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This guidance's document provides answers to frequently asked questions regarding Section 93, Opioid Health Home (OHH) Services pass-through payment flexibilities. Please refer to the full Section 93 policy for complete requirements.

Questions about Pass Through Payments

Question: What is a "pass-through" payment?

Answer: A pass-through payment is an additional amount that the OHH receives from MaineCare when an OHH member is receiving additional clinically appropriate supports due to a higher acuity need (e.g., Serious and Persistent Mental Illness (SPMI), HIV, homelessness). The pass-through payment for OHH services is $394.40.

The OHH "passes" this payment to whomever the member is seeing for additional supports, i.e., all outside Case Management (CM) agencies providing the additional support.

Question: Why is it important to have the option for an additional support provider as part of the OHH team?

Answer: This option allows for a member to get their clinical needs met even if it means that the OHH team must be broadened to include other clinicians/providers. The payments all go through one entity to support this coordination across providers.

Question: Is the OHH expected to have at least one mental health goal in their plan to justify having an additional support provider for the member such as Section 17 Community Integration Services (CIS), Section 13 Targeted Case Management (TCM), or Section 92 Behavioral Health Home (BHH)?

Answer: Yes. The OHH provider coordinates with the additional support provider from Section 92, Section 17 CIS, or Section 13 TCM to make sure they have goals and objectives as part of the OHH treatment plan. Section 92, Section 17 CIS, or Section 13 TCM providers operate from a shared/joint treatment plan for these members, maintained by the OHH.

Question: Are Section 92, Section 17 CIS, or Section 13 TCM providers that are providing additional support to members who are also getting OHH services still required to attest to or bill for those members?

Answer: The additional provider (Section 92, Section 17 CIS, or Section 13 TCM) no longer bills claims or attest on the Value-Based Management System (VMS) portal. The OHH provider submits a claim for the services provided and receives the $394.40 to pass-through to the additional support provider for their services. The OHH provider receives notes from the additional support provider to justify the services they provided.

Question: Are OHH providers supposed to send four percent of the payment to sub-contracted agency?

Answer: The $394.40 pass-through payment does not include the four percent reduction related to the performance measures, so OHH providers do not need to withhold or later repay the subcontract agency four percent of the payment.

Question: Is an OHH required to have a Memorandum of Understanding (MOU) or provider agreement with an additional support provider if they feel it will be too much of an administrative burden to their organization?

Answer: No. An OHH provider can decide if they want to enter an agreement with additional support providers. If they decide it is in the best interest of their program and/or organization to NOT contract, they must have a conversation with their members who are currently receiving Section 92 BHH, Section 17 CIS, or Section 13 TCM about their options for continuing those services. The OHH must also have conversations with future members who are eligible or seeking additional provider support to ensure members are aware of their choices. Ultimately, the member decides which services they would like to continue to receive and from which providers.

Question: 42 Code of Federal Regulations (CFR) ruling prohibits Section 92 BHH, Section 17 CIS, or Section 13 TCM providers from finding out about the OHH service, what do we do in this situation?

Answer: Providers should have conversations with the members about which services they will receive prior to delivering services. A provider can support the member at the time of intake by calling Kepro and finding out what services they have that would be a duplication. Kepro only speaks with the member, so the member needs to be on the phone. If a member is in OHH and a Section 92 BHH, Section 17 CIS, or Section 13 TCM provider picks up a member, the provider will receive a duplication of service notification when putting them in to the Atrezzo system and won't be able to open them. This is the same for the OHH provider if they pick up a member who has case management already and they try to submit a certification. We are consulting with the privacy team on whether we can share more information with OHHs about non-SUD services.

Question: The current rate for OHH services is $413.88, but $394.40 is the current pass-through payment. Is it still $394.40 for Section 13 and 17 as well?

Answer: If the member is with an OHH and they are contracting with a Section 92 BHH, Section 17 CIS, or Section 13 TCM provider, those additional support providers receive the same rate of $394.40 for the services they provided. This rate is distinct from the BHH rate in policy.

Questions Regarding Kepro

Question: Will there be a transition period granted?

Answer: Yes. The Department allows a maximum 90-day transition period for providers to coordinate services, develop contracts for passthrough payments, and discuss these changes with members. The transition period is from August 21, 2022, through November 20, 2022.

Question: Do I need to upload a treatment plan or eligibility letter for the additional case management services under Section 13 TCM, 17 CIS, or 92 BHH?

Answer: No. This is not required for a Kepro Authorization.

Question: Can I request an additional case management service if the member is not in an OHH program?

Answer: No, to receive an authorization for an additional case management service under Section 13, 17, or 92 the member must have an open certification for OHH. If a request for additional case management is submitted and there is no open OHH certification, Kepro voids your request and instructs you to resubmit under the regular Section 13 TCM, 17 CIS, or 92 BHH codes.

Question: What if I am providing an additional case management service and I do not have a diagnosis code?

Answer: You can use R69 Illness Unspecified as the diagnosis code for an additional case management service for the first certification.

Question: A member has a certification for additional case management services under Section 13 TCM, 17 CIS, or 92 BHH and has a certification for T1012 or T1041HH. What happens if the member discharges from the additional case management service?

Answer: Kepro notifies the OHH provider through the Atrezzo portal to enter a new request under the T2022 or T1041 code.

Question: A member has a certification for additional case management services under Section 13 TCM, 17 CIS, or 92 BHH and has a certification for T1012 or T1041HH. What happens if the member discharges from OHH service?

Answer: Kepro end dates the additional case management request and send a notification to the provider through the Atrezzo portal

Question: What if an OHH provider puts in a certification for T1012 but the member does not have an additional case management service under Section 13, 17, or 92?

Answer: Kepro voids the request and send a notification to the provider through the Atrezzo portal to enter a new request under the T2022 code.

Question: If a Section 92 BHH, Section 17 CIS, or Section 13 TCM provider has an authorization and a OHH provider goes in to put in a certification, what happens in this case?

Answer: The Section 92 BHH, Section 17 CIS, or Section 13 TCM provider who already has the approval stays open and the OHH provider gets notification there is a duplication of services. If the OHH already has the certification and one of these providers goes into to Kepro, they receive the duplication notice.