Opioid Health Home Frequently Asked Questions

How are individuals identified to participate in OHH?

Home Home Partners (HHPs) can identify eligible customers from their current customer roster and as new customers enter their program. SWMBH's Access Department will screen new customers for eligibility when they are requesting information about treatment options.

What are the eligibility requirements to participate in OHH?

Customers must:

- Live in Kalamazoo or Calhoun counties
- Have an opioid use disorder diagnosis
- Have active Medicaid or HMP in Kalamazoo or Calhoun counties and not be enrolled in another waiver program.

What benefit plans exclude an individual from being eligible for OHH?

A customer cannot be enrolled in HHBH (Behavioral Health Home), HHMICare (Health Home MI Care Team), ICO-MC (Integrated Care MI Health Link), NH (Nursing Home), or Hospice during the same month. A customer cannot be in spend down.

Can dual eligible individuals (Medicaid/Medicare) participate in OHH?

Dual customers are eligible for Opioid Health Home, but those participating in MI Health Link are not eligible. Customers cannot be enrolled in two separate waiver programs.

What are the benefits for customers participating in OHH?

Customers will receive support from an integrated team of providers who can:

- Coordinate care with other doctors/specialists/providers.
- Help customers understand and manage other conditions they may have.
- Refer customers to resources focusing on overall health.
- Assist customers with housing, legal issues, transportation, employment, educational goals, etc.
- Connect customers to community resources.

What documents are required for individuals enrolled in OHH?

Health Home Partners are required to submit the following:

- MDHHS 5515 Consent to Share Behavioral Health Information for Care Coordination Purposes*
- Opioid Health Home Program Enrollment Consent to Treatment form
- Treatment Needs Questionnaire**
- Biopsychosocial Assessment*
- Opioid Health Home Care Plan (within 30 days of enrollment)**

*These documents will be updated at least yearly
**These documents will be updated at least every six months
***Valid SUD BH TEDS must be in SWMBH system.

What is the MDHHS 5515 form and how is it used?

The MDHHS 5515 form is used by the customer to give and take away consent to share health care information between providers, SWMBH, and MDHHS. The date on this form is the date the customer had their initial OHH meeting and will be used as their enrollment date. This form needs to be completed yearly and updated with new providers.

What is the Opioid Health Home Program Enrollment Consent form?

The consent form provides a brief overview of Opioid Health Home and grants permission to enroll the customer into OHH. The date on this form should be the same date as on the MDHHS 5515 Consent form (enrollment date).

What information needs to be included on the OHH Care Plan?

The OHH Care Plan must include:

- Opioid diagnosis goals/objectives
- Other SUD diagnosis goals/objectives (if applicable)
- Mental Health diagnosis goals/objectives (if applicable)
- Medical health risk goals/objectives (if applicable)
- Behavioral health risk goals/objectives (if applicable)
- General goals/objectives (if applicable)

The Care Plan will be reviewed by the OHH team as needed but at least every six months. The Treatment Needs Questionnaire must be used to develop goals for the customer's needs and updated in conjunction with the care plan. HHP's can utilize "*Opioid Health Home Care Plan Template"* when creating care plans.

How do HHP's submit documents to SWMBH?

HHP's who have access to the WSA will submit paperwork through the WSA. HHP's who do not have access to the WSA must submit all paperwork through SWMBH's SmartCare system. SUD BH TEDS must be submitted through SWMBH's SmartCare system for all OHH customers.

How is a provider notified when an enrollment has been processed?

HHP's who be notified via email when enrollments are completed.

What services are considered an OHH encounter?

As seen in the OHH Handbook under section 1.3 OHH Services:
"OHH services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health condition."
OHH services must be tied to one of the six categories described in the handbook (care management, care coordination, individual and family support, health promotion, comprehensive transitional care, and referral to community and social supports) and payments are intended to cover services not otherwise covered by other funding sources or other Medicaid reimbursement mechanisms. If a service can be billed through Medicaid, then it cannot be submitted or billed as an OHH encounter.

What are some examples of OHH encounters?

- Care coordination with other service providers (primary care, pharmacy, mental health providers, specialists, etc.)
- OHH team meetings/case consultation
- Entering toxicology screenings
- Meeting with customers focused on one of the 6 core services
- Coordination with community resources

See "Opioid Health Home Encounters" for more information and examples.

How are OHH services billed?

The specific code requirements for OHH billings are described in the OHH Handbook under *Section 4.4 OHH Service Encounter Coding Requirements.* HG modifier is used when the service is provided face-to-face with the customer. HG:TS modifier is used when the customer is not present.

- S0280 (with no modifier) should be billed one (1) time per month, when the first valid OHH service is delivered that month. S0280 (with no modifier) will be reimbursed at the monthly case rate.
- S0280 HG or HG:TS should be billed for every valid OHH service delivered in a month. These codes have a $0.00 rate attached to them. S0280 HG or HG:TS should be billed IN ADDITION to S0280 for the first service.

Example: First OHH service of the month is delivered on 10/01/2020, face-to-face: bill S0280 AND S0280 HG. For all subsequent OHH services delivered during the month: bill S0280 HG (or HG:TS).

What is the timeframe for submitting OHH billing?

OHH services must be submitted within 90 days of providing an OHH service to ensure timely service verification. Providers must submit billing for at least one service, per customer, to be paid for a given month.

See *OHH Handbook Section IV: OHH Payment* for more details.

How does someone become disenrolled in OHH?

Customers can be disenrolled from OHH in the WSA for the following reasons:

- Voluntary disenrollment
- Move from an eligible county
- No longer eligible for Medicaid
- Deceased
- Enrolled in another waiver program and no longer eligible for OHH
- Unresponsive for three months

See *"Opioid Health Home Disenrollment Process"* for more information.

What is the effective date of disenrollment?

The disenrollment date for OHH is the last day of the month of the customer's last OHH service. For example, a customer receives an OHH service on December 7th and chooses to voluntarily disenroll. Their disenrollment date is December 31st.

Can OHH services be billed while an individual is in residential treatment?

Yes. OHH services can be billed while a customer is in residential treatment, if appropriate. Medicaid billing cannot be duplicated.

Can OHH services be billed while an individual is incarcerated?

No. Because Medicaid is no longer active while incarcerated, a customer would no longer be eligible for OHH.

Who do I contact with questions about OHH that are not listed here?

Please submit all OHH-related questions to SWMBH's OHH Coordinator: Emily.flory@swmbh.org.