Adirondack Health Institute

Lead Empower Innovate

# POLICY AND PROCEDURE

***Title***: Health Home Billing Policy

***Intended Population***: Health Home Serving Adults and Children

***Effective Date***: 9/21/2015

***Review Date***: 4/1/2020; 2/1/2021

***Date Revised***: 4/23/2019; 9/1/2019; 2/1/2021, 2/1/2022

## Purpose of Policy

To define and put parameters around the Adirondack Health Institute Health Home (AHIHH) billing processes and procedures. It is the policy of the AHIHH to ensure that services billed through the Health Home program meet minimum requirements as defined by NYSDOH, as well provide transparency around the billing process. This policy is meant to enhance, not supersede guidance set forth by NYSDOH.

## Scope

1. This policy must be distributed to all AHI Health Home Program staff and all subcontracting Health Home Service Providers.
2. All questions regarding this policy or its implementation may be directed to the AHI Health Home Program Director.

## Statement of Policy

AHI shall develop, disseminate, and review at least annually a Health Home Billing Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of Health Home Billing procedures.

## Definitions

***Health Home Service Provider (HHSP)***: an organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

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***Health Home Candidate:*** a person who is potentially eligible to become a Health Home Participant and is assigned by an MCO or NYSDOH to AHI or is referred by an organization.

***Health Home Enrollee:*** a person who meets the eligibility criteria for Health Home and has agreed to enroll, or whose parent/guardian has consented for him/her to enroll.

***"Assignment" and "Re-Assignment":*** the process by which a Health Home Candidate is assigned to an AHI Health Home Services Provider or re-assigned from one AHI Health Home Services Provider to another AHI Health Home Services Provider.

***Care Management Record System:*** a structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

***Core Health Home Services:*** The list of five (5) approved categories of services for which a Health Home Care Management Agency can be paid for services to an enrolled Health Home member, as defined by the New York State Department of Health:

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Member & Family Support
- Referral and Community & Social Support Services

Note: the sixth category of Core Health Home Services, "The use of HIT [Health Information Technology] to link services, as feasible and appropriate," is NOT considered a billable activity.

***NYSDOH:*** New York State Department of Health

***HARP:*** Health and Recovery Plan

***HCBS:*** Home and Community Based Services

***Workforce member:*** means Employees, board members, volunteers, interns, independent contractors, vendors, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity. This includes full and part time employees, affiliates, associates, volunteers, and staff from third party entities who provide service to the covered entity.

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***AOT:*** Assisted Outpatient Treatment is a court-ordered plan for individuals with mental illness to receive and accept outpatient treatment. In these cases, an order is issued to the director of community services (DCS) who oversees the mental health program of a locality (i.e., the county or the City of New York mental health director). The court orders will require the director to provide or arrange for those services described in the written treatment plan that the court finds necessary. The initial order is effective for up to 1 year and can be extended for successive periods of up to one year. The legislation also establishes a procedure for evaluation in cases where the individual fails to comply with the ordered treatment and may pose a risk of harm.

***CANS-NY:*** The Child and Adolescent Needs and Strengths – New York (CANS-NY) serves as a guide in decision making for Health Homes Serving Children regarding acuity, as well as to guide service planning specifically for children and adolescents under the age of 21 with behavioral needs, medical needs, developmental disabilities and juvenile justice involvement.

**Background**

The Health Home Billable Services Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

**POLICY**

The Adirondack Health Institute Health Home (AHIHH) is a NYSDOH lead entity designated in Clinton, Saratoga, Warren, Washington, Hamilton, St. Lawrence, Franklin, Hamilton, and Essex counties. Effective 12/1/2016, lead Health Homes assumed the responsibility of billing all Health Home claims for Health Home service providers (HHSP's). As such, AHIHH will submit all Health Home billing on behalf of our HHSP's.

HHSP's are responsible for submitting a billing assessment; High, Medium, Low (HML) assessment for Adults and the Children's Billing Questionnaire (CBQ) assessment for Children. Billing assessments serve as the HHSP attestation that a billable service occurred in the month of the billing assessment.

All Health Home services must be documented timely in the AHIHH Care Management record system. HHSP's should complete all billing assessments/questionnaires by the 10$^{th}$ calendar day of the month following the end of the previous month, but no later than 60 days. Any claims submitted after 60 days may not be paid.

AHIHH will extract all billing information from the care management record system and submit claims on a weekly basis. Each HHSP will be granted access to the AHIHH billing portal as outlined in the Health Home Administrative Service Agreement. To assure that HHSP's are paid timely, AHIHH will process Health Home claim payments to HHSP's, at minimum, on a bi-weekly basis. AHIHH administrative fees will be deducted prior to distribution. ***Refer to your agencies Health Home Administrative Agreement for details regarding administrative fees.***

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***See Appendix C for current Health Home Billing rates and a link to restricted billing codes***

**HEALTH HOME CANDIDATE OUTREACH**

The purpose of outreach is to locate the Health Home Candidate, explain the services available to them under the Health Home program, answer any questions, and engage the person in active care management. Outreach and engagement activities must focus on supporting an individual in their care and promoting continuity of care.

Effective July 1, 2020 Health Home Outreach and Engagement is no longer a billable service. As of July 1, 2020, the Outreach Billing Questionnaire is no longer be required.

***See Appendix D for Outreach Activities***

**BILLABLE SERVICES DURING ENROLLMENT- ADULTS**

Any billable service provided to or on behalf of an enrolled Health Home participant must include one of the five (5) core Health Home services as defined in the Definitions section above (exclusive of HIT).

Active, ongoing and progressive engagement with the client must be documented in the care management record to demonstrate care planning and/or the client achieving their personal goals. Although periodic face-to-face interaction with the Health Home enrollee is desirable, there is no face-to-face contact requirement for adults and care management activities can be conducted remotely if appropriate for the enrollee; except in the case of conducting the Adult Comprehensive Assessment and the Community Mental Health Assessment for HARP clients and some specialty populations. ***See attached billing desk guide for specialty populations.***

Although rare, it is possible to bill for Health Home services for a month in which the Care Manager did not directly interact with the enrollee. Such examples include but are not limited to:

- Case conferencing with consented collateral contacts for coordinating care, evaluating goals, or getting feedback/input into the plan of care
- Interactions with other members of the care team for coordinating care, discussing enrollee needs, or consulting about enrollee goals
- Following up on referrals to community, behavioral health, or medical service providers, including providers of HCBS for HARP enrollees
- Advocating for services on behalf of the enrollee

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The delivery of one of the five (5) core Health Home services (exclusive of HIT) can be delivered via the following means:

- In-person communications with an enrollee, team member, practitioner, practitioner's staff member, or consented collateral contacts
- Phone communication by speaking with the enrollee, team member, practitioner, or practitioner's staff member
- Electronic communications including e-mails and text messages provided a return response is received from the enrollee, team member, practitioner, or practitioner's staff member
- If a voicemail is left and the call is returned with a subsequent voicemail by the enrollee, team member, practitioner, or practitioner's staff, that shall constitute a billable service.

**BILLABLE SERVICES DURING ENROLLMENT- CHILDREN**

Any billable service provided to or on behalf of an enrolled Health Home participant must include one of the five (5) core Health Home services as defined in the "Definitions" section above (exclusive of HIT).

Active, ongoing and progressive engagement with the child must be documented in the care management record to demonstrate care planning and/or the child achieving their goals as developmentally appropriate.

Children with medium and high acuity (as determined by the CANS-NY) must be provided with a minimum of two billable services per month, one of which must include a face-to-face encounter with the child.

In cases where the child is considered low acuity (as determined by the CANS-NY), the care manager must have at least one monthly contact with the child. A face-to-face encounter with the child a minimum of quarterly.

The CANS-NY and Children's Comprehensive Assessment will be conducted face-to-face with the child and/or his/her guardian.

Although rare, it is possible to qualify Health Home services as billable when the Care Manager did not directly interact with an enrolled child. (Note: This does not negate the need for at least one face-to-face encounter with the child if the child is considered medium or high acuity.) Such examples include but are not limited to:

- Case conferencing with consented collateral contacts for coordinating care, evaluating goals, or getting feedback/input into the plan of care
- Interactions with other members of the care team for coordinating care, discussing enrollee needs, or consulting about enrollee goals
- Following up on referrals to community, behavioral health, or medical service providers
- Advocating for services on behalf of the enrollee

**POLICY AND PROCEDURE**

- The delivery of one of the five (5) core Health Home services (exclusive of HIT) can be delivered via the following means:

**Electronic communication including e-mails and text messages**

- Electronic communications including e-mails and text messages are considered billable if one of the core Health Home services are provided (i.e. it cannot just be a "checking in") AND a response is received from the child or his/her guardian as appropriate, team member, practitioner, or practitioner's staff member

**Phone communication**

- Phone communication is billable if one of the core Health Home services are provided by speaking with the child and/or his/her guardian as appropriate, team member, practitioner, or practitioner's staff member
- If a voicemail is left and another is returned by the enrollee (or his/her guardian), team member, practitioner, or practitioner's staff, that shall constitute a billable service.

**In-person communication**

- All in-person communications with an enrolled child (and his/her guardian as appropriate), team member, practitioner, practitioner's staff member, or collaterals shall be considered billable if one of the five (5) core Health Home services are provided.
- There is a requirement to have at least one successful face-to-face encounter with the child (and his/her guardian as appropriate) if the child has a medium or high acuity score as determined by the CANS-NY.

**BILLING DURING DILIGENT SEARCH EFFORTS (*See Continuity of Care Policy for additional information related to Diligent Search Efforts)***

Acceptable Diligent Search Effort Activities include, but are not limited to:

- Attempting face to face visit to the last known address
- Phone contact with care/service providers
- Contact with the Local Government unit (LGU)/ Single Point of Access (SPOA)
- Contact with collaterals, emergency contacts and supports to include parent or guardian, family, etc.
- Contact with the member's Parole Officer or Probation Officer, if applicable.
- Accessing online criminal justice resources (e.g., WebCrim, https://www.doccs.ny.gov, VineLine, Mobile Patrol)
- Contact with school
- Contact with Local clinics (Methadone Clinic)
- Contact with homeless shelters
- Reviewing Hospital Alerts, RHIO or PSYCKES
- Others, appropriate to the member and support search efforts.

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**SERVICES THAT ARE NOT BILLABLE DURING ENROLLMENT**

The below services are not considered billable.

- Mailing a letter
- E-mailing an enrollee without receiving a response
- Texting an enrollee without receiving a response
- Receiving a piece of information from or regarding an enrollee. This includes letters, faxes, voicemails, and e-mails.
- Leaving a single voicemail for an enrollee, team member, practitioner, or practitioner's staff member.
- Any interaction with or on behalf of a member that does not provide one of the core five (5) Health Home services, regardless of mode of delivery, is not billable.

**TIMELY DOCUMENTATION**

The Health Home Service Provider will document all billable activities in the AHIHH Care Management Record.

- The record will include a description of the activity/service provided, the date of service and the type of contact (face-to-face, telephone, mail, e-mail).
- While not considered a billable activity, the HHSP may contact AHI Health Home to request additional or updated contact information for a prospective Health Home participant who is enrolled in a Medicaid Managed Care Plan (HARP [Health and Recovery Plan] or non-HARP). AHI Health Home will reach out to the Managed Care Organization within 48 hours via a secure method to obtain this information and will share it with the HHSP within 48 hours of receiving the information back from the Managed Care Plan.
- Document ALL Diligent Search Efforts, including the notification to AHIHH and the MMCP, and outcomes of all activities. Each activity should be documented in the Care Management Record System. Each activity should be documented separately to show the progression through the month.

**Quality and Performance**

HHSP's must develop internal Quality Assurance processed to assure appropriate billing submissions.

AHIHH will review a random sample of cases for appropriate billing and documentation to support the billing rate as part of the quality and performance improvement program. AHIHH will alert HHSP's of any case found to be lacking appropriate billing and/or documentation as part of the review process. HHSP's will be responsible to promptly mitigate any such circumstances.

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**TRAINING**

This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of office hours a training will be developed to understand what constitutes a billable service across all segments.

***Contact Person:*** Director, Care Management and Health Home

***Responsible Person:*** Health Home Service Provider

***Approved By:*** Chief Operating and Compliance Officer

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**Appendix A**

**Health Home Standards for Billable Core Services**

| Core Service | Type of Activities |
|---|---|
| Comprehensive Care Management | • Complete a comprehensive health assessment/reassessment inclusive of medical/behavioral /rehabilitative and long-term care and social service needs.<br>• Complete/revise an individualized patient centered plan of care with the patient to identify patient 's needs/ goals and include family members and other social supports as appropriate.<br>• Consult with multidisciplinary team on client's care plan/needs/goals.<br>• Consult with primary care physician and/or any specialists involved in the treatment plan<br>• Conduct client outreach and engagement activities to assess on going emerging needs and to promote continuity of care & improved health outcomes.<br>• Prepare client crisis intervention plan. |
| Care Coordination & Health Promotion | • Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.<br>• Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery and self-management.<br>• Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs.<br>• Advocate for services and assist with scheduling of needed services.<br>• Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.<br>• Monitor/support/accompany the client to scheduled medical appointments.<br>• Crisis intervention, revise care plan/goals as required. |
| Comprehensive Transitional Care | • Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.<br>• Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to ensure a safe transition/discharge that ensures care needs are in place.<br>• Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.<br>• Link client with community supports to ensure that needed services are provided.<br>• Follow-up post discharge with client/family to ensure client care plan needs/goals are met. |
| Patient & Family Support | • Develop/review/revise the individual's plan of care with the client/family to ensure that the plan reflects individual's preferences, education and support for self-management.<br>• Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues, as needed.<br>• Meet with client and family, inviting any other providers to facilitate needed interpretation services.<br>• Refer client/family to peer supports, support groups, social services, entitlement programs as needed. |
| Referral to Community & Social Support Services | • Identify resources and link client with community supports as needed.<br>• Collaborate/coordinate with community base providers to support effective utilization of services based on client/family need |

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**Appendix B**

**Desk Guide: Billing Desk Guide for Specialty Populations**

| Population | Service Level | Intensity |
|---|---|---|
| Adult Mainstream | Minimum 1 Core Service per month | • Comprehensive Assessment must be face-to-face |
| Adult AOT | Minimum of 4 Core Services per month | • All 4 Core Services must be face-to-face<br>• Comprehensive Assessment must be face-to-face |
| Adult HH+ | Minimum of 4 Core Services per month | • 2 Core services must be face-to-face<br>• Comprehensive Assessment must be face-to-face |
| Adult HH+ Stepdown | Minimum 1 Core Service per month or more depending on the members needs | • Minimum of one core service that does not need to be face to face<br>• HML should be marked that the member is a HH+ member<br>• HHSP should state in the HML that the minimum services were NOT provided; this will trigger billing at the High Risk/High Need rate (1874 Rate Code) |
| Adult HARP | Minimum 1 Core Service per month | • HCBS Eligibility Assessment must be face-to-face<br>• Comprehensive Assessment must be face-to-face |
| Children (Low Acuity) | Minimum 1 Core Service per month | • Quarterly face-to-face<br>• CANS-NY must be completed face-to-face<br>• Comprehensive Assessment must be face-to-face |
| Children (Medium/High Acuity) | Minimum 2 Core Services per month | • 1 Core Service must be face-to-face<br>• CANS-NY must be completed face-to-face<br>• Comprehensive Assessment must be face-to-face |

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**Appendix C**

**Health Home Billing Rates**

| Health Home Rate Codes in Effect for Health Home Services on/after July 2020 (Rate changes highlighted in yellow) | | | | |
|---|---|---|---|---|
| Rate Code | Rate Code Description | Rates Apply to | Rates Effective July 1, 2020 | |
| | | | Upstate * | Downstate* |
| 1853 | Health Home Plus/Care Management | Health Homes Serving Adults | $750.00 | $800.00 |
| 1860 | Health Home Services - Adult Home Transition ** | HHs Serving Adult Home Class Members | N/A | $800.00 |
| 1861 | Adult Home Assessment and Management Fee ** | HHs Serving Adult Home Class Members | N/A | $200.00 |
| 1873 | Health Home Care Management | Health Homes Serving Adults | $200.00 | $213.00 |
| 1874 | Health Home High Risk/Need Care Management | Health Homes Serving Adults | $360.00 | $383.00 |
| 1862 | Health Home Outreach (Adult) | Health Homes Serving Adults | N/A | N/A |
| 1863 | Health Home Outreach (Children) | Health Homes Serving Children | N/A | N/A |
| 1864 | Health Home Services - Children (Low) | Health Homes Serving Children | $225.00 | $240.00 |
| 1865 | Health Home Services - Children (Med) | Health Homes Serving Children | $450.00 | $479.00 |
| 1866 | Health Home Services - Children (High) | Health Homes Serving Children | $750.00 | $799.00 |
| 1868 | Health Home-CANS Assessment (Children) | Health Homes Serving Children | $185.00 | $185.00 |
| 1869 | Health Home Services - Children (Low) (Inc FFP) | Health Homes Serving Children | $225.00 | $240.00 |
| 1870 | Health Home Services - Children (Med) (Inc FFP) | Health Homes Serving Children | $450.00 | $479.00 |
| 1871 | Health Home Services - Children (High) (Inc FFP) | Health Homes Serving Children | $750.00 | $799.00 |

**Notes:**

* Downstate includes NYC, Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk and Westchester Counties. Upstate includes all other counties.

** Rates only apply to impacted Adult Home class members.

Health Home billing rates can also be found by clicking on the link below:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/current_hh_rates.pdf

See link below for Health Home billing code restrictions
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf

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**Appendix D**
**Outreach Activities**

**Outreach Activities:**

The below activities are appropriate to conduct in progressively outreaching a client.

Phone calls

- Phone calls which result in the care manager/outreach worker having a conversation with the prospective Health Home member, or their parent or guardian as appropriate.
- Phone calls which result in the care manager/outreach worker leaving a voicemail for a prospective Health Home member, or their parent or guardian as appropriate, with information on how to call agency back

In person/Street Level Outreach

- In person outreach that has been successful (as defined by the care manager/outreach worker communicating face-to-face with a prospective Health Home client his/her parent or guardian as appropriate).
- Street level outreach is defined as the care manager/outreach worker communicating face-to-face with a prospective Health Home client, or their parent or guardian as appropriate.

Research to Locate

- Research to locate the prospective Health Home member utilizing various websites (including but not limited to whitepages.com, Google, NYS Inmate Lookup, and Vinelink.com).
- Research to locate the prospective Health Home member utilizing an organization's EHR.
- Interaction with a significant other, family member, provider, or other person who confirms or offers new contact information about a Health Home Candidate.
- Contact with a referral source for the purpose of connecting with an individual referred for Health Home Care Management who cannot be located at the phone number or address provided on the referral form.

The below activities are appropriate to conduct in progressively outreaching a client and must be accompanied or followed up by another outreach attempt (phone call, in person attempt, research to locate).

Phone

- A phone call to a disconnected/wrong/out of service number does not constitute outreach.

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Mailings

- The sole act of mailing a letter to a prospective Health Home client, or their parent or guardian as appropriate, does not constitute outreach.

E-mail

- The sole act of sending an e-mail to a prospective Health Home client, or their parent or guardian as appropriate, does not constitute outreach unless a reply from the prospective Health Home member is received. An e-mail that has been "bounced back" as undeliverable does not constitute outreach.