Medicaid Managed Care Plan Billing and Payment Protocol for Health Home Services

Effective: July 1, 2018
Revised: March 2019

Purpose
The purpose of this document is to provide technical protocols to Medicaid Managed Care Plans (MMCP) including HARP and HIV/SNP lines of business to comply with the New York State Medicaid Health Home requirements and expectations for billing and submitting claims. This document is intended to serve as resource for Medicaid Managed Care Plans.

Medicaid Health Home providers are required to read and comply with the claims submission procedures for each Medicaid Managed Care Plan's specific billing manual to assure accurate and timely claims submission, payment, and remittance guidance.

Billing and Payment Protocol

Medicaid Managed Care Plans (MMCP) capitation payment will be adjusted to include Health Home services and administrative costs in June 2018. All Health Home services with service dates on or after July 1, 2018 will be billed through the Medicaid Managed Care Plan. MMCP may not charge additional administrative fees to the Health Homes outside of the capitation payment. MMCP capitation will be calculated based on utilization and health home rate projections developed by the Department.

Administrative Service Agreements

Pursuant to Section 21.27 of the NYS Department of Health Medicaid Managed Care Model Contract, the MMCP must execute Administrative Service Agreements (ASA) with an adequate number of State Designated Health Homes to ensure enough capacity is available to serve eligible members. The MMCP is not required to execute provider contracts with State Designated Health Homes as Health Home services, as defined by the State Plan amendment, are not considered health care services. Therefore, execution of provider contracts is not applicable. The approved ASAs are sufficient however, the MMCP may choose to amend their current Health Home ASA to reflect this additional guidance no later than March 1, 2018. The MMCP may use DOH-approved language in existing provider contracts by which to amend these ASAs. MMCPs must agree to remit the State approved rates for Health Home services for a period of two fiscal years or as directed by the Department.

Claims Submission

Health Homes will submit claims to MMCP using electronic formats. Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, institutional providers who submit claims electronically are required to use the HIPAA 837 Institutional (837i) transaction. This is the preferred method of claims transmission by most Medicaid Managed Care Plans and is strongly encouraged for all Medicaid Health Home claims transmission. The UB-04 may be used when applicable and in accordance with plan specific guidance.

HIPAA compliant HCPCS and modifiers have been approved for Health Home Services. For more detailed information see Health Home Service Coding Taxonomy (Appendix A).

To avoid billing and claims errors Medicaid Managed Care Plans will provide Health Homes and designated billing vendors with a provider resource and/or billing manual which must include:

- **EDI Transmission procedures**
- **Example of HIPAA Compliant valid transaction set**
- **Clean Claim submission guidance including sample claim for Health Home Services**
- **Any other information pertinent to Managed Care claims and remittance process**

Remittance Advice

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, Medicaid Managed Care Plan Remittance Advice must be in a compliant format regarding the communication of claims status and cannot be modified. Therefore, MMCP may supplement the 835 with additional elements recommended by the Health Home MCO Workgroup Billing Subcommittee.

Reporting Requirements

A. **Required Elements for Encounter:** Non- inpatient Reporting Requirements
   a. Date of Service
   b. Provider Specialty Code- 371
   c. Revenue Code - 0500
   d. Place of Service
   e. Procedure Code – see Appendix A
   f. Modifier (as applicable)- see Appendix A
   g. Diagnostic Code – See Appendix A
   h. Category of Service -15
   i. Units- 1
   j. Charges - corresponding rate

i. Transaction Segment: Institutional
ii. COS -15
iii. Provider Specialty Code 371
iv. Rate Code

B. **Medicaid Managed Care MMCOR** - The New York State Department of Health, Bureau of Managed Care Fiscal Oversight is revising the MMCOR required reporting instructions for Health Home and will issue instructions for Medicaid Managed Care and Health and Recovery Plans (HARP).

Additional questions can be directed to: bmcfhelp@health.ny.gov

C. **Quality Reporting** (HEDIS/QARR) - Quality reporting will not be modified, changed or restructured.

CONFIGURING OUTREACH PARAMETERS FOR ADULTS AND CHILDREN

Outreach rates should be configured to pay for no more than two (2) consecutive months.

Health Home Care Management Agencies will enter outreach segments into the MAPP-HHTS.

MMCP may allow additional outreach months for predetermined circumstances as defined by the Department in policy.

CONFIGURING ENROLLMENT PARAMETERS FOR ADULTS AND CHILDREN

Adult & Child Designation

Only Health Homes that have been designated to serve children may bill Children's High, Medium, and Low rates, as determined by the CANS-NY acuity algorithm, for members under age 21. A monthly Children's Billing Questionnaire in the MAPP HHTS must also be completed prior to submitting a children's Health Home care management claim.

Health Homes that are not designated to serve children who enroll children (anyone under 21) must bill at the adult rate which is determined using the MAPP- HHTS Clinical and Functional Assessment (formerly known as HML adult billing questionnaire).

Health Homes Serving Children shall be allowed to submit claims for an initial CANS-NY assessment and a core service in that same month. An initial assessment is defined as the first assessment for an enrollment segment. If a child is disenrolled for a period of time or is transitioned to a new Health Home a new enrollment segment will result in an initial CANS-NY and billing is allowable.

Plans should ensure claim systems are able to adjudicate and reimburse claims appropriately for the following:

1) a CANS-NY assessment when performed as an initial assessment (first assessment during an enrollment segment)

2) a CANS-NY initial assessment and core service billed a) in the same month and/or b) on the same claim.

3) a CANS-NY initial assessment where the child has been disenrolled from the HH for a period of time, and is now a) re-enrolling with the same HH or b) enrolling with a new HH.

4) a second CANS-NY initial assessment performed in one month if the child changes HH's.

The following Rate/Procedure Code combinations are compatible:
1868/G0506 and T2022 U1, U2 or U3

Rate Code	Rate Code Description	Procedure Code	Modifier
1864	Health Home Services - Children (Low)	T2022	U1
1865	Health Home Services - Children (Medium)	T2022	U2
1866	Health Home Services - Children (High)	T2022	U3
1869*	Health Home Services - Children (Low) (Inc FFP)	T2022	U1
1870*	Health Home Services - Children (Med) (Inc FFP)	T2022	U2
1871*	Health Home Services - Children (High) (Inc FFP)	T2022	U3
1868	Health Home-CANS Assessment (Children)	G0506	

* Rate Codes are separated in the taxonomy to delineate a sub population of children meeting complex trauma criteria. This distinction is not necessary for Medicaid Managed Care Plans and therefore the procedure codes and modifiers are identical.

Any Health Home that serves a member that is 21 or over must bill the appropriate Adult Rate. This also applies to members 21 years and older that elect to be served by a Children's Health Home.

Enrollment rates for adults will be determined by policy guidance and clearly documented in the care management record. Health Homes are required to validate that all claims meet the requirements for the rate billed and supported by the MAPP-HHTS Billing Support Download.

Appendix A

Managed Care Plans will configure systems to receive the following Codes and corresponding rates.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm

MMCPs are will pay the corresponding rate based on the members county of residence as issued to the MMCP by the Department of Health Enrollment File (834).

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. Managed Care Plans will provide specific information regarding billing procedure 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 sub population of children

meeting 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 assessment yield 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 Caseload - 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 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. If an Adult Home member does not meet the minimum Adult Home plus requirements, then the member will be billed under 1873/1874 based on the member's responses to the clinical and functional assessment.

Health Home Plus (1853/G9005-U4)- Mandatory Maximum Caseload - 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 Health Home Plus 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 assessment. 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. If a Health Home Plus member does not meet the minimum Health Home Plus requirements in a given month, then the member is billed under rate code 1874 Health Home High Risk/Need Care Management (1874/ G9005-U2).

***** 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 Department of Labor.

SAMPLE 837i

segment	segment description	notes	example
ISA	Interchange Control Header		ISA*00* *00* *ZZ*RELEVANTHEALTH *ZZ*MEGACLRNGHOUSE *180302*1445*^*00501*000000123*1*P*:~
GS	Functional Group Header		GS*HC*RELEVANTHEALTH*MEGACLRNGHOUSE*20180302*14453612*123*X*005010X223A2~
ST	Transaction Set Header	we submit a single transaction set per file (containing claims for multiple HHs and/or multiple payers when allowed by the recipient)	ST*837*0123*005010X223A2~
BHT	Beginning of Hierarchical Transaction		BHT*0019*00*123*20180302*14453612*CH~
		Loop 1000A - Submitter Name	
NM1	Submitter Name		NM1*41*2*RELEVANT HEALTHCARE TECHNOLOGIES*****46*RELEVANTHEALTH~
PER	Submitter EDI Contact Information		PER*IC*EMILY NELL*TE*2125555555~
		Loop 1000B - Receiver Name	
NM1	Receiver Name	identify the file recipient (e.g. clearinghouse) here	NM1*40*2*MEGACLRNGHOUSE*****46*123456789~
		Loop 2000A - Billing Provider Hierarchical Level	
HL	Billing Provider Hierarchical Level		HL*1**20*1~
PRV	Billing Provider Specialty Information	HH taxonomy code (always 251B00000X)	PRV*BI*PXC*251B00000X~
		Loop 2010AA - Billing Provider Name	
NM1	Billing Provider Name	HH name and NPI	NM1*85*2*Almost Perfect Health Home*****XX*1234567893~
N3	Billing Provider Address	HH address	N3*123 Avenue of the Health Homes*Floor 4~
N4	Billing Provider City, State, ZIP Code	HH city, state, zip	N4*New York*NY*123456789~
REF*EI	Billing Provider Tax Identification	HH tax id (without hyphen)	REF*EI*123456789~
		Loop 2000B - Subscriber Hierarchical Level	
HL	Subscriber Hierarchical Level		HL*2*1*22*0~
SBR	Subscriber Information	MC for claim filing indicator code	SBR*P*18*******MC~ **MMCPS must include specific to plan in their billing manual**
		Loop 2010BA - Subscriber Name	
NM1	Subscriber Name	patient name and medicaid id	NM1*IL*1*Cage*Nicolas*****MI*HH12345H~
N3	Subscriber Address	patient address	N3*987 Dinosaur St.*Apt. #6F~
N4	Subscriber City, State, ZIP Code	patient city, state, zip	N4*Brooklyn*NY*11217~
DMG	Subscriber Demographic Information	patient DOB and gender	DMG*D8*19601231*M~
		Loop 2010BB - Payer Name	
NM1	Payer Name	payer name and payer ID (payer ID is usually 5 digits)	NM1*PR*2*Super Payer*****PI*12345~ **MMCPs must include in their billing manual**
N3	Payer Address	payer address OR blank (usually blank)	N3*12 Payer Way*Floor 34~ optional
N4	Payer City, State, ZIP Code	payer city, state, zip OR blank (usually blank)	N4*Albany*NY*10024~ optional
		Loop 2300 - Claim Information	
CLM	Claim Information	our internal claim id, charge amount, bill type (always 34)	**voiding claims in billing maual)**
DTP*434	Statement Dates	DOS-DOS (e.g. 20180301-20180301)	DTP*434*RD8*20180301-20180301~
DTP*435	Admission Date	**Use DOS for admission date**	DTP*435*D8*20180301~
CL1	Institutional Claim Code		CL1*3*1*01~ **MMCPs must include in their billing manual**
REF*EA	Medical Record Number	our internal patient id	REF*EA*654321~ optional used by vendors for internal tracking
HI*ABK	Principal Diagnosis	**Z71.89- outreach ; Z76.89 enrollment or valid dx code on BSD**	HI*ABK:R69~
HI*APR	Patient's Reason For Visit	**Z71.89- outreach ; Z76.89 enrollment or valid dx code on BSD**	HI*APR:R69~
HI*BE	Value Information	rate code	HI*BE:24:::1873~
		Loop 2310A - Attending Provider Name	
NM1	Attending Provider Name	"UNKNOWN" for the attending provider name	NM1*71*1*UNKNOWN~
REF*G2	Attending Provider Secondary Identification	NYS DOH HH unlicensed practitioner ID (to be issued at later date)	REF*G2*02249145~
		Loop 2400 - Service Line Number	
LX	Service Line Number		LX*1~
SV2	Institutional Service Line	revenue code, procedure code, modifier, charge amount	SV2*0500*HC:G9005:U1*213*UN*1~
DTP*472	Date - Service Date	DOS	DTP*472*D8*20180301~
REF*6R	Line Item Control Number		REF*6R*87654321~ optional used by vendors
SE	Transaction Set Trailer		SE*35*0123~
GE	Functional Group Trailer		GE*1*123~
IEA	Interchange Control Trailer		IEA*1*000000123~