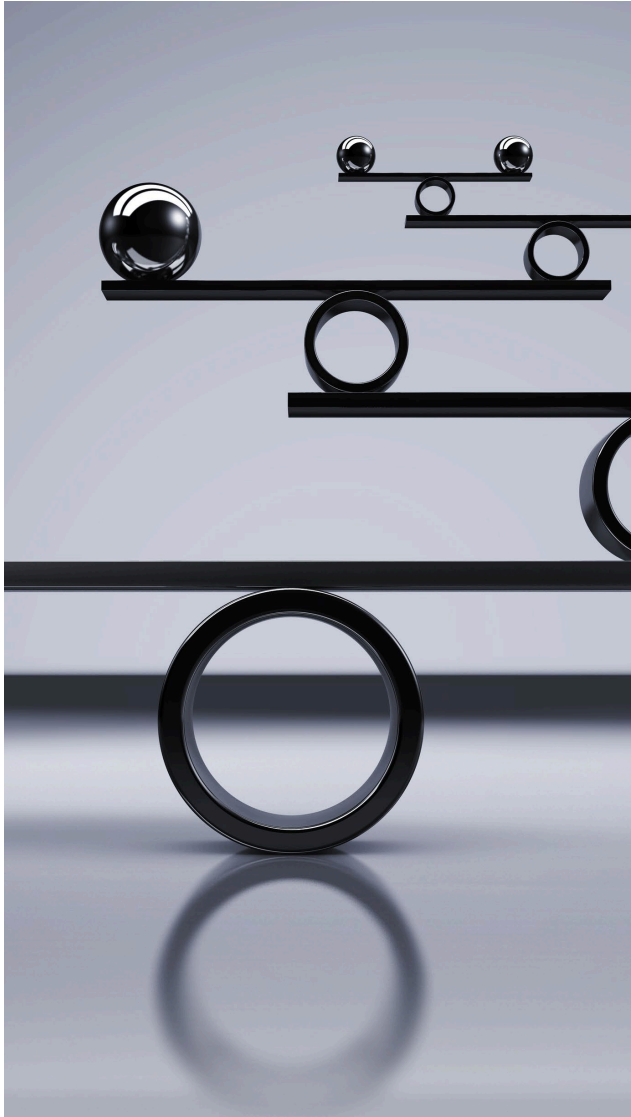


Medical Consultant

- Health Home Partner staff
- 0.1 FTE per 100 enrolled beneficiaries
- Primary care physician, physician assistant, pediatrician, or nurse practitioner

Core Responsibilities

- 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

- Health Home Partner staff
- 0.1 FTE per 100 enrolled beneficiaries
- Psychologist, psychiatrist, psychiatric nurse practitioner

Core Responsibilities

- Communicates treatment methods and expert advice to Behavioral Health Specialist

Health Information Technology

Waiver Support Application

- LE Support for Identifying Potential Beneficiaries
- Enrollment and Disenrollment Management
- Health Home Report Generation
- Shared Document Management between LE and HHP

CareConnect360

- Care Management Web Portal that Provides a Comprehensive View of Individuals in Multiple Health Care Settings Based on Claims Data
- Share Information Across Health Settings - Including Behavioral Health, Physical Health, and Assistance and Support Services

Electronic Health Records and Health Information Exchanges

- Utilize the Same Platform to Optimize Care Coordination (if possible)

File Transfer System

- Send and Receive Confidential Document Securely

Six Required Health Home Services

Health Home Philosophy

- Section 2703 Medicaid Health Homes share a consistent philosophy regardless of how the program manifests:

Whole-Person Care

- Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.
- Using an integrated care team approach will help to achieve the whole-person care philosophy.

Objectives for Whole-Person Care

- Relationships between the patient, the family, and provider must be fostered and supported.
- Emphasis on wellness of the whole person, family, and community including physical, mental, and emotional wellness.
- Locations that are convenient for the patient (minimal stops for service)
- Access is optimized and waiting times are limited
- Working together with the patient as an active partner
- Intentional whole system design to maximize coordination and minimize duplication
- Outcome and process measures to continuously evaluate and improve
- Not complicated but simple and easy to use
- Services are financially sustainable and viable
- Encourage understanding
- Listen with an open mind
- Notice the dignity and value of ourselves and others
- Engage others with compassion
- Share our stories
- Strive to honor and respect ourselves and others

Health Home Services



Comprehensive Care Management

Assessment of each beneficiary, including behavioral and physical health care needs

Assessment of beneficiary readiness to change

Development of behavioral health home care plan

Documentation of assessment and care plan in the Electronic Health Record

Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization

Care Coordination

- 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, care team huddles, tracking 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

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

Comprehensive Transitional Care

- 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

- 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
- Aiding with development of social networks.

Referral to Community and Social Support Services

- 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
- Providing referral tracking and follow-up



BREAK

BHH Enrollment, Disenrollment, and Transfers



The Waiver Support Application

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

MDHHS Michigan Department of Health and Human Services

Home Training Program Admin DBA Reports Print Contact Logout

Search WSA Case Load: This page will search data from WSA application only.

Quick View and Filter

Beneficiary ID Search

Case ID Search

Beneficiary Name

Health Plan

Case Status

Work Queue

PIHP Region

Search Reset

- Enrollment management for Behavioral Health Homes
- HHPs and LEs will have access
- LEs process all enrollments, disenrollment's, and transfers
- LEs can see eligible BHH beneficiaries to assist with outreach
- LE and HHPs will have access to report
- Trainings scheduled for April and May 2023

Michigan's BHH – Enrollment

LE Enrollment

- Identifies potential enrollees
- Coordinates with HHP to fully enroll Medicaid beneficiary
- Enrolls beneficiaries through the Wavier Support Application (WSA)
- Collects Consent to Share Behavioral Health Information for Care Coordination Purposes (MDHHS-5515) and submit through WSA to fully enroll

Provider Recommended Enrollment

- Recommend potential enrollees for the Health Home benefit via the WSA
- Must provide documentation of eligibility, diagnosis, and obtain consent using the MDHHS-5515

Disenrollment

- Medicaid beneficiaries may opt-out at any time
- Beneficiaries who move out of eligible geographic area, are deceased, or are no longer eligible for Medicaid
- Beneficiary is unresponsive

Transfer



Beneficiaries can be transferred from one health home partner to another within the same PIHP region or to one PIHP region to another

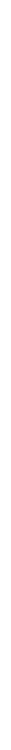


New MDHHS-5515, verification of clinical criteria, and care plan must be completed



Past health home partner will have access to documents and information obtained while beneficiary was enrolled

BHH Care Plan



Overview

Focused on the six required BHH services

Must be developed within 90 days of enrollment

Developed with the beneficiary, beneficiary's support system, and BHH care team

Must integrate physical health, behavioral health, and social support needs

Minimum Requirements

- The tasks to be completed by each BHH team member.
- The tasks to be completed by the beneficiary and the beneficiary's support system (family, caregiver, etc.) when available.
- SMART goals and objectives developed by and agreed upon by the beneficiary, beneficiary's support system, and BHH care team to achieve improved health outcomes. Improved health outcomes are defined with the beneficiary and beneficiary support system.
- 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 behavioral health home care plan progress and update goals.
- Must be updated annually but should be reviewed and revised over time based on the beneficiary's progress and changing needs.



Care Plan and Existing IPOS/Treatment Plan

Can be added to existing IPOS/Treatment

Bill S0280 code when a member of the BHH care team adds health home specific goals and objectives

Must ensure that billing for care plan/treatment plan development and modification is not duplicative

Example Care Team Roles – Care Plan

Behavioral Health Specialist

- Meets regularly with care team to plan care and exchanges information to inform care plan

Nurse care manager

- Initial care plan development
- Strategies to implement care plan goals for clinical and non-clinical needs
- Monitors assessments and screenings to incorporate into care plan

Peer Support Specialist/Peer Recovery Coach, CHW, Medical Assistant

- Provides education and strategies to implement care plan goals

Medical Consultant and Psychiatric Consultant

- Provides information that can be added to the development of the care plan

Payment

Michigan's BHH – Payment

Standard Payments

- MDHHS provides a monthly case rate to the LE based on the number of beneficiaries served during a calendar month
- The LE reimburses the HHPs for delivering the 6 core health home services
 - Straight case rates
 - Value Based Payment
- HHPs also submit Z-codes to indicate social determinants
- MDHHS reconciles payments based on actual services provided

Pay for Performance

- MDHHS to LE
 - MDHHS will issue a performance payment based on defined quality metrics
- LE to HHP
 - LE may employ a value-based payment agreement with their HHPs

Michigan's BHH – Case Rates and P4P

BHH Case Rates from MDHHS to LE

- MDHHS will provide a monthly case rate to the LE based on the number of BHH beneficiaries with at least one BHH service within a given month.

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

LE Payment to HHPs

- The LE will reimburse the Health Home Partner (HHP) for delivering health home services.
- Specific guidelines are outlined in the BHH Handbook.

BHH Pay-for-Performance (P4P)

MDHHS will afford P4P via a 5% performance withhold. The LE must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the with the approved SPA, Policy, and the BHH Handbook.

Performance Measures:

- Measurement Year Only: increase in the number of BHH beneficiaries enrolled per quarter
- Reduction in Ambulatory Care
- Increase in Controlling High Blood Pressure
- Access to Preventative/Ambulatory Health Services
- *The metrics and specifications will be maintained in the BHH Handbook and on the MDHHS website.*

Timelines:

- Measurement year (MY) – first year the BHH SPA is in effect.
- Performance year (PY) – each subsequent fiscal year the SPA is in effect.
- P4P will be distributed within one year of the MY and PY

Michigan's BHH – Encounter Codes

- Payment for BHH services is dependent on the submission of the appropriate encounter codes
- Codes must be submitted by HHPs to the LE within 90 days of providing an BHH service
- S0280
 - Initial services must be delivered in-person unless otherwise specified by state or federal guidelines.
 - All subsequent services may be delivered non-face-to-face by using the TS modifier

Service Description	HCPCS & Revenue Codes	Reporting Code Description from HCPCS and CPT Manuals	Reporting Units/ Duplicate Threshold "DT"	Reporting and Costing Considerations
Health Home-Behavioral Health Home	S0280	S0280-Behavioral Health Home	Monthly Case Rate	Use TS modifier for non-face-to-face encounters after the initial face-to-face encounter.

Health Homes Diagnostic Z- Codes

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

- [Z55](#) Problems related to education and literacy
- [Z56](#) Problems related to employment and unemployment
- [Z57](#) Occupational exposure to risk factors
- [Z59](#) Problems related to housing and economic circumstances
- [Z60](#) Problems related to social environment
- [Z62](#) Problems related to upbringing
- [Z63](#) Other problems related to primary support group, including family circumstances
- [Z64](#) Problems related to certain psychosocial circumstances
- [Z65](#) Problems related to other psychosocial circumstance

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

Michigan's BHH – Payment Schedule

The enrollment file for the month will be sent to CHAMPS on the 26th of the month.

For example:

- Payment for newly enrolled beneficiaries added to BHH from July 1 through July 25.
- Retroactive payment for beneficiaries enrolled from June 26 to June 30.
- Prospective payment for the month of August (for all enrolled beneficiaries, as of July 26)
- Payment will be made on the second pay cycle (the Thursday after the 2nd Wednesday of the month).
- The payment will be included with any other scheduled payments associated with the LE's tax identification number.

Michigan's Health Home – Recoupment

The payment for Health Home services is subject to recoupment from the PIHP if the beneficiary does not receive a health home service during the calendar month.

- The recoupment look back will occur six months after the monthly payment is made.
 - Ex: 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.
 - 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.

Monitoring and Reporting

Federal (CMS) Monitoring and Reporting

Core Utilization Measures (reported annually by MDHHS)

- Admission to a Facility from the Community (AIF-HH)
- Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)
- Inpatient Utilization (IU-HH)

Core Quality Measures (reported annually by MDHHS)

- Colorectal Cancer Screening (COL-HH)
- Controlling High Blood Pressure (CBP-HH)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)
- Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)
- Follow-Up After Hospitalization for Mental Illness (FUH-HH)
- Initiation and Engagement of Substance Use Disorder Treatment (IET-HH)
- Plan All-Cause Readmissions (PCR-HH)
- Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)
- Screening for Depression and Follow-Up Plan (CDF-HH)
- Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)

Resources

Resources

Federal Health Home Website:

- <https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html>

Michigan's Behavioral Health Home Website:

- www.Michigan.gov/bhh

Michigan's Behavioral Health Home Handbook

Microsoft Teams

Behavioral Health Home Team Contacts

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