Behavioral Health Home (BHH) Michigan Handbook

Version 3.0

Michigan Department of Health and Human Services
Health Services Administration

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The purpose of this Handbook is to provide Medicaid policy and billing guidance to providers participating in Michigan's BHH program.

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

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Preface

The Michigan Department of Health & Human Services (MDHHS) created the Behavioral Health Home (BHH) Handbook to provide Medicaid policy and billing guidance to providers participating in Michigan's BHH program – an optional service authorized under the Michigan Medicaid State Plan Amendment (SPA). This Handbook provides detailed instructions to help providers complete and submit the documentation required for policy and billing compliance. Where applicable, the handbook also provides links to additional resources and guidance.

MDHHS requires all providers participating in the BHH program to be familiar with all Medicaid policies and procedures prior to rendering services to beneficiaries. This includes policies and procedures currently in effect, as well as any future updates or revisions.

While MDHHS makes every effort to keep the document current, the information contained within is subject to change. All current and future policies and procedures will be maintained on the MDHHS BHH website.

The BHH Handbook will be maintained on the website: www.michigan.gov/bhh

Section I: Introduction to the Health Home Service Model

1.1 Overview of Behavioral Health Home (BHH)

The Michigan Department of Health & Human Services (MDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) to amend the current BHH State Plan to optimize and expand the BHH in select Michigan counties. The BHH provides comprehensive care management and coordination services to Medicaid beneficiaries with a qualifying serious mental illness/serious emotional disturbance (SMI/SED) diagnosis. For enrolled beneficiaries, the BHH functions as the central point of contact for directing person-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop a person-centered BHH care plan (also known as a care plan throughout this document) to best manage their care. The model elevates the roles of Peer Support Specialists and Community Health Workers (CHWs) to strengthen engagement, promote empathy, and support whole-person health and wellness by addressing both health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

Michigan has three goals for the BHH program:

1) improve care management of beneficiaries with SMI/SED;

2) improve care coordination between physical and behavioral health care services;

3) improve care transitions between primary, specialty, and inpatient settings of care.

Michigan's BHH model is team-based and includes a Lead Entity (LE) and designated Health Home Partners (HHPs). Providers must meet the qualifications outlined in the State Plan Amendment (SPA) and this Handbook and deliver the six federally required core Health Home services. BHHs are also expected to coordinate with community-based providers to manage the full range of beneficiary needs.

MDHHS provides the LE with a monthly case rate based on the number of enrolled beneficiaries. HHPs must contract with or establish a memorandum of understanding (MOU) with a LE to be designated a HHP and receive payment. The LE will reimburse the HHP for the delivery of Health Home services. MDHHS will also implement a pay-for-performance (P4P) incentive that rewards providers based on outcomes. MDHHS will claim federal matching funds for P4P payments only after performance requirements are met and providers are paid.

1.2 BHH Population Criteria

Eligible beneficiaries meeting geographic area requirements cited in Section 2.1 include those enrolled in Medicaid, the Healthy Michigan Plan, MIChild, Freedom to Work, Full Fee-for-Service Medicaid, and Full Fee-for-Service Healthy Kids - Expansion who have a select SMI/SED diagnosis.

Individuals enrolled in BHH services remain eligible for all Medicaid-covered services. BHH services were designed to help beneficiaries access medically necessary care. However, payment for duplicative services in the same calendar month is prohibited. The Health Home team must select the available Medicaid-covered service that best meets the person's needs.

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

Additional enrollment, eligibility verification, and billing limitations related to BHH participation are described in Section III: Beneficiary Enrollment, Transfers, and Disenrollment.

1.3 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
F91	Conduct Disorders
F98	Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence

1.4 BHH Services

BHH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions.

BHH must provide the following **six core services**, linked as appropriate by health information technology (HIT):

Comprehensive Care Management, including but not limited to:

- Assessment of beneficiary, including behavioral and physical health care needs;
- Assessment of beneficiary readiness to change;
- Development of the BHH care plan (see Section 3.3);
- Documentation of assessment and care plan in the Electronic Health Record (EHR);
- Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.

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;
- 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 the BHH 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)
- Connection of beneficiary to resources (e.g., smoking cessation, SUD treatment, nutritional counseling, 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.);

- Connection of beneficiary to resources (e.g., smoking cessation, SUD treatment, nutritional counseling, disease-specific education, etc.);
- Promoting healthy lifestyle interventions;
- Encouraging routine preventative care, such as immunizations;
- Assessing the patient and family's understanding of the health condition and motivation to engage in self-management; and
- Using evidence-based practices to engage and help patients 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 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., CHWs, 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 the beneficiary's level of functioning; and
- Providing assistance with the development of social networks.

Referral to Community and Social Support Services*,* including but not limited to:

- Providing beneficiaries with referrals to support services;
- Collaborating with community-based organizations and stakeholders;
- Emphasizing resources closest to the beneficiary's home;
- Emphasizing resources that 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.

1.5 Health Home Partner (HHP) Qualification Criteria

Eligible BHH providers must meet all applicable state and federal licensing requirements, including specifications set forth in this Handbook. Additionally, eligible providers will sign the MDHHS-5745 (Health Home Provider Application), attesting that they meet the requirements set forth in MSA Policy 20-48, the SPA, and other applicable MDHHS policies and procedures. HHPs must establish a contract or MOU with the LE.

1.5a. Geographic Area

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

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

1.5b. Provider Types

The LE is responsible for providing BHH services in partnership with community-based HHPs. The LEs currently contract with the State of Michigan for Medicaid services. HHPs are permitted to recommend prospective BHH beneficiaries for enrollment into the BHH via the LE. BHH providers must provide documentation indicating whether a prospective BHH beneficiary meets all eligibility requirements for the benefit, including diagnostic verification, obtaining consent (MDHHS-5515), and establishing the BHH care plan. The LE must review and process all recommended enrollments in the Waiver Support Application (WSA).

BHH Lead Entity (LE)

- Be a regional entity as defined in Michigan's Mental Health Code (330.1204b),
- Must contract or develop a MOU with HHPs and pay negotiated rate (the scope of work established with the HHPs shall be defined by the HHP requirements set forth in the BHH handbook, SPA, and BHH Policy),
- Must maintain a network of providers that support the BHH to service beneficiaries with a SMI/SED,
- Have authority to access Michigan Medicaid claims and encounter data for the BHH target population,
- Have authority to access Michigan's WSA and CareConnect360,
- Provides leadership for the implementation and coordination of BHH activities,
- Serves as a liaison between the HHPs and MDHHS staff/contractors,
- Champions practice transformation based on Health Home principles,
- 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 BHH performance and leads quality improvement efforts,
- Designs and develops prevention and wellness initiatives, and referral tracking,
- 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 HHP in care coordination,
    - Collecting and sharing member-level information regarding health care utilization and medications,
    - Providing quality outcome protocols to assess HHP effectiveness, and
    - Developing training and technical assistance activities that support HHPs in the effective delivery of BHH services.

Health Home Partners (HHPs)

Must contract or establish MOUs with a LE to deliver BHH services. Additionally, HHPs must enroll in or be enrolled in Michigan Medicaid and agree to comply with all Michigan Medicaid program requirements. Examples of HHPs include the following:

- Community/Behavioral Health Agency
- Clinical Practice or Clinical Group Practice
- Community Mental Health Services Program (CMHSP)
- Federally Qualified Health Center (FQHC)/Primary Care Safety Net Clinic
- Rural Health Center
- Tribal Health Center

1.5c Minimum Standards

MDHHS's minimum requirements and expectations for BHH providers are:

BHH Lead Entity (LE) must:

- Be a **regional entity** defined in Michigan's Mental Health Code (330.1204b),
- Have authority to access Michigan Medicaid **claims and encounter data** for the BHH target population,
- 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 the effective delivery of BHH service,
- Must **maintain a network of providers that support the HHPs** to service beneficiaries with a serious mental illness and serious emotional disturbance,
- Must **reimburse HHPs** for providing BHH services,
- The **LE must be contracted with MDHHS** to execute the enrollment, payment, and administration of the BHH with providers; MDHHS retains overall oversight and direct administration of the LE.
- The LE also serves as part of the Health Home team, **providing care management and coordination services**.

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

- HHPs must be **enrolled in the Michigan Medicaid program** and in compliance with all applicable program policies.
- HHPs must **enroll and execute any necessary agreement(s)/**contract(s) with the LE; HHPs must also **sign the MDHHS-5745** with MDHHS.

- HHPs must **adhere to all federal and state laws** regarding Section 2703 of the Affordable Care Act recognition/certification, including the capacity to perform all core services specified by CMS:

  Attain accreditation from a national recognizing body specific to a Health Home, Patient-Centered Medical Home (PCMH), or integrated care (e.g., NCQA, AAAHC, Joint Commission, CARF, etc.). The LE/HHP may be pursuing such accreditation at the time of BHH implementation,

  OR

  In the absence of specific accreditation from a national recognition body (Health Home, PCMH, or integrated care, etc.), the LE must **verify that a HHP meets the standards** required to provide Health Home services, consistent with those required for accreditation. The LE must establish and use a template for HHPs that aligns with the BHH Partner Standards Document, the BHH Handbook, the SPA, and the BHH Policy. *MDHHS reserves the right to review all templates created by the LE.*

- Provide **24-hour, seven-day-a-week availability of information and emergency** consultation services to beneficiaries,
- Ensure access to timely services for enrollees, including **seeing enrollees within seven days and 30 days of discharge** from an acute care or psychiatric inpatient stay,
- Ensure **person-centered and integrated care** planning that coordinates and integrates all clinical and non-clinical health care-related needs and services,
- Provide quality-driven, cost-effective Health Home services in a **culturally competent manner** that addresses health inequities and improves health literacy,
- **Utilize the MDHHS-5515** Consent to Share Behavioral Health and SUD
- Demonstrate the ability to **perform each of the following** functional requirements. This *includes documentation* of the processes and methods used to execute these functions.
  - Coordinate and provide the **core services in Section 2703**
  - Coordinate and provide access to high-quality health care services **informed by evidence-based clinical practice** guidelines
  - Coordinate and provide access to **preventive and health promotion** services, including the prevention of mental illness
  - Coordinate and provide access to physical and mental health, as well as chronic disease management, including self- management support to individuals and their families
  - Demonstrate a **capacity to use HIT** to link services, facilitate

communication among team members, and between the health team and individual and family caregivers
- 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

- Demonstrate the ability to **report required data** for both state and federal monitoring of the program.

Conflict of Interest (COI)

The section requirements are intended to mitigate COIs that may occur when a LE also serves as a HHP.

Staffing

- The LE staff must be separate and distinct from HHP staff. LE staff should not serve as part of the Health Home care team or in a supervisory role over any HHP staff.
- The LE staff must oversee HHP as described under Minimum Standards in this section. LEs cannot delegate Health Home oversight responsibilities to a CMHSP.

Guardrails for Referrals and Assignment to HHPs

If a LE is referring a beneficiary to a HHP, the LE must determine which HHP is best positioned to serve the beneficiary according to the following factors:

- **Choice:** If the individual served has expressed a choice/preference for a specific HHP, the LE must honor that choice to the maximum extent possible.
- **Existing Provider Relationship:** The LE must consider whether the beneficiary has an existing relationship with a HHP and give preference to that provider when making a referral unless there is a specific reason not to do so.
- **Geographic Location:** The LE must consider the individual's geographic location to ensure reasonable accessibility to the HHP.
- **Capacity:** The LE must ensure they refer/assign individuals to HHPs that have the capacity to serve new individuals in a timely manner.

Section II: Provider Requirements for Participation

2.1 BHH General Provider Requirements

The LEs must adhere to the BHH contractual and policy requirements with MDHHS. HHPs must meet the requirements indicated in the Health Home Provider Application with MDHHS and the LE requirements. The LEs and HHPs must adhere to the requirements of the SPA, all Medicaid statutes, policies, procedures, rules, and regulations, and the BHH Handbook.

2.2 Enrollment

All HHPs must be properly paneled with the LE through contract or MOU, conveying a mutual partnership to execute BHH services. Moreover, all HHPs must sign and attest to the requirements set forth in the Health Home Provider Application (MDHHS-5745).

BHH Service Model Delivered Without Health Home Billing

Organizations participating in the CCBHC demonstration may choose to operationalize care coordination, population health management, and whole-person care practices aligned with Michigan's BHH model without billing Health Home S-codes, if the provider has built these activities into the CCBHC PPS.

In these circumstances:

- The provider is not considered an enrolled Medicaid Health Home provider for purposes of PMPM payment, attribution, or federal Health Home reporting.
- The delivery of BHH-like services under the CCBHC PPS is treated as part of the CCBHC service array and not as a duplicative Medicaid benefit.

MDHHS will not recognize these providers as Medicaid Health Home participants unless they maintain an active HHP designation and billing.

2.3 Disenrollment

To promote continuity of care and the patient-provider relationship, MDHHS expects HHPs to establish and maintain lasting relationships with enrolled beneficiaries.

A HHP that elects to discontinue participation in the BHH program must submit written notice to the LE and MDHHS at least six months prior to the intended termination date. The notification must include a cessation plan that outlines procedures for beneficiaries' transition and continuity of services. The HHP remains responsible for all Health Home program requirements, including delivery of required services, through the MDHHS-approved termination date. MDHHS will review and approve cessation plans to ensure:

- Clear communication with beneficiaries and partnering agencies regarding the transition;
- Continued access to required Health Home services during the transition period;

- Timely reassignment of beneficiaries to another qualified HHP or appropriate Medicaid service structure; and
- Compliance with all Health Home program requirements through the effective termination date.

2.4 Termination

Failure to comply with the terms of the BHH Policy and applicable program requirements may result in corrective or disciplinary action, including placement on probation and, up to and including, termination as a HHP.

MDHHS may terminate a HHPs participation when the provider no longer meets program requirements, including but not limited to:

- Failure to deliver one or more of the required Health Home services;
- Inability to maintain required staffing or care coordination capacity;
- Failure to maintain required HIT infrastructure to support BHH operations;
- Improper billing, false claims, or other program integrity violations; and
- Loss of Medicaid provider enrollment status

2.5 Provider Infrastructure

HHPs, through the LE, ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. Each service setting, LE and HHP, has its own unique set of requirements commensurate with the scope of its operations to reflect beneficiary needs. The staffing structure below is based on 100 consumers enrolled in the Health Home.

Although the staffing structure is expected to be in place for 100 beneficiaries, it does not need to be in place before enrolling 100 beneficiaries. This also means that each staff member's FTE need not be dedicated solely to BHH. Contingent upon MDHHS exceptions, specific minimum requirements for each setting are as follows:

Lead Entities (per 100 beneficiaries)

- Health Home Director (0.25 FTE)
- One director and related administrative staff

Health Home Partners (per 100 beneficiaries*)*

- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SOAR Navigator, Housing Specialist (3.00-5.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.10 FTE)

2.6 Requirements and Expectations

The responsibilities outlined below are intended to provide general guidance regarding the expected functions of the roles described. This list is not exhaustive and does not limit, supersede, or replace other applicable program requirements.

Any provider type can be assigned the “lead” based on their patient-centered plan.

Health Home Director (Lead Entity Professional)

- Provides leadership for the implementation and coordination of 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,
- Coordinates and utilizes HIT with the BHH provider team to maximize care coordination and care management,
- Serves as a liaison between the HHPs and MDHHS staff/contractors,
- Champions practice transformation based on Health Home principles,
- Develops and maintains working relationships with primary and specialty care providers, including CMHSPs 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,
- Provides training and technical assistance, and
- Provides data management and reporting.

Behavioral Health Specialist

An individual who has a minimum of a bachelor’s degree from an accredited four-year institution of higher learning, with specialization in behavioral health, behavioral sciences, counseling, human development, mental health and human services, psychology, social work, sociology, special education, nursing, or a closely related field; OR has a bachelor’s degree from an accredited four-year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience.

- Screens beneficiaries for mental health and SUD, and SDOH that may contribute to disease and/or present as barriers to self-management,
- Refers beneficiaries to a mental health provider and/or SUD therapist as necessary,
- Conducts brief intervention for beneficiaries with behavioral health problems,
- Supports primary care providers in identifying and intervening with patients,
- Focuses on population health management versus specialty care,
- Works with beneficiaries to identify chronic behaviors, discuss their impact, and develop improvement strategies and specific, goal-directed interventions.
- Develops and maintains relationships with community-based mental health and SUD providers,
- Provides patient education,

- Coordinates and provides access to individual and family supports, including referral to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Nurse Care Manager

A licensed registered nurse (RN) or licensed practical nurse (LPN). LPNs must meet the following requirements to fill this role: Minimum of one year experience in a managed care setting preferred, and a minimum of three to five years of medical nursing, surgical nursing, and/or nursing in the acute care setting. LPNs can perform all functions of the role, including administering assessments and participating in initial care plan development; however, a portion of the Nurse Care Manager FTE must be designated to hire an RN. The RN case manager will be responsible for the ongoing review of all assessments and care plans, coordination for complex patients, and providing high-level education as needed.

- Participates in the selection of strategies to implement evidence-based wellness and prevention initiatives, and initial care plan development, including goals,
- Communicates with medical providers, subspecialty providers, including mental health and substance use service providers, long-term care, and hospitals regarding records, including admission/discharge,
- Provides education in health conditions, treatment recommendations, medications, and strategies for care plan goals, including both clinical and non-clinical needs.
- Monitors assessments and screenings to ensure integration in the care plan,
- Facilitates the use of the EHR and other Health HIT to link services, facilitate communication among team members, and provide feedback.
- Monitors and reports performance measures and outcomes, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Peer Support Specialist, Peer Recovery Coach, Community Health Worker, Medical Assistant

- Conducts referral tracking,
- Screens beneficiaries for SDOH that may contribute to disease and/or present as barriers to self-management,
- Coordinates and provides access to chronic disease management,
- 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.
- Accompanies beneficiaries to appointments and support groups,
- Coordinates and provides access to individual and family supports, including referral to community social supports, and

- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Youth Peer Support Specialist

- Supports youth/young adults to identify personal barriers or challenges,
- Encourages increased engagement in services, if identified by the youth/young adult,
- Empowers youth/young adults to identify and connect with additional community supports and resources upon request.
- Supports and empowers youth/young adults to advocate for their needs and goals,
- Collaborates with the agency and care team to ensure information is accessible, youth-friendly, and understandable, and
- Promotes Family-Driven, Youth-Guided planning and goal setting throughout the care planning process.

Parent Support Partner

- Supports the parent/caregiver to identify barriers to participation or progress,
- Encourages increased engagement in services, as identified by the parent/caregiver,
- Empowers families to identify and access additional community supports and resources when this support is requested by parents/ caregivers,
- Supports parents/caregivers to advocate effectively for their family's needs,
- Collaborates with the agency and care team to ensure information is accessible, family-friendly, and understandable,
- Promotes Family-Driven and Youth-Guided planning and goal setting throughout the care planning process, and
- Assists in the development of social networks and community connections, when desired by the parent/caregiver.

SOAR Navigator

SOAR is designed to increase access to SSDI/SSI for eligible adults and children experiencing or at risk of homelessness AND have a SMI, medical impairment, and/or co-occurring SUD.

- Interviews beneficiaries to collect information for completing SSI/SSDI applications,
- Collects medical records and additional information to complete applications,
- Prepares SOAR medical summaries for SSI/SSDI applications,
- Accompanies beneficiaries to appointments at the Social Security Administration,
- Coordinates appointments with medical doctors, psychiatrists, and other specialists to obtain evidence for SSI/SSDI applications,
- Coordinates and provides access to individual and family supports, including referrals to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Housing Specialist

- Respond to housing crises by providing immediate support and intervention strategies to stabilize beneficiaries' situations,
- Utilizes a strength-based case management approach to assess housing needs and identify and leverage strengths, resources, and support in pursuit of stable housing.
- Collaborates with beneficiaries to develop personalized housing goals and objectives,
- Assists beneficiaries in identifying and securing appropriate housing options.
- Provides information and training to beneficiaries on tenants' rights, budgeting, and maintaining housing,
- Regularly monitors beneficiaries' progress towards their housing goals and provides ongoing support,
- Conducts follow-up visits to ensure beneficiaries maintain housing stability,
- Builds and maintains relationships with landlords, property managers, and community organizations to expand housing options for beneficiaries,
- Coordinates and provides access to individual and family supports, including referrals to community social supports, and
- Meets regularly with the care team to plan care and discuss cases, and exchanges appropriate information with team members in an informal manner as part of the daily routine of the clinic.

Psychiatric Consultant

The care team must have access to a licensed mental health professional (e.g., psychologist, psychiatrist, psychiatric nurse practitioner) who provides psychotherapy consultation and treatment plan development.

This provider is responsible for communicating treatment methods and expert advice to the Behavioral Health Specialist (who is part of the care team). It is the responsibility of the Behavioral Health Specialist (and/or other members of the care team as assigned) to develop the licensed mental health provider's treatment into the patient care plan.

Medical Consultant

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

Other

In addition, BHH providers should coordinate care, as appropriate, with other health care and community-based partners. Examples include, but are not limited to:

- Dentists
- Dietician/Nutritionists
- Pharmacists
- Diabetes educators
- School personnel
- Others as appropriate

2.7 Training and Technical Assistance

MDHHS requires HHPs to actively participate in state- and LE-sponsored training and technical assistance (TA) activities and imposes additional functional provider requirements to optimize care management, coordination, and behavioral health integration. Requirements are:

Training, Technical Assistance, and Program Participation

- Participate in state and LE-sponsored activities designed to support HHP in transforming service delivery. This includes a mandatory BHH orientation for providers and clinical support staff before the program is implemented,
- Participate in ongoing TA (including but not limited to trainings and webinars),
- Participate in ongoing individual assistance (including but not limited to audits, site visits, trainings, provided by MDHHS or contractual staff),
- Support Health Home team participation in all related activities and trainings, including coverage of travel costs associated with attending Health Home activities.
- Work collaboratively with MDHHS and contractors to adopt program processes for the Health Home care team to use at participating sites.
- Engage in Health Home process and outcome achievement activities, including ongoing coaching, data feedback, and customized improvement plans to meet initiative goals.

Care Team Structure and Relationships

- Provide each beneficiary, at a minimum, with access to a care team comprised of the providers mentioned in Section 2.6.
- Ensure each patient has an ongoing relationship with a personal member of their care team who is trained to provide first contact and to support continuous, comprehensive care, with the patient and care team recognizing each other as partners.
- 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.

Integrated, Whole-Person Care Delivery

- Embed behavioral health care services into primary health care services, as applicable, with real-time behavioral health consultation available to each primary care provider.
- Provide behavioral and physical health care to beneficiaries using a whole-person orientation and with an emphasis on quality and safety,
- Provide care or arrange for other qualified professionals to provide care. This includes, but is not limited to, care at all stages of life, acute care, chronic care, preventive services, long-term care, and end-of-life care.
- Coordinate and integrate each beneficiary's behavioral health care,
- Develop a person-centered care plan for each beneficiary that coordinates and integrates all clinical and non-clinical health care-related needs and services.

Required Service Capacity

HHPs must directly provide or contract to provide:

- Mental health and SUD 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).

Access, Engagement, and Communication

- Communicate with each beneficiary (and authorized representative(s), family, and caregivers) in a culturally and linguistically appropriate manner,
- Provide each beneficiary with 24/7 access to the care team, including a telephone triage system with after-hours scheduling to avoid unnecessary emergency room visits and hospitalizations.
- Enhance beneficiary access to behavioral and physical health care,
- Monitor access outcomes, including but not limited to same-day scheduling availability,
- Implement policies and procedures to operate with open access scheduling and available same-day appointments,
- Use technology effectively for patient communication.

Care Coordination and Transitions

- Conduct Health Home outreach to local health systems,
- Provide comprehensive transitional care from inpatient to other settings, including appropriate follow-up,
- Review and reconcile beneficiary medications,
- Maintain a reliable system, including written standards/protocols, for tracking patient referrals.

Screening, Assessment, and Prevention

- Perform assessment of each beneficiary's social, educational, housing, transportation, and vocational needs contributing to disease and/or present barriers
- Implement evidence-based screening tools such as SBIRT, PHQ9, GAD, diabetes, and asthma risk tests to assess treatment needs,
- Monitor, arrange, and evaluate appropriate evidence-based and/or evidence-informed preventive services and health promotion.

Health Information Technology (HIT) and Data

- Use HIT, including but not limited to an EHR capable of integrating behavioral and physical health care information,
- Use HIT to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to providers.

- Demonstrate use of clinical decision support within the practice workflow specific to the conditions identified in the Health Home project.
- Demonstrate use of a population management tool such as a patient registry and the ability to evaluate results and implement interventions that improve outcomes,
- Possess the capacity to electronically report to MDHHS and/or its contracted affiliates information regarding service provision and outcome measures.

Quality, Privacy, and Compliance

- 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.
- Adhere to all applicable privacy, consent, and data security statutes,
- 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, Transfers, and Disenrollment

3.1 Beneficiary Identification and Assignment

Enrollment Process

Potential BHH enrollees are identified using a multifaceted approach.

- MDHHS provides a generated list that pulls potential enrollees from administrative claims data into the WSA monthly.
- The LE will identify potential enrollees from the WSA and coordinate with a HHP to fully enroll the Medicaid beneficiary into the BHH benefit.
- The LEs provide information about the BHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings.
- The LEs strategically provide these settings with informational brochures, posters, and other outreach materials for awareness and drive engagement with the BHH.
- A care plan can be established 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.

Lead Entity Identification of Potential Enrollees

The LE is responsible for identifying potential enrollees with a qualifying BHH diagnosis in the WSA and referring them to a prospective HHP, and for providing information regarding BHH services to the Medicaid beneficiary, in coordination with the HHP.

Provider-Recommended Identification of Potential Enrollees

HHPs are permitted to recommend potential enrollees for the BHH benefit through the WSA. BHH providers must provide documentation indicating whether a potential BHH enrollee meets all eligibility requirements for the Health Home benefit, including diagnostic verification, consent, and the establishment of a care plan. The LE must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

While identifying potential enrollees is automatic, full enrollment into the BHH benefit plan is contingent upon completion of the following:

- 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 in which the potential Health Home enrollee is most likely to succeed. 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 enrollment.

Billing Limitations

LEs are responsible for verifying beneficiary eligibility in CHAMPS prior to submitting encounters. The following restrictions apply to beneficiaries enrolled in the BHH benefit:

- Beneficiaries may not be concurrently enrolled in BHH and Substance Use Disorder Health Home (SUD HH) or Health Home MI Care Team (HHMICare).
- BHH services may not be billed while a beneficiary is: **incarcerated**, residing in a **nursing facility**, or during a Medicaid **spend-down period**.
- For beneficiaries enrolled in BHH who are receiving **hospice services,** BHH services may not be billed on the same date of service as hospice services.

3.2 Screening for Social Determinants of Health (SDOH)

Upon enrollment, beneficiaries must be screened for SDOH.

- Screening must be repeated at least annually and more frequently as indicated by beneficiary needs or changes in circumstances.
- HHP staff who administer SDOH screenings must complete motivational interviewing training at least every two years.
- Identified SDOH needs should be documented and addressed within the care plan.

ICD-10 Z-codes must be submitted, as applicable, for each BHH encounter related to identified SDOH needs and documented care plan activities. The LE is responsible for reviewing HHP's screening tool to ensure that questions address, at a minimum, the following domains:

- Housing stability
- Food security
- Transportation access
- Utility needs
- Interpersonal safety

Examples of validated SDOH screening tools:
WellRx Questionnaire
American Academy of Family Physicians (AAFP) Screening Tool
Accountable Health Communities Health Related Social Needs Screening Tool
Protocol for Responding to and Assessing Patients' Risks and Experience Tool (PRAPARE)

3.3 Care Plan Requirements

Within 30 days of enrollment, the BHH care team must work with the beneficiary to develop and complete a BHH care plan.

- The BHH care plan must align with the six required services (listed in Section 1.4) and serve as a guide for care and support services.
- The care plan must integrate the beneficiary's physical, behavioral, and social support needs.
- The care plan must be updated annually and reviewed and revised over

time based on the beneficiary's progress and changing needs.

- The care plan must be developed with the BHH care team, the beneficiary, and the beneficiary's support system (family, caregiver, etc.).
- It is best practice that all parties agree to and sign off on the care plan before it is implemented.
- Crisis needs should be assessed monthly, and crisis response plans should be added as necessary.

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

- Defined roles and responsibilities for each BHH team member.
- Identified actions and responsibilities for the beneficiary and, when available, the beneficiary's support system (family, caregiver, etc.).
- SMART goals and objectives (specific, measurable, achievable, realistic, and time-bound) developed collaboratively by the beneficiary, beneficiary's support system (when applicable), and the BHH care team to support improved health outcomes, as defined in partnership with the beneficiary and their support system.
- Alignment with the six required Health Home core services.
- Integration of physical health, behavioral health, and social support needs in a coordinated and person-centered manner.
- A process for monitoring progress and updating the care plan, including review of goals and interventions at least annually and more frequently as warranted by changes in beneficiary needs or circumstances.

3.3a. Care Plan and Existing IPOS/Treatment Plan

HHPs should bill the S0280 for development of the BHH care plan and related activities. The BHH care plan goals and objectives can also be added to an existing Individualized Plan of Service/Treatment Plan (IPOS) developed for a Medicaid beneficiary. In this scenario, HHPs can bill the S0280 code when a member of the BHH care team adds Health Home-specific goals and objectives to an existing plan. HHPs and LEs must ensure that billing for care plan/treatment plan development and/or modification is not duplicative (see Section 1.2).

3.4 Targeted Case Management

For beneficiaries enrolled in BHH and Targeted Case Management (TCM), special consideration is required to avoid duplicative billing within a calendar month. The activities listed below identify areas of service overlap between BHH and TCM.

HHPs and LEs may bill for BHH and TCM in the same calendar month; however, the activities identified below must not be billed by both programs during the same month. For these activities, the HHP and/or LE must determine whether services will be billed under BHH or TCM.

Comprehensive Care Management

- Outreach and engagement activities to gather information from the beneficiary, beneficiary's support member(s), and other primary and specialty care providers
- Completion of a comprehensive needs assessment
- Development of a comprehensive person-centered care plan

Care Coordination

- Monitoring progress towards goals identified in the care plan through face-to-face and collateral contacts with the beneficiary, beneficiary's support member(s), and primary and specialty care providers
- Participation in hospital discharge processes to support the beneficiary's transition to a non-hospital setting
- Communication and consultation with the beneficiary, the beneficiary's support member(s), and other providers as appropriate

Referrals to Community and Social Support Services

- Referral and information assistance to support the beneficiary in accessing community-based resources and social support services
- Identification of resources to reduce barriers and support the beneficiary in achieving their highest level of function and independence.
- Monitoring and follow-up with the beneficiary, the beneficiary's support member(s), and referral sources to ensure appointments and other activities, including employment and social/community integration, are established, and the beneficiary is engaged in services.

3.5 Coordination with MI Coordinated Health (MICH) HIDE D-SNPs

When a beneficiary is enrolled in both BHH and a MICH HIDE D-SNP, the BHH care team will collaborate with the MICH HIDE D-SNP to support coordination of services and alignment of care management activities in a timely and non-duplicative manner. Coordination will reflect each benefit plan's respective authority and scope. Ultimately, it is up to the provider and the plan to assess and determine whether there is service duplication. The BHH care team remains responsible for developing and maintaining the BHH care plan and completing health assessments in accordance with BHH program requirements.

3.6 Beneficiary Consent

Beneficiaries must provide BHH providers a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form (MDHHS-5515) to receive the BHH benefit. The MDHHS-5515 must be collected and stored in the beneficiary's health record with attestation in the WSA. The form should also be available at the designated HHP's 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.

3.7 Beneficiary Transfer Process

A beneficiary who is enrolled in the BHH can be transferred to another HHP via the WSA within the same PIHP region or to a different PIHP region. HHPs may recommend a transfer to the LE via the WSA. Detailed information on the process is available in the WSA under the Training tab.

The transfer recommendation will automatically be moved to the PIHP work queue as an "Enrolled (Transfer Recommended)" case status. The LE will review the HHP transfer recommendation and approve, send back for additional information, or deny the transfer. LE's can also initiate a transfer without receiving a HHP recommendation.

The "new" LE region will receive the transfer request and either approve it, send it back for additional information, or deny it. If the transfer is denied, the beneficiary will remain in "Enrolled" status. The existing HHP/LE will discuss next steps and, if the individual is no longer receiving services, possibly disenroll them from the BHH.

A **new** MDHHS-5515 must be obtained to complete a transfer to a new HHP. In addition, the new HHP care team must **develop a new care plan**. After the transfer is complete, the previous HHP will have access to the information obtained while the beneficiary was enrolled in their service. This includes the following information, which is stored within the WSA:

- Documents
  - Care Plan
  - Consent to Share Behavioral Health Information
- Enrollment History
- Transfer History

3.8 Beneficiary Disenrollment

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

3.9 Disenrollment Process

Lead Entity Disenrollment

The LE is responsible for disenrolling all BHH beneficiaries in WSA. Prior to disenrollment, the LE must verify the reason for disenrollment by reviewing both CHAMPS and WSA. Once the LE confirms that a beneficiary should be disenrolled from the BHH, they must complete the process in WSA. The disenrollment date should be the beneficiary's last date of BHH service. Upon disenrollment, the case is closed and may no longer be edited.

Provider-Recommended Disenrollment

HHPs may recommend beneficiary disenrollment through 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 disenrollments in the WSA. MDHHS reserves the right to review and verify all disenrollments from BHH. More information on the disenrollment process is available in the WSA HHBH User Training Manual.

Beneficiaries enrolled in the BHH can be disenrolled for the following reasons, as listed in the WSA:

- Loss of Medicaid eligibility
- Moved out of the eligible geographic region
- Deceased
- No longer in the required benefit plan or enrolled in an excluded benefit plan
- Unresponsive
- Voluntarily Optout
- Administrative removal
- Completion of BHH Services

Beneficiaries who are involuntarily disenrolled from the Health Home may appeal the 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 here.

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

- Beneficiaries who have **relocated** 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 in accordance with the standard MI Bridges protocol. Providers will receive updated files accordingly.

- Beneficiaries who are unresponsive for **reasons other than relocation or death**.
    - The LE or HHP must document at least three unsuccessful contact attempts within three consecutive months for MDHHS to deem a beneficiary unresponsive.
    - During this time, the beneficiary must remain enrolled in BHH. Once a beneficiary is deemed unresponsive, the LE can disenroll the beneficiary from the BHH.
    - The LE and MDHHS must maintain a list of disenrolled beneficiaries. Following disenrollment, the LE must attempt to re-establish contact with the beneficiary at least every six months for up to one year, or until eligibility changes to make the beneficiary ineligible for services.

Note: The LE may delegate re-engagement efforts to the HHP when the HHP has an existing relationship with the beneficiary. The HHP must document all contact attempts and submit the documentation to the LE.

3.10 Beneficiary Changing BHH Providers

While the beneficiary's care plan will be utilized to determine the appropriate setting and BHH provider of care, beneficiaries will have the ability to change BHH providers to the extent feasible within the LE's designated BHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen BHH provider. However, if a beneficiary decides to change BHH providers, they should notify their current BHH provider immediately.

The current and future BHH providers must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should take effect on the first day of the next month regarding the new BHH provider's appointment availability. Only one BHH provider may be paid per beneficiary per month for BHH services (see Section 4.5 for Payment Schedule).

Section IV: Behavioral Health Home Payment

4.1 General Provisions for BHH Payment

MDHHS will provide the LE with a monthly case rate based on the number of enrolled BHH beneficiaries who received at least one BHH service during the month. The LE will reimburse the HHP for delivering BHH services in accordance with the guidelines below.

Additionally, MDHHS will implement a pay-for-performance (P4P) withhold that rewards providers based on outcomes. MDHHS will claim the federal match for P4P incentive payments only after P4P qualifications have been met and providers have been paid (see Section 4.7 for more information).

4.2 Rate Workup

Case rates reflect the following staffing model for BHH per 100 enrollees:

- Health Home Director (0.25 FTE)
- Behavioral Health Specialist (0.25 FTE)
- Nurse Care Manager (1.00 FTE)
- Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Parent Support Partner, Community Health Worker, Medical Assistant, SOAR Navigator, Housing Specialist (3.00 - 5.00 FTE)
- Medical Consultant (0.10 FTE)
- Psychiatric Consultant (0.10 FTE)

Rate Amounts

Case rates were established using the publicly available State Fiscal Year (SFY) 2025 comparison rate analysis. Wage data used in this analysis were derived from the May 2023 Bureau of Labor Statistics (BLS) data for Michigan and the 2024 MDHHS Provider Survey for Salary and Expense Reporting. These rates are effective as of October 1, 2025.

Rates will be reviewed annually and adjusted as appropriate, with a minimum rebasing every three years. Detailed rate information is maintained at www.michigan.gov/BHH.

BHH LE Case Rates

Case Rate	PMPM	PMPM with P4P
Composite	$445.18	$468.61

PIHP Payment to HHPs

MDHHS will provide the LE with a monthly case rate based on the number of BHH beneficiaries who received at least one BHH service during a calendar month. The LE will reimburse the HHP for the delivery of BHH services.

LE must have a monitoring plan in place to review BHH services and ensure appropriate billing. Depending on the services currently provided by the HHP, the LE may negotiate a

rate with the HHP for value-based payment (VBP) while following the guidelines below, the requirements in the approved SPA, the BHH Policy, and the BHH Handbook.

The LE must provide at least 80% of the monthly case rate to the HHP. The LE may retain up to 20% for Health Home activities, per the LE's expectations in the approved SPA, Policy, and the BHH Handbook.

Of the 80% monthly case rate required to go to the HHP, the **LE has the following options:**

Pay the HHP the **full case rate** *(preferred for HHPs whose case rate will be used to support BHH required staff, and where the LE does not wish to engage in a VBP)*

OR

Pay on a **VBP arrangement** whereby outcome metrics are established with the HHPs in concert with MDHHS access and quality goals.

If VBP is pursued, the LE must pay the HHP pursuant to one or both of the following options:

Option 1 (for HHPs *with greater staffing* infrastructure needs):

- Pay at least 90% of the case rate to the HHP and
- Reserve 10% for VBP, and if outcomes are met, distribute as appropriate
- Preferred for HHPs whose case rate will mainly be used to support the BHH required staff.

Option 2 (for HHPs *with less staffing* infrastructure needs):

- Pay at least 25% of the case rate to the HHP and
- Reserve 75% for VBP, and if outcomes are met, distribute as appropriate
- Preferred for HHPs who already have staff to provide core BHH services and want to engage in a VBP arrangement to focus on outcomes.

Note: If the VBP goals set forth by the LE and the HHPs are not met, the LE should utilize those funds for the Health Home program.

4.3 BHH Service Encounter Codes

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

BHH Care Management Encounters

HHPs must provide at least one BHH service (as defined in Section 1.4) within the service month. HHPs must submit the BHH service encounter code in addition to any pertinent ICD-10 Z-codes (to indicate any applicable SDOH) to the LE: **S0280**

The initial service must be delivered in person, meaning the beneficiary and provider are physically present together at the same location. All subsequent services are expected to be delivered face-to-face. A face-to-face encounter is defined as either in person or via telehealth (simultaneous audio and video).

HHPs must actively engage the beneficiary or care team staff to initiate a BHH service. MDHHS supports the use of simultaneous audio-visual technology as a primary modality for telehealth service delivery. However, when a beneficiary is unable to access services through an audio-visual platform due to technological limitations or other barriers, audio-only service delivery is permitted. When audio-only services are provided, HHPs must clearly document that the encounter occurred via audio-only and specify the BHH service delivered.

The TS modifier is required anytime a BHH service is delivered without a care team member being physically present with the beneficiary. This includes, but is not limited to, audio-only calls (with or without the beneficiary present), care team huddles, communication with other providers, and care coordination discussions.

Applicable ICD-10-CM Z diagnosis codes with S0280 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

4.4 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 **submit 837 HIPAA Encounter Files** through the **FTS to MDHHS,** and to recognize files that MDHHS returns to your billing agent's "mailbox".
- When submitting encounters, use Class ID/file number 5476 for encounter files.
- After submission, you will receive a response via a 999-acknowledgment file.
- The 999 file does not indicate that all submitted encounters were accepted.
- Once the **5476 file is processed by MDHHS, you will receive a 4950 file**, also known as the Encounter Transaction Results Report (ETRR), which will provide details on accepted and rejected encounters.

BHH organizations are encouraged to review the "Electronic Submissions Manual" (ESM) for additional information and instructions on submitting data electronically and using the FTS.

The Data Analysis and Quality Specialist in Health Services Administration and the Encounter Team will handle all electronic questions related to Encounter file submission and FTS issues for BHH organizations.

Questions or issues can be directed to MDHHSEncounterData@michigan.gov

4.5 Payment Schedule

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

The July 26th enrollment file would include:

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

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

4.6 Recoupment of Payment

- CHAMPS conducts an automatic recoupment process that searches for an approved encounter code (see Section 4.3) documenting that the HHP provided at least one of the six core BHH services during the calendar month.

- Payment is subject to recoupment by MDHHS if the beneficiary does not receive a BHH service during the calendar month.
- The recoupment lookback occurs six months after the monthly payment (for example, in January, the look-back month is July's payment).
- The recoupment process runs automatically on the second day of the month.
- The LE must submit encounters by the end of the month before the scheduled recoupment (for example, on January 2, the recoupment will process for July; July encounters must be submitted no later than December 15 to ensure accurate recoupment. This allows the LE to submit encounters over a five-month period.
- Once a recoupment has occurred, there is no further opportunity to submit a valid BHH encounter code and/or claim for that month.

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

MDHHS will offer P4P via a 5% performance withhold. HHPs that have been active participants in the BHH program for the entire performance year are eligible to receive P4P payments. The LE is responsible for distributing P4P funds to HHPs that meet established quality improvement benchmarks, in accordance with the timelines and processes outlined below.

Measurement Year (MY) is the first year the BHH SPA is in effect.

P4P will be available during the MY contingent upon LEs meeting the process measure(s) established by MDHHS. MDHHS may modify, add, or replace established process measure(s).

The currently established process measure requires demonstration of a quarterly increase in the number of enrolled BHH beneficiaries.

During the MY, MDHHS will establish baseline values for the performance metrics used to assess performance in subsequent payment years.

Performance Year (PY) includes each subsequent fiscal year the SPA is in effect.

Within nine months following the end of each PY, MDHHS will evaluate the HHPs' performance and notify LEs of their P4P determinations.

MDHHS will distribute P4P payments to the LEs within one year of the end of the PY.

Prior to receipt of P4P funds, LEs must submit a P4P distribution plan to MDHHS for review. LEs must distribute P4P payments to contracted HHPs within 30 calendar days of receiving payment from MDHHS.

PY performance is assessed using the metrics and technical specifications outlined in the table below.

Measure Name and NQF	Measure Steward	Allocation P4P Budget	Source
Follow Up After Hospitalization (FUH-7)	NCQA	50%	HEDIS
Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	20%	HH Core Set
Access to Preventive/Ambulatory Health Services (AAP)	NCQA	30%	HEDIS

Assessment and Distribution

MDHHS will compare the LE's regional BHH program metric performance against the performance of the entire state and the PIHP Region.

The P4P allocation for each metric will be determined as follows:

- **100 percent** of the P4P allocation will be awarded if the BHH's metric performance exceeds both statewide and regional performance levels.
- **75 percent** will be awarded if the metric performance exceeds either statewide or regional performance, but not both.
- **0 percent** will be awarded if the metric performance does not exceed either statewide or regional performance. Accordingly, the allocation for that metric will be redistributed among regions that exceeded the BHH metric.

MDHHS will apply this methodology to all subsequent PYs unless otherwise specified.

Threshold numerator (N) and denominator (D) requirements must be met (N ≥ 5, D ≥ 30) for a measure to be included in the P4P budget and award. If the threshold numbers are not met, the allocation for that measure will be redistributed equally to the other eligible performance measures.

Example: *If the FUH-7 measure does not meet the N and/or D thresholds, its allocated P4P weight (50%) will be removed and equally distributed between the remaining measures, resulting in adjusted allocations of 45% for CBP-HH and 55% for AAP.*

Distribution

Upon determination that performance benchmarks have been met, MDHHS will issue P4P funds to the LE for distribution. The LE may retain up to 5% of the total P4P allotment and must distribute the remaining 95% to HHPs in accordance with the approved distribution plan.

If performance benchmarks for a given PY are not met by any region, the P4P funds will be distributed equally among providers with a recoupment rate below 30%. The redistribution structure will apply to subsequent PYs unless modified by MDHHS.

Section V: Behavioral Health Home and Managed Care

5.1 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 BHH program. The LE is responsible for SMI/SED services for all enrolled Medicaid beneficiaries in its region (Michigan Mental Health Code) and will maintain a list of all qualifying beneficiaries, including the health plan to which each is assigned.

MDHHS will require the LE and health plans to collaborate to optimize community-based referrals and to develop informational materials for beneficiaries regarding the BHH. The LE will have primary responsibility for outreach to eligible beneficiaries, while health plans will support the handling of beneficiary questions. Bidirectional communication is imperative throughout the process to ensure all parties have current information regarding beneficiaries.

There are two scenarios MDHHS anticipates for eligible beneficiaries enrolled in a health plan who wish to participate in the BHH program. Those are:

- For health plan beneficiaries whose **current primary care provider is a designated HHP**, health plans, upon beneficiary request, will direct beneficiaries to set up an appointment with their BHH primary care provider and inform the beneficiary that their provider will help them obtain BHH services.

- 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 HHP.

  This may include changing the beneficiary's primary care provider to a HHP selected by the beneficiary that is participating in the health plan's provider network. If there is no in-network HHP in the eligible county, the health plan should work with the LE to establish an MOU between the designated HHP and the beneficiary's primary care provider to support delivery of BHH services and continuity of care. The health plan and LE should assist beneficiaries seeking to change primary care providers to a designated HHP by helping them identify an in-network HHP within the region, as applicable. See Section 3.6 for guidance on Beneficiary Transfer Process.

5.2 Coordination and Health Plans

Health Plans are contractually obligated to provide a certain level of care coordination and care management services to their beneficiaries. However, all SMI/SED services are managed by the LE, while comorbid physical and mild-to-moderate behavioral health conditions remain under the health plan's auspices.

To minimize confusion and maximize patient outcomes, bidirectional communication between the LE and the health plan is essential. MDHHS expects the LE, in coordination with the designated HHP, to take the lead in providing care management across 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 HIE technology will be critical to the success of the BHH and the beneficiary’s health status.

Section VI: Health Information Technology (HIT)

6.1 Waiver Support Application (WSA)

The WSA supports the LE in beneficiary enrollment, including pre-enrollment activities (e.g., maintaining an updated list of potential 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

CareConnect360 supports statewide care coordination activities for the BHH program by serving as a centralized care management web portal that provides a comprehensive, claims-based view of beneficiaries across multiple health care programs. The platform enables the LE and other authorized entities to analyze health data across the continuum of care, and supports improved care coordination and smoother care transitions for beneficiaries.

Access to CareConnect360 provides HHPs with a more complete snapshot of beneficiary information, supporting timely and informed decision-making in beneficiaries' care. Provider access is limited to beneficiaries who are established as patients of record within the organization. With appropriate consent, CareConnect360 facilitates the secure sharing of cross-system information, including behavioral health, physical health, and social support services.

6.3 Electronic Health Records (EHRs) and Health Information Exchanges (HIEs)

The use of EHRs and HIEs is essential to the BHH program's overarching goals, as they enable the maintenance and transmission of data needed to optimize care coordination and management. MDHHS intends for the EHR to reflect the CMS Promoting Interoperability Program.

6.4 File Transfer Service (FTS)

Michigan's data-submission portal is the File Transfer Service (FTS), formerly known as the Data Exchange Gateway (DEG). 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 FTS to submit and retrieve files electronically with MDHHS. MDHHS has established an internet connection to FTS via Secure Sockets Layer (SSL). 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.

BHH organizations are encouraged to review the "Electronic Submissions Manual" (ESM) for additional information and instructions relating to the FTS.

Section VII: Monitoring and Evaluation

7.1 Monitoring & Evaluation Requirements

Both CMS and MDHHS have quality monitoring and evaluation requirements for the BHH. To the extent necessary to fulfill these requirements, providers must agree to share all BHH clinical and cost data with MDHHS. MDHHS aims to use administrative data whenever possible to reduce administrative burden on providers. MDHHS will report the data to CMS annually.

7.2 Federal Monitoring & Evaluation Requirements

The Centers for Medicare and Medicaid (CMS) provides reporting requirements and guidance for BHH.

There are two broad sets of requirements – core utilization and core quality measures.

It is essential that BHH providers are aware of these measures, how they are calculated for evaluation purposes, and their role in the program's longevity. In addition to the CMS Core Measures, CMS 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, available on the CMS Health Homes Quality Reporting page.

7.3 State Monitoring and Evaluation

In addition to Federal requirements, CMS requires states to develop a separate quality monitoring plan for the population their BHH program will target. MDHHS monitors and reports on the core utilization and quality measures (Section 7.2) and the following P4P measures: FUH-7, CBP-HH, and AAP.

Appendix A: List of Qualifying ICD-10 Codes

Serious Mental Illness and Serious Emotional Disturbance (SMI/SED)

F06 Other mental disorders due to known physiological condition

- F06.0 Psychotic disorder with hallucinations due to known physiological condition
- F06.1 Catatonic disorder due to known physiological condition
- F06.2 Psychotic disorder with delusions due to known physiological condition
- F06.3 Mood disorder due to known physiological condition
  - F06.30 …… unspecified
  - F06.31 …… with depressive features
  - F06.32 …… with major depressive-like episode
  - F06.33 …… with manic features
  - F06.34 …… with mixed features
- F06.4 Anxiety disorder due to known physiological condition
- F06.7 Mild neurocognitive disorder due to known physiological condition
  - F06.71 …… with behavioral disturbance
- F06.8 Other specified mental disorders due to known physiological condition

F20 Schizophrenia

- F20.0 Paranoid schizophrenia
- F20.1 Disorganized schizophrenia
- F20.2 Catatonic schizophrenia
- F20.3 Undifferentiated schizophrenia
- F20.5 Residual schizophrenia
- F20.8 Other schizophrenia
  - F20.81 …… Schizophreniform disorder
  - F20.89 …… Other schizophrenia
- F20.9 Schizophrenia, unspecified

F25 Schizoaffective disorders

- F25.0 Schizoaffective disorder, bipolar type
- F25.1 Schizoaffective disorder, depressive type
- F25.8 Other schizoaffective disorders
- F25.9 Schizoaffective disorder, unspecified

F31 Bipolar disorder

- F31.0 Bipolar disorder, current episode hypomanic
- F31.1 Bipolar disorder, current episode manic without psychotic features
  - F31.10 …… unspecified
  - F31.11 …… mild
  - F31.12 …… moderate
  - F31.13 …… severe
- F31.2 Bipolar disorder, current episode manic severe with psychotic features
- F31.3 Bipolar disorder, current episode depressed, mild or moderate severity
  - F31.30 …… unspecified
  - F31.31 Bipolar disorder, current episode depressed, mild
  - F31.32 Bipolar disorder, current episode depressed, moderate
- F31.4 Bipolar disorder, current episode depressed, severe, without psychotic features
- F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features
- F31.6 Bipolar disorder, current episode mixed

F31.60 …… unspecified
F31.61 …… mild
F31.62 …… moderate
F31.63 …… severe, without psychotic features
F31.64 …… severe, with psychotic features
F31.7 Bipolar disorder, currently in remission
F31.70 …… most recent episode unspecified
F31.71 Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72 Bipolar disorder, in full remission, most recent episode hypomanic
F31.73 Bipolar disorder, in partial remission, most recent episode manic
F31.74 Bipolar disorder, in full remission, most recent episode manic
F31.75 Bipolar disorder, in partial remission, most recent episode depressed
F31.76 Bipolar disorder, in full remission, most recent episode depressed
F31.77 Bipolar disorder, in partial remission, most recent episode mixed
F31.78 Bipolar disorder, in full remission, most recent episode mixed
F31.8 Other bipolar disorders
F31.81 Bipolar II disorder
F31.89 Other bipolar disorder
F31.9 Bipolar disorder, unspecified

F32 Major depressive disorder, single episode
F32.0 Major depressive disorder, single episode, mild
F32.1 Major depressive disorder, single episode, moderate
F32.2 Major depressive disorder, single episode, severe without psychotic features
F32.3 Major depressive disorder, single episode, severe with psychotic features
F32.4 Major depressive disorder, single episode, in partial remission
F32.5 Major depressive disorder, single episode, in full remission
F32.8 Other depressive episodes
F32.81 Premenstrual dysphoric disorder
F32.89 Other specified depressive episodes
F32.9 Major depressive disorder, single episode, unspecified
F32.A Depression, unspecified

F33 Major depressive disorder, recurrent
F33.0 Major depressive disorder, recurrent, mild
F33.1 Major depressive disorder, recurrent, moderate
F33.2 Major depressive disorder, recurrent severe without psychotic features
F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms
F33.4 Major depressive disorder, recurrent, in remission
F33.40 …… unspecified
F33.41 Major depressive disorder, recurrent, in partial remission
F33.42 Major depressive disorder, recurrent, in full remission
F33.8 Other recurrent depressive disorders
F33.9 Major depressive disorder, recurrent, unspecified

F41 Other anxiety disorders
F41.0 Panic disorder [episodic paroxysmal anxiety]
F41.1 Generalized anxiety disorder
F41.3 Other mixed anxiety disorders
F41.8 Other specified anxiety disorders
F41.9 Anxiety disorder, unspecified

F43 Reaction to severe stress, and adjustment disorders

- F43.0 Acute stress reaction
- F43.1 Post-traumatic stress disorder (PTSD)
  - F43.10 Post-traumatic stress disorder, unspecified
  - F43.11 Post-traumatic stress disorder, acute
  - F43.12 Post-traumatic stress disorder, chronic
- F43.2 Adjustment disorders
  - F43.20 Adjustment disorder, unspecified
  - F43.21 Adjustment disorder with depressed mood
  - F43.22 Adjustment disorder with anxiety
  - F43.23 Adjustment disorder with mixed anxiety and depressed mood
  - F43.24 Adjustment disorder with disturbance of conduct
  - F43.25 Adjustment disorder with mixed disturbance of emotions and conduct
  - F43.29 Adjustment disorder with other symptoms
- F43.8 Other reactions to severe stress
  - F43.81 Prolonged grief disorder
  - F43.89 Other reactions to severe stress
- F43.9 Reaction to severe stress, unspecified

F90 Attention-deficit hyperactivity disorders

- F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type
- F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type
- F90.2 Attention-deficit hyperactivity disorder, combined type
- F90.8 Attention-deficit hyperactivity disorder, other type
- F90.9 Attention-deficit hyperactivity disorder, unspecified type

F91 Conduct Disorders

- F91.0 Conduct disorder confined to family context
- F91.1 Conduct disorder, childhood-onset type
- F91.2 Conduct disorder, adolescent-onset type
- F91.3 Oppositional defiant disorder
- F91.8 Other conduct disorders
- F91.9 Conduct disorder, unspecified

F98 Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence

- F98.0 Enuresis not due to a substance or known physiological condition
- F98.1 Encopresis not due to a substance or known physiological condition
- F98.2 Other feeding disorders of infancy and childhood
  - F98.21 Rumination disorder of infancy
  - F98.29 Other feeding disorders of infancy and early childhood
- F98.3 Pica of infancy and childhood
- F98.4 Stereotyped movement disorders
- F98.5 Adult-onset fluency disorder
- F98.8 Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- F98.9 Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

Appendix B: Coexisting Benefit Plan List

Benefits Monitoring Program (BMP)
Certified Community Behavioral Health Clinic Demonstration (CCBHC-FFS)
Children's Special Health Care Services (CSHCS)
Children's Special Health Care Services Managed Care (CSHCS-MC)
CSHCS Medical Home (CSHCS-MH)
Children's Waiver Program Managed Care (CWP-MC)
Community Transition Services (CTS)
Freedom to Work (MA-FTW)
Full Fee-for-Service Medicaid (MA)
Full Fee-for-Service Healthy Kids – Expansion (HK-EXP)
Habilitation Supports Waiver Program Managed Care (HSW-MC)
Healthy Kids Dental (HK-Dental)
Healthy Michigan Plan Emergency Services Only (MA-HMP-ESO)
Healthy Kids Expansion Emergency Services Only (HK-EXP-ESO)
Healthy Michigan Plan (MA-HMP)
Healthy Michigan Plan Behavioral Health NOT Enrolled in an MHP (BHHMP)
Healthy Michigan Plan-Managed Care (MA-HMP-MC)
Home and Community-Based Waiver Services-Managed Care (MICHOICEMC)
Hospice
Long Term Care Exempt (LTC-EXEMPT)
Maternity Outpatient Medical Services (MOMS)
Medicaid Managed Care (MA-MC)
Medicaid-Medicare Dually Eligible-Managed Care (MME-MC)
Medical Assistance Emergency Services Only (MA-ESO)
MIChild Program (CHIP) (MA-MICHILD)
MIChild Program Emergency Services (CHIP) (MICHILDESO)
Non-Emergency Medical Transportation (NEMT)
Nursing Home (NH)
PIHP Healthy Michigan Plan (PIHP-HMP)
Prepaid Inpatient Health Plan (PIHP)