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Opioid Health Home (OHH) Policy

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to provide an optional service under the Michigan Medicaid State Plan Amendment (SPA), the Opioid Health Home (OHH). OHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. Michigan has three overarching goals for the OHH program: 1) improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT); 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care.

This policy is intended to provide standards and guidelines regarding the Opioid Health Home (OHH).

PURPOSE

The purpose of this policy is to establish the philosophy and requirements of the Opioid Health Home and Opioid Health Home Partners. OHH Partners will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions.

APPLICATION

1. The following groups are required to implement and adhere to this policy: DWIHN Staff, Contractual Staff, and applies to all Health Home Partners who are contracted to participate in the Opioid Health Home.
2. This policy serves the following populations: Adults, Children, Individuals with Intellectual and/or Developmental Disabilities (I/DD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), Autism

3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

1. **Opioid Health Home (OHH)**: A model of care comprised of a partnership between a Lead Entity (LE) and Health Home Partners (HHP).
2. **Lead Entity (LE):** A regional entity as defined in Michigan's Mental Health Code (330.1204b). DWIHN is the Lead Entity for Region 4.
3. **Health Home Partner (HHP)**: Agency that is contracted with the LE, to provide OHH services. Eligible providers must meet all applicable state and federal licensing requirements and provide Medication Assisted Treatment (MAT).
4. **Opioid Treatment Program (OTP)**: One type of Health Home Partner. Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as an OTP.
5. **Office-Based Opioid Treatment Provider (OBOT)**: One type of Health Home Partner. Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as an OTP.
6. **Substance Use Disorder Provider other than Opioid Treatment Program**: One type of Health Home Partner. Must meet applicable Federal and State licensing standards in addition to Medicaid provider certification and enrollment requirements as an OTP.
7. **Opioid Use Disorder (OUD)**: Any opioid related disorder.
8. **Waiver Support Application (WSA)**: The enrollment, maintenance, and management tool for the Opioid Health Home. Both LEs and HHPs have access to the WSA.
9. **Medication Assisted Treatment (MAT)**: An evidence-based treatment consisting of medications utilized in conjunction with other treatment modalities to assist those diagnosed with an OUD.

STANDARDS

Responsibilities:

- DWIHN, as the Lead Entity, is responsible for managing enrollment and disenrollment of OHH beneficiaries. DWIHN is responsible for required payment to Health Home Partners as outlined below and in the current version of the OHH Handbook.
- Health Home Partners are responsible for providing care for OHH beneficiaries as outlined below and in the current version of the OHH Handbook.

Guidelines

1. OHH Population Criteria:
    a. Eligible beneficiaries must meet the following requirements:
        1. Live in Wayne County
        2. Have active Medicaid or Healthy Michigan Plan

3. Have a diagnosis of opioid use disorder.

2. OHH Required Provider Infrastructure:
    a. LEs (per 100 beneficiaries):
        1. Health Home Director (0.5 FTE)
    b. HHPs (per 100 beneficiaries):
        1. Behavioral Health Specialist (0.25 FTE)
        2. Nurse Care Manager (1.00 FTE)
        3. Peer Recovery Coach, Community Health Worker, Medical Assistant (2.00-4.00 FTE)
        4. Medical Consultant (0.10 FTE)
        5. Psychiatric Consultant (0.05 FTE)
3. Core OHH Services:
    a. Comprehensive Care Management
    b. Care Coordination
    c. Health Promotion
    d. Comprehensive Transitional Care
    e. Individual and Family Support
    f. Referral to Community and Social Services
4. Overarching OHH Goals:
    a. Improve care management of beneficiaries with opioid use disorders, including Medication Assisted Treatment (MAT).
    b. Improve care coordination between physical and behavioral health care services.
    c. Improve care transitions between primary, specialty, and inpatient settings of care.
5. OHH Enrollment Process: HHPs and LEs can both recommend beneficiaries for enrollment through the WSA.
    a. HHP will **ensure** that client meets eligibility requirements, discuss program and services with client, complete required forms and recommend enrollment through the WSA.
    b. DWIHN will confirm that client meets eligibility requirements, all enrollment forms are complete, and that client meets clinical criteria to enroll in OHH.
    c. DWIHN will *Approve*, *Send Back*, or *Deny* the request. When enrollment is approved, DWIHN will create the authorization in the Mental Health Wellness Information Network (MHWIN) for S0280 code.
    d. Once the enrollment is approved, HHP will have access to beneficiary information such as Case Info/Demographics/Counts within the WSA.
    e. The OHH care plan must be uploaded into the MHWIN when requesting approval for

authorization.

6. OHH Disenrollment Process:
    a. HHPs will recommend disenrollment in the WSA.
    b. Reason for disenrollment and date of client's last OHH service date must be completed.
    c. LE will be responsible for completing the disenrollment in WSA and MHWIN.
    d. Disenrollment date will be the last day of the last month client received OHH services.
7. Reasons for Disenrollment:
    a. Beneficiary-initiated disenrollment.
    b. Beneficiaries who have moved out of an eligible geographic area.
    c. Beneficiaries who are no longer eligible for Medicaid.
    d. Beneficiaries who are deceased.
    e. Beneficiaries who are unresponsive (for reasons other than moving or death) for 180 days.
8. Utilizing the WSA: The WSA will provide support to the LE in the areas of beneficiary enrollment, including pre-enrollment activities, enrollment management including beneficiary disenrollment, and report generation.
    a. All enrollments and disenrollment's will be completed within the WSA.
    b. Required paperwork must be uploaded into the WSA.
9. Required Paperwork:
    a. Consent to share behavioral health information for care coordination purposes (MDHHS 5515)
    b. OHH Consent to Treatment
    c. Treatment needs questionnaire
    d. Current ASAM assessment
    e. OHH Care Plan
    Potential enrollees must provide HHPs a signed consent to share behavioral health information for care coordination purposes form (MDHHS-5515) to receive the OHH benefit
10. The Care Plan must include individualized goals developed by the beneficiary and the care team utilizing the treatment needs questionnaire and will need to be reviewed at least every six months. The Care Plan document must include:
    a. Opioid diagnosis goals/objectives
    b. Other SUD diagnosis goals/objectives (if applicable)
    c. Mental Health diagnosis goals/objectives (if applicable)
    d. Medical health risk goals/objectives (if applicable)

e. Behavioral health risk goals/objectives (if applicable)

f. General goals/objectives (if applicable)

g. Beneficiaries strengths and barriers

11. OHH Payment: The OHH payment rate reflects a monthly case rate per OHH beneficiary with at least one OHH service within a given month. MDHHS pays the LE who will then reimburse the HHP for delivering services.

    a. Recoupment of Payment:

        1. Payment is subject to recoupment if the beneficiary does not receive an OHH service during the calendar month.
        2. Once recoupment has occurred, there shall be no further opportunity to submit a valid OHH encounter code and/or claim for the month that has a payment recouped.
        3. A recoupment could also occur if the beneficiary is no longer eligible for the OHH benefit due to a higher priority benefit plan activating.

12. OHH Service Encounter Coding Requirements: Valid OHH encounters must be submitted by HHPs to the LE within **60 days** of providing an OHH service to ensure timely service verification.

    a. OHH Care Management Encounters:

        1. HHPs must provide at least **three** OHH service each month to obtain the monthly case rate.
        2. Authorization code: S0280 HG
        3. TS Modifier must be used when service is non-face-to-face.
        4. The initial encounter will be submitted as S0280 HG **each month** and paid for that case rate, all subsequent encounters may be delivered as to S0280 HG or as S0280 TS, for non-face-to-face
        5. **The HG Modifier MUST be used for ALL encounters**
        6. **Utilization Management Department will authorize services in 6 or 12 month increments.**

13. **OHH Services**

    OHH services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Individuals eligible for opioid health home services are eligible for all Medicaid services. Opioid health home services were designed to help beneficiaries connect to medically necessary services. However, payment for duplicate services in the same calendar month is prohibited. The health home team must choose which available Medicaid covered service best meets the person's needs. OHH must provide the following six core health home services as appropriate for each beneficiary:

    a. ***Comprehensive Care Management***, including but not limited to: o Assessment of each beneficiary, including behavioral and physical health care needs; Draft V1.17 5 o Assessment of beneficiary readiness to change; o Development of an

individualized care/treatment plan; o Documentation of assessment and care plan in the Electronic Health Record; and o Periodic reassessment of each beneficiary's treatment, outcomes, goals, self- management, health status, and service utilization.

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

c. ***Health Promotion***, including but not limited to: o Providing patient and family activation and education; o Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and o Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.); o Promoting healthy lifestyle interventions; o Encouraging a routine preventative care such as immunizations and screenings; o Assessing the patient and family's understanding of the health condition and motivation to engage in self-management; o Using evidence-based practices, to engage and help patient participate in and manage their care.

d. ***Comprehensive Transitional Care***, including but not limited to: Draft V1.17 6 o Connecting the beneficiary to health services; o Coordinating and tracking the beneficiary's use of health services through Health Information Technology (HIT) in conjunction with the LE Coordinator; o Providing and receiving notification of admissions and discharges; o Receiving and reviewing care records, continuity of care documents, and discharge summaries; o Post-discharge outreach to ensure appropriate follow-up services for all care in conjunction with the LE Coordinator; o Medication reconciliation; o Pharmacy coordination; o Proactive care (versus reactive care); o Specialized transitions when necessary (i.e., age, corrections); and o Home visits to ensure stability through transitions.

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

directives; o Contributing assistance with maximizing beneficiary's level of functioning; and o Providing assistance with development of social networks.

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

14. Health Home Partner Termination:
    a. Failure to abide by the terms of the OHH policy and requirements may result in disciplinary actions, including placing the provider in a probationary period or termination as an HHP.

15. OHH Performance Measures:
    a. Initiation and engagement of alcohol and other drug dependence treatment NCQA.
    b. Follow-up after Emergency Department visit for alcohol or other drug dependence.
    c. Emergency Department utilization for SUD.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, risk management program, and Quality Assessment/Performance Improvement Program (QAPIP) Work-plan.

The quality improvement programs of Network Providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Contracted Network Providers, and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended..

LEGAL AUTHORITY

1. Opioid Health Home (OHH) Handbook Version 1.17 (effective 10,1,2021)
2. Michigan Department of Health and Human Services Medicaid Provider Manual (in effect, and as as amended)
3. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/CMHSP contracts in effect, and as amended)

RELATED POLICIES AND PROCEDURES

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Approval Signatures

Step Description	Approver	Date
Final Approval	Melissa Moody: Chief Clinical Officer	03/2023
Stakeholder Feedback	Allison Smith: Project Manager, PMP	03/2023