Health Home FAQs

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1) eMedicaid Health Home Registration

Q: I do not see the Health Home tab option. Help!

A: When you first register your base site with eMedicaid, the administrator needs to activate the Health Homes option for the provider. Once activated, the provider should register Health Home access to each user at the respective Health Home locations.

The site administrator needs to log in using the PRP, OTP, or MT provider number, as the Health Homes tab is only available to these provider types. There is one administrator for each base provider number, which is the one ending in 00, and that person can activate the Health Home option for each site corresponding to that base number (those ending in 01, 02, etc). Additionally, the administrator can assign each user to have access to a specific site.

Q: Why do I see the error message, "This provider is already registered" when I try to log in to eMedicaid to activate the Health Home tab?

A: Make sure that you enter the correct Medicaid base provider number. If the Medicaid base provider number if correct, this means that your site has already been registered at some point in the past by the site administrator. You will need to log-in using that administrator's information to access the Health Home tab for that base number.

Q: How can I find out who is my site administrator?

A: If you have your own eMedicaid login but do not know who your site administrator is, use the "who is my administrator" button to identify this person. If you do not have your own login and do not know who your site administrator is, you may e-mail the Health Homes account at mdh.healthhomes@maryland.gov and we can look this up for you.

Q: How can I change our eMedicaid administrator information?

A: Please contact Lisa Runk at 410-767-5351 to update your eMedicaid administrator. She will reset the administrator's password so that you can login and change the administrator information.

Q: I'm logged in, but not all of my sites are showing up.

A: Only sites that share the same base Medicaid provider number will show up on the Health Home tab. To have access to sites with different base Medicaid provider numbers, they must be registered separately by the site administrator. If you are not the site administrator, confirm that your administrator gave you access to all the sites you need.

2) Participant Enrollment and Discharge

Q: What information should I collect during the intake process in order to enroll participants into the Health Home?

A: Depending on the program type, you will need to collect different information. For a complete list, please refer to the eMedicaid Intake Documents:
https://health.maryland.gov/bhd/Pages/eMedicaid-Participant-Intake-Documents.aspx

Q: What fields are required and what fields are optional to complete for the initial participant intake?

A: The fields that are required for the initial intake are height, weight, BMI (automatically calculated), and measures associated with reported diagnoses. The exception is measures associated with Diabetes Glucose Tolerance Test (GTT) and Lipid Density Profile (LDL) fields may be left blank if they are not medically appropriate for participants with diabetes or high blood pressure. Other fields not marked with an asterisk are optional.

Q: What's an "incomplete intake" option?

A: The incomplete intake option is when the blood pressure and HbA1c fields may be left blank upon initial intake due to the challenge of obtaining up to date medical information for some participants. However, these measures must be reported within 60 days of intake to ensure an accurate baseline and the participant's reengagement with primary care. You will receive an alert after 45 days, to remind you to complete the participant intake. This will appear at the top of the Health Homes home page.

You may update all incomplete intakes within 60 days by clicking on "View Incomplete Intakes" under the Reports section. After 60 days, you will no longer be able to update the participant intake information.

Q: When does a Health Home Nurse Practitioner or a Physician Consultant have to sign off on the intake assessment?

A: A Health Home Nurse Practitioner or a Physician Consultant must review and sign-off on the initial intake assessment within 60 days of a participant's enrollment in the Health Home.

Q: Should I use a standard statement for the Nurse Practitioner or Physician Consultant sign off?

A: No, you're free to develop you own standard statement with the understanding that sign off indicates that the Nurse Practitioner or Physician Consultant reviewed the assessment to ensure appropriateness and identify areas of necessary medical follow-up.

Q: If I completed a comprehensive assessment for a participant in the last 6 months, can I use that information during the Health Home intake?

A: As stated in the provider manual, if a comprehensive assessment has been performed in the past 6 months, the findings from this should be used during the Health Home intake.

The primary purpose of the intake assessment is to confirm that the Health Home has up-to-date information regarding their participants' physical and behavioral health needs. We expect that this information will be gathered through a variety of sources that may include an on-site assessment, recent PCP records, or current PRP staff knowledge of the participant. As long as the data points in the eMedicaid intake are accurately completed (see the last appendix in the manual), and the Health Home Physician/NP Consultant has reviewed and signed off on the final assessment, you have fulfilled the intake requirement.

Q: I am not able to make changes to a participant's intake information anymore! What's going on?

A: The participant intake may only be updated within 60 days of the initial intake submission date. After 60 days, the "Update Intake" button will no longer appear on the screen and you will no longer be able to make changes to the participant intake information.

Q: Some of our participants that have moved from one of our sites to another. How do I make this change in eMedicaid?

A: The participants must be first discharged from the current location and then enrolled in the new location:

1) Select "Discharge Patient" on the bottom of the Patient Profile screen.
2) Select the reason for the discharge from the drop down menu (in this case it would be relocation).
3) Enter the discharge date.
4) Select "Discharge" to officially discharge the participant. The discharge information will now appear on the bottom of the participant's profile
5) Enroll the participant to the new location.

Q: How do I delete or modify a previously reported service?

A: You may modify an entry in eMedicaid within 30 days of the initial intake report using these steps:

1) Go to the Search Patient tab on the Health Home screen.
2) Enter the recipient's Medicaid number in the corresponding field.
3) Click on the recipient's account ID to open the recipient information.
4) Click on the "Services" tab in the Patient Home screen.
5) Click the service entry that you wish to modify or delete. This will open the service information entry page.
6) You may unselect or modify a service on the services information entry page. Then resubmit it to finalize the change.

Q: Where in eMedicaid should I place six month reassessment data for participants?

A: Reassessment should be used to update participants' medical conditions, outcomes and social indicators as well as to report any new diagnoses into eMedicaid. To report the six month reassessment, use the "enter new" feature in the system.

Q: When I try to enroll a participant in eMedicaid, I receive an error message that says "Patient is not eligible for Health Home services." Why is this message showing up?

A: This could mean that the participant is not eligible for Health Home services because he or she does not meet the participant requirements, is not eligible for full Medicaid benefits on the day of enrollment, or may already be enrolled with another Health Home provider.

Q: Should I check eligibly prior to enrolling a participant in eMedicaid or delivering Health Home services?

A: Yes, Medicaid eligibility should be confirmed prior to performing the intake process, enrolling a participant in the Health Home, and delivering any services. Providers can check eligibility using the Eligibility Verification System (EVS).

The eMedicaid system checks participant eligibility only upon participant intake. This means that participants without Medicaid will not be automatically discharged or blocked within the in eMedicaid system but claims submitted with dates of service from ineligible periods will be denied. For this reason, it is important to check EVS before delivering services.

Q: Should I discharge a participant from eMedicaid if they lose Medicaid eligibility? Will I be paid for Health Home services provided during a period in which they retroactively regain eligibility?

A: If a participant loses Medicaid eligibility, we recommend that you delay discharging the participant through eMedicaid unless it is unlikely that the participant will regain eligibility. This is because re-enrolling a previously discharged individual requires performing a new intake record, rather than simply "reactivating" the existing record in eMedicaid.

In these scenarios, it is the provider's decision whether he/she wishes to deliver Health Home services. Medicaid will deny any claims for services delivered when the participant was Medicaid ineligible. However, if the participant regains coverage, the provider can bill for services delivered during the retroactive eligibility period.

Q: Can a participant be considered eligible for Health Homes as a Specified Low Income Medicare Beneficiary (SLMB) beneficiary?

A: No, only those with full Medicaid coverage are eligible for Health Homes, which does not include the SLMB eligibility group.

3) Service-Related Questions

Q: What does the "Care Plan Update" service entail? Is this only for official biannual assessments resulting in changes to the care plan?

A: The "Care Plan Update" service is not limited to the biannual reassessment and formal update. Any time in which the care plan is updated to include a substantive change related to a Health Home goal, this may be reported as a Health Home service for that month. For example, if a participant has been struggling to control their Diabetes, and the Health Home Care Manager and PRP staff member meet to discuss ways in which this could be better addressed, then determine a new course of action in partnership with the participant, recording it in the care plan, this would qualify as a Health Home service.

Q: Can a participant be dually enrolled in the Health Home for an OTP program and the Health Home for PRP services?

A: A participant may only be enrolled with one Health Home at a time, so in the event that someone receives both PRP and OTP services, and both service providers are Health Homes, they will need to decide with which Health Home they would like to enroll the participant.

Q: Our organization merged with another program. What should we do from a Health Home perspective?

A: Participants must be enrolled with the Health Home of the PRP, OTP, or MT program for which they receive regular behavioral health services. This means that you should discharge participants from your previous Health Home and re-enroll them by creating a new record in eMedicaid under the post-merger Health Home site.

You should use the previous intake assessment/historical information to complete the new intake in eMedicaid and you will not be able to bill for a new intake assessment.

Q: If a participant is enrolled in an OTP program, what are the criteria for that individual to be eligible to participant in a Health Home?

A: In order to participate in the Health Home, a participant must have one of the risk factors for current use or history of dependence on alcohol, tobacco, or other substances in addition to their opioid substance use disorder.

Q: Can a Health Home service be delivered on the same day as an OTP counseling session?

A: Yes, an OTP staff member can deliver a Health Home service on the same day as OTP counseling and bill using a bundled rate. However, the Health Home service must be clearly differentiated from the counseling service in purpose and in documentation. This would exclude any services directly related to substance use prevention or management.

Q: May MSW students performing their field placement with a Health Home deliver Health Home services?

A: Services delivered by a paid staff member, including volunteers or interns, must be supervised by a licensed professional. In addition, any staff delivering services must be appropriately trained and certified to deliver services.

Q: Is there any guidance on the 24 hour coverage requirement for Health Homes?

A: The requirement for 24 hour coverage is fulfilled by compliance with PRP program regulations, which require on-call and crisis services 24/7. Please refer to COMAR 10.21.21.07.

4) Health Home Billing

Q: Can I bill for Health Home services prior to a participant's eMedicaid enrollment date?

A: Services provided prior to the participant's enrollment date in eMedicaid will be denied. Health Homes may begin billing for an individual's participation in the Health Home only after the intake has been performed and successfully submitted into eMedicaid.

Q: I'm confused about the intake process billing date. Where can I find more information about this?

A: In general, since the intake process involves more than the assessment alone, the date of service for the intake claim should be the date the intake was submitted into eMedicaid, and not the date of the assessment.

For more information, please refer to the following memo:
https://health.maryland.gov/bhd/documents/healthhomeupdateintakesignoffandoutcomes5_7_2014.pdf

Q: What date of service should I use to bill for services?

A: For the W1760 intake code, use the date the intake was submitted to eMedicaid. For the W1761, use the date of the last service delivered in that month.

Q: Can individuals disenroll from the health home for any reason at any time? Can they do so mid-month? What happens if individuals want to go in and out of health homes?

A: An individual may disenroll from the Health Home at any time for any reason, revoking their consent to participate. If this occurs mid-month, and the minimum of two services delivered has already been met, the provider may submit a claim for that individual's monthly rate. If the disenrollment involves substantive discharge planning outside the normal scope of PRP, MT, or OTP services, this may count towards the service minimum for the month. Providers may not bill the monthly rate if the service minimum has not been met.

Q: If I re-enroll a discharged participant into a Health Home, can I bill for the intake process?

A: The intake procedure may be billed only once upon initial intake. However, if a participant is discharged from a Health Home and after 90 days re-enrolls with the same Health Home, a provider can bill for a new intake process. If less than 90 days have passed, the intake may not be billed.

Q: If a participant did not complete all six PRP visits in a month but received both Health Home visits, can the Health Home still deliver and bill for services?

A: Yes, the Health Home may deliver and receive payment for Health Home services as long as the participant is engaged in PRP services (and has therefore met the medical necessity criteria for these services). The PRP case rate does not have to be met before Health Home services can be delivered.

Q: If our agency includes a PRP and OMHC, can an OMHC doctor deliver a Health Home service for a participant enrolled in the PRP Health Home, assuming we do not double bill?

A: No, only services delivered by the PRP, MT/ACT, or OTP provider may be counted as Health Home services. However, if the agency wishes to employ a part-time clinic doctor as their Physician Consultant at the required level, a service like the one mentioned could qualify, although this is not a role we typically expect the Physician/NP consultant to play.

Q: Can a Health Home bill for two services in the same category in a given month?

A: Yes, a Health Home can bill for two services in the same category in a month as long as they are appropriate to the participant's plan of care.

Q: Can OTP staff who are not designated as Health Home staff bill for services?

A: OTP staff cannot bill for Health Home services that are part of the bundled rate. Additionally, only Health Home care managers or MD/NP consultants may deliver group services. Restrictions beyond this depend on the qualifications, training, or licensure of the particular staff member.

Q: Do DSM V codes affect eMedicaid in anyway?

A: The only impact of DSM V codes on eMedicaid is if you are using the eClaims system. In this case, you should report the current DSM V code(s) on the claims.

Q: For population health service, should I create separate individual Health Home billing tickets for each participant?

A: In order to count population health services toward the minimum of 2 required services for the monthly rate, you need to report the service in eMedicaid for each individual. However, you do not have to have a separate note in each of the participant's case file as long as you are able to produce the complete PHM report with all names if requested by the Department.

Q: Our claims were paid incorrectly, how do we make adjustments to these claims?

A: To correct claims that were paid incorrectly, please submit an Adjustment Request Form. Be sure to attach any supporting documentation, such as remittance advices and CMS 1500 claim forms, along with your Adjustment Request Form. Please mail the Adjustment Request Form and supporting documentation to the following address:

Medical Assistance Adjustment Unit
P.O. Box 13045
Baltimore, MD 21203

You can also refer to the Health Home Billing Instructions for additional information on this process, accessible here.

5) Services for Children and Adolescents

Q: Are there specific regulations for providing Health Home services to children and adolescents?

A: Yes, please refer to the Health Home Regulations COMAR (10.09.33) for specific requirements related to serving children and adolescents in a Health Home. You may also refer to the Health Home Provider Manual for additional resources, available on the website and accessible here.

Q: We would like to start providing Health Home services to children and adolescents. Is there another Health Home I may contact for questions?

A: If you wish to contact other Health Home providers serving children and adolescents, you may refer to the list of approved Health Home providers found on the Health Homes website and accessible here.

6) Other Questions

Q: We combined the Health Home Director Role with the Consultant Role for the Health Home. How many hours are sufficient for this combined role?

A: The number of hours depends on your enrollment levels. The individual must be employed at the level for their director duties, *plus* the additional hours required as the MD consultant. For more information, please refer to the provider manual.