Billing and Documentation Guidance for Health Home Adult Rates with Clinical and Functional Adjustments Effective May 1, 2018 Revised March 2019

Health Home Rate Determination and Coding

MAPP-Health Home Tracking System (MAPP-HHTS)

Effective May 1, 2018, the MAPP-HHTS Clinical and Functional Questionnaire (HML) will be enhanced to support the transition to a new streamlined rate structure. The MAPP-HHTS will continue to be used to determine the risk adjusted criteria necessary to determine the appropriate rate/procedure and modifier code where applicable.

The answers to these questions are critical and any questions that don't apply to a member or any questions that cannot be answered may be answered with *Unknown*. Documentation as outlined below is required to bill for High Risk/Need or Health Home Plus (HH+) rates.

If no questions are answered, or all are answered *Unknown*, the rate must be billed as Health Home Care Management.

The Clinical and Functional Questionnaire will be required every 6 months. If circumstances change, the Clinical and Functional Questionnaire can be updated to reflect those changes. This will trigger the system to calculate the member's rate and begin a new 6-month period.

Providers are **REQUIRED** to identify if a member is part of a special population (AOT, Adult Home, HH+) and indicate if a core service/minimum service was provided **every month**. When billing for the HH+ rate, minimum contacts and face to face requirements must be met each month. If these minimum contact requirements are not met for HH+, then the High Risk/High Need rate will be billed.

If a *month 1* HML is voided, then all subsequent HMLs (months 2-6) that used that *month 1* HML response to calculate the monthly HH rate will also be voided.

If a provider responds to a non-required question in *months 2-6*, then that month becomes a new *month 1* and triggers a new 6-month period. For example, if a member becomes homeless in month 2 and the HML is updated, the rate will adjust, and this will now be considered *month 1* for which the agency may bill at the corresponding rate. Any modifications in the Clinical and Functional Questionnaire should be supported by documentation as defined and described below.

Rate/Procedure Codes Definitions

COS	Provider Specialty Code	Revenue Code	Member Identifer	Billing Type	Taxonomy code
15	371	0-500	CIN	34	251B00000x
Rate Code	**Rate Code Description**	**Rates Apply to**	**Revenue Code**	**Procedure Code**	**Modifier**
1862	Health Home Outreach (Adult)	Health Homes Serving Adults	0500	G9001	
1863	Health Home Outreach (Children)	Health Homes Serving Children	0500	G9001	U1
1864	Health Home Services - Children (Low)	Health Homes Serving Children	0500	T2022	U1
1865	Health Home Services - Children (Medium)	Health Homes Serving Children	0500	T2022	U2
1866	Health Home Services - Children (High)	Health Homes Serving Children	0500	T2022	U3
1869	Health Home Services - Children (Low) (Inc FFP)	Health Homes Serving Children	0500	T2022	U1
1870	Health Home Services - Children (Med) (Inc FFP)	Health Homes Serving Children	0500	T2022	U2
1871	Health Home Services - Children (High) (Inc FFP)	Health Homes Serving Children	0500	T2022	U3
1868	Health Home-CANS Assessment (Children)	Health Homes Serving Children	0500	G0506	
1853	Health Home Plus/Care Management	Health Homes Serving Adults	0500	G9005	U4
1860	Health Home Services - Adult Home Transition	HHs Serving Adult Home Class	0500	G9005	U3
1873	Health Home Care Management	Health Home Serving Adults	0500	G9005	U1
1874	Health Home High Risk/Need Care Management	Health Home Serving Adults	0500	G9005	U2

*****Important Note*****

- Health Homes will bill the corresponding rate codes for dates of service May 1, 2018 through June 30, 2018. ***All dates of service on or after July 1, 2018 will be billed through Managed Care using the corresponding procedure code and modifiers as appropriate. For specific information regarding Managed Care billing procedures please refer to the Managed Care Organizations individual billing manual.***
- Rate codes will continue to be utilized for all fee for service Medicaid members. Health Homes and their billing vendors must use the appropriate rate codes when direct billing. All Medicaid Managed Care Plan billing instances must contain the applicable procedure code and modifier where applicable.
  Health Homes Serving Children will use current billing rates**.**
- Rate Codes are separated in the taxonomy to delineate a subpopulation of children meeting the complex trauma criteria. This distinction is not necessary for Medicaid Managed Care Plans and therefore the procedure codes and modifiers are identical.
- Health Homes must submit a valid diagnosis code which can be found on the MAPP-HHTS, Billing Support Download File. In the absence of a valid diagnosis code the following codes should be used for adults and children
  - **Z71.89- outreach**
  - **Z76.89 enrollment**

Health Home rates are posted on the DOH website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm - under: *Rates and Billing Guidance* (see: Current Health Home Rate Codes)

Health Home Serving Adults

Health Home Care Management (1873/G9005-U1) *Recommended Case Load Size: 45
This risk adjusted category must be billed at this rate if the Clinical and Functional Questionnaire yields a medium or low risk and **do not meet**:

- HARP/ HIVSNP (HARP Eligible) or;
- Adult Home Plus criteria or;
- Health Home Plus criteria

Health Home High Risk/Need Care Management (1874/ G9005-U2) *Recommended Case Load Size: 25
This risk adjusted category will include all HARP and HIV/SNP (HARP eligible) Plan enrolled members. These members can be identified by the following restriction exemption codes: H1 H2, H3, H4, H5, or H6. In addition, any member who scores High on the clinical and functional assessment can bill at this rate.

Adult Home Plus (1860/G9005-U3) Mandatory Maximum Case Load Size: 12
This risk adjusted category is applicable only to four of the five boroughs of NYC and is guided by separate guidance. Health Homes are responsible for attesting and verifying that the Care Management Agency is approved to serve this population. This subset of the Health Home population represents a group of members transitioning from Adult Homes to the community. Health Homes are required to produce documentation to Medicaid Managed Care Plans as requested for the purposes of billing audits. Care Management agencies must indicate that the member meets the Adult Home Plus rate category when completing the MAPP-HHTS clinical and functional assessment.

Health Home Plus (1853/G9005-U4) Mandatory Maximum Case Load Size: 15
This risk adjusted category is guided by separate guidance distributed in partnership with the Office of Mental Health and the AIDS Institute at the following link: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/hh_plus.htm

This category serves the highest risk members who meet the single qualifying conditions of Severe Mental Illness (SMI) and HIV/AIDS. Meeting the single qualifying condition criteria alone however is not enough to bill at this rate. Members who meet criteria for HH+ must also meet additional clinical criteria. In addition, Health Homes must attest that the Care Management Agency employs staff that have the credentials and meet the supervisory qualifications to serve this population. This attestation also requires that Health Homes are verifying that care managers are meeting a minimum face to face contact per member per month. Care Management Agencies must indicate that the member meets the Health Home

Plus rate category when completing the MAPP-HHTS Clinical and Functional Questionnaire. If the care manager has met the minimum contact requirements this will be documented in the MAPP-HHTS by attesting to a core service and indicating that the member meets HH+ criteria.

***** Medicaid rates for Health Home services are based on recommended case load sizes and total care management costs. Total care management costs are based on cost reporting and average annual salary from the Department of Labor.

Documentation Standards

The following documentation standards are applicable to the clinical and/or functional indicators, client self-report, or care manager observation where applicable.

Self-Report and Care Manager Observation Documentation Framework

The goal of any documentation standard is that it be flexible enough to allow for the circumstances confronted daily. ***External documentation*** is ideal and therefore ***preferred*** to self-report or care manager observation. Given the population and systems that care managers work in, obtaining this documentation may pose significant challenges and detract from time spent with clients. In some specific circumstances obtaining the documentation may not be possible; therefore, ***substantiation*** from ***multiple sources*** is required if written external documentation is not available. A care manager ***must clearly incorporate client self-report or care manager observation in the individual's record and*** have this ***observation corroborated by additional resources such as supervisors, natural supports, etc***. Member self-report is acceptable ***if, and only if,*** there is a ***goal*** related to that area of concern ***on the care plan, and the intervention for that goal or objective matches the intensity of need*** of the person and the billing level. For example, if there is no ability to secure documentation for a member that is homeless and not utilizing any formal assistance such as shelters, this state of homelessness can be substantiated through observation and/or multiple source reports. There must be a goal to secure housing, and the interventions and objective for that goal must match the intensity of need; this would substantiate the reported level of intensity. Examples are provided below that meet the standard for goal related objectives that require higher intensity interventions.

1. In the early phases of work, some individuals may be resistant to attending appointments, getting testing, etc. which generate external documentation. For these members, care managers need to be able to document using their personal observation, or the self-report of the member and other members of their care team, to create and update plans of care that clearly document goals and interventions which will be performed to justify the billing rate.
2. Connecting the self-report documentation to service planning makes this a manageable and auditable process that encourages the practices necessary to gain the best outcomes from Health Home care management.

3. Care managers must clearly document observed functional indicators in the form of progress notes and plans of care that clearly outline goals and interventions that accurately reflect the intensity of care management services and directly align with the care management activities that will substantiate the rate.
4. Care managers ***must secure external documentation within 90 days***. Client self-report and care manager observation ***cannot exceed 90 days*** as substantiation of a clinical or functional indicator.
5. **Functional indicators for homelessness and active SUD ONLY may be substantiated by client self-report or care manager observation beyond 90 days**.

HIV Status

- **Outline of HIV - AIDS Institute Clinical Guidelines**
    - CD4 (T-cells) testing is recommended at 12 weeks and every four months after initiation of ARV until CD4 is > 200 cells/mm3 on two measures.
    - For those who are virally suppressed, CD4 testing is recommended at least every six months if CD4 is less than or equal to 300 cells/mm3.
    - Every 12 months if CD4 >300 cells/mm3 and less than or equal to 500 cells/mm3.
    - Optional if CD4 greater than 500 cells/mm3.
    - Practitioners agree that a six-month period of more aggressive care management is appropriate for an HIV+ member with a medium or high range viral load, even though they should be tested again within that period.
        - Quarterly for HIV+ persons with recent history of non-adherence, MH disorders, SU, poor social support, or other major medical conditions;
        - Every four months for most individuals after complete viral suppression;
        - Every six months for those with complete suppression for over one year and CD4 counts greater than 200 cells/mm3;
        - Note, when a person is failing viralogically, testing is recommended within four (4) weeks from a change in ARV, and at least every eight (8) weeks until completely suppressed.
- **External Documentation** – Lab results, medical records, or documented conversation from collateral contact. For the purposes of this documentation a collateral contact must be documented as a service provider or managed care organization that can confirm lab results and/or have access to the individual's medical record.
- **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity, level of need, and billing category. Documentation would include progress notes and a care plan that reflects the intensity of services needed to address the category of billing claimed. The documentation of a care plan and progress notes would maintain billing for 90 days until external documentation is obtained.

- e.g. Goal is to secure needed community services including outpatient care, routine testing and illness self-management, food resources, etc. Objectives may include:
    - Secure primary care physician (PCP) and/or specialty care, mental health or substance abuse services;
    - Secure transportation to/from appointments for behavioral and/or physical health appointments for assessment labs, etc.;
    - Reestablish benefits including Medicaid, public assistance; and,
    - Address homelessness by completing applications for housing such as HRA2010E, or secure shelter placement or other supportive housing intervention.

Interventions are the evidence that more than routine care management services of a greater scope or frequency are necessary. ***Health Homes must provide quality oversight and monitoring by auditing a sample of billing instances to assure and validate*** clear and specific interventions are associated with a clinical and/or functional indicator where applicable.

Functional Adjustments and Corresponding Documentation

Homelessness

- **Definition of Homelessness**
    - ***HUD Category 1*** - An individual who lacks a fixed, regular, and adequate nighttime residence.
        - An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
          An individual or family living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); or
        - An individual residing in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided.
    - ***HUD Category 2*** - An individual or family who will imminently lose their housing.
        - As evidenced by a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;
        - Having a primary nighttime residence that is a room in a hotel or motel, and where they lack the resources necessary to reside there for more than 14 days, or credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days; and,
        - Any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered; has no

subsequent residence identified; and lacks the resources or support networks needed to obtain other permanent housing.

- **Date Housed** – If Category 1 or Category 2 they will maintain that level of billing category for six months.
- **If Category 1 or 2 and not housed**, they will maintain that level of billing category with appropriate observation documentation until housed or discharged from the program.

- **External Documentation** - Letter from shelter or other homeless housing program, hospital discharge summary, eviction notice, documentation from local Homeless Management Information System (HMIS), or self-report.
- **Observation -** Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing until external documentation is obtained.
    - e.g. Goal is to find safe and stable housing. Objectives may include:
        - Submit applications
        - Landlord list
        - Re-establish benefits
        - Interventions would be evidence that more than routine care management services of a greater scope or frequency are necessary.

Incarceration

- **Definition of Incarcerated** – Released from state prison or county jail after sentence is served. May be on probation or parole, but that is not required to meet the definition of incarceration. Incarceration would also include detention or arrest for charges not adjudicated or sentenced; violations of probation/parole; released on bail awaiting arraignment; or other criminal justice status in which the person has an ongoing criminal justice issue requiring care management intervention.
- **External Documentation** - Release papers; documentation from parole/probation; documented conversation from collateral contact; print-out from Webcrims or other criminal justice database; letter from halfway house; or self-report (for 90 days).
- **Observation** – Substantiation of reports from care providers, the person, family, or other third-party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the rate for 90 days until external documentation is obtained.
    - e.g. Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        - Secure primary care physician (PCP), mental health or substance abuse services

        - Secure transportation to/from appointments for behavioral or physical health
        - Reestablish benefits
        - Reestablish housing

Interventions would be evidence that more than routine care management services of a greater scope or frequency are necessary.

Inpatient (IP) Stay for Physical Illness (PI)

- **Definition of IP for PI-** Inpatient admission, regardless of duration, that would require significant care coordination post discharge**. *Significant* will be defined as a member disengaged from care prior to hospitalization or the discharge plan requires linkage to care not currently established requiring additional care coordination needs such as arranging appointments, transportation, and follow-up testing.**
- **External Documentation-** Hospital discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); print out from PSYCKES; RHIO alerts of inpatient admission or MCO confirmation of admission. Self report **does not meet criteria** as sufficient documentation.
- **Observation** – Substantiation of reports from care providers, the person, family, or other third party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.
    - e.g. Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        - Secure PCP, mental health or substance abuse services, follow up appointments
        - Secure transportation to/from appointments for behavioral or physical health
        - Re-establish housing if in jeopardy or as part of discharge plan

Interventions would be evidence that more than routine care management services of a greater scope or frequency are necessary.

Inpatient (IP) Stay for Mental Illness (MI)

- **Definition of IP Stay for MI** – Inpatient admission, regardless of duration, that would include CPEP under an observation status or other psychiatric emergency/respite programs. Inpatient admission for MI that includes a transfer to other units for complex needs, including physical health, would qualify as an inpatient stay for MI. For example, a member is admitted to a MH IP unit, then transferred to the medical floor, and discharged from a medical bed to community.

- **External Documentation --** Hospital discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); documentation of Mobile crisis episodes; print out from PSYCKES; RHIO alerts of inpatient admission or MCO confirmation of admission; Self report **does not meet criteria** as sufficient documentation.
- **Observation** – Substantiation of reports from care providers, the person, family, or other third party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. The documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.
    - e.g. Goal is to secure needed community services including outpatient care, financial benefits, food resources, etc. Objectives may include:
        - Secure PCP, mental health or substance abuse services, follow up appointments
        - Secure transportation to/from appointments for behavioral or physical health
        - Re-establish housing if in jeopardy or as part of discharge plan

Interventions would be evidence that more than routine care management services of a greater scope or frequency are necessary.

Inpatient (IP) Stay for Substance Use Disorder (SUD) Treatment

- **Definition of IP Stay for SUD Disorder –** Inpatient admission in a hospital or community based setting regardless of duration that could include detoxification services (medically managed, medically supervised or medically monitored, but not ambulatory detox), inpatient rehabilitation, residential stabilization and rehabilitation or other inpatient services as defined by OASAS.
- **External Documentation --** Hospital or provider discharge summary; documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date); print out from PSYCKES or MCO confirmation; and self-report
- **Observation** – Substantiation of reports from care providers, the person, family, or other third party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. For High category of billing, the documentation of care plan and progress notes would maintain the category of billing for 90 days until external documentation is obtained.
    - Goal could be accessing community services, financial stability, developing safety plans, accessing higher levels of care, housing issues, food insecurity, access to medication, transportation, to attending medical or behavioral outpatient services.
    - Objectives must include.

- Secure primary care physician (PCP), mental health or substance abuse services, follow up appointments
- Reestablish housing if in jeopardy or as part of discharge plan

Interventions will be evidence that more than routine care management services of a greater scope or frequency are necessary.

Substance Use Disorder Active Use/Functional Impairment –

Definition of SUD Active Use/Functional Impairment – Positive lab test for Opioids, Benzodiazepines, Cocaine, Amphetamines, or Barbiturates; OR care manager observation (with superviser sign off) of continued use of drugs (including synthetic drugs) or alcohol with superviser sign off ; OR MCO report of continued use of drugs or alcohol; AND demonstration of a funcitonal impairment including continued inability to maintain gainful employment ; OR continued inability to achieve success in school OR documentation from family and/or criminal courts that indicates domestic violence and/or child welfare inolvementwith the last 120 days; OR documentation indicating Drug Court involvement AND the presence of six or more criterion of SUD under the DSM-5 which must also include pharmacological criteria of tolerance and/or withdrawal.

- **External Documentation** - Based on assessment and information gathered by the care manager from substance use providers, probation/parole, court ordered programs, domestic violence providers, local DSS, and other sources.
- **Observation** – Substantiation of reports from care providers, the person, family, or other third party sources that support the level of intensity of need and billing category. Documentation of this observation would include progress notes and a care plan that reflects the intensity of service needs to address the category of billing claimed. For High category of billing, the documentation of care plan and progress notes would maintain the High category of billing for 90 or more days if, and only if, progress notes clearly document evidence of care management interventions to support SUD intervention. This includes motivational interviewing, education, referral and linkage to recovery coaching, and other peer supports. External documentation is preferred and every effort must be clearly documented, including specific efforts to engage the individual in harm reduction and safety planning.
    - Goals related to barriers to attending medical or behavioral outpatient services,, as a result of substance use; or evidence of motivational interviewing or stages of change related goals or objectives related to the attainment of vocational and educational goals.
        - For example, goals and objectives might be utilizing motivational interviewing and stages of change approaches to move people towards active participation in treatment. In this case, a goal would be something like “I want my children back” in the person’s words.
        - The objectives would be to participate in programming or treatment and the interventions would be using these approaches to help the person see

how addressing their substance use issues might help them reach their goals.

Interventions will be evidence that more than routine care management services of a greater scope or frequency are necessary.