

Policy Title: **Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings**

Policy number: HH0011

Effective date: February 21, 2020

Last revised:

Applicable to: This policy pertains to adults in excluded settings, eligible for enrollment in the Health Home Program and children/youth in excluded settings eligible for enrollment in the Health Home Program and/or Home and Community Based Services (HCBS).

Purpose

This policy specifically addresses steps that must be taken to manage new referrals from excluded settings of potentially eligible Health Home or HCBS (for children/youth) individuals.

IMPORTANT: There is a difference in the way Health Homes/Health Home Care Management Agencies must handle an individual in an *excluded setting* who is newly referred for enrollment in the Health Home program versus an already enrolled Health Home member who enters an *excluded setting*.

For already enrolled Health Home (HH) members who enter an excluded setting, Care Management Agencies (CMA)/Health Home Care Managers (HHCM) must follow requirements in the ***Continuity of Care and Re-engagement for Enrolled Health Home Members HH0006*** policy, which can be accessed on the Health Home Policy and Updates webpage at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_home/policy/greater6.htm - under: General Health Home

HHs and CMAs MUST have policies and procedures in place that address the specific protocols of this policy separately from policy HH0006 regarding excluded settings.

Policy

When an individual in an excluded setting is newly referred to the Health Home program for enrollment, it is important for the HHCM to connect with the discharge planning staff of the excluded setting to discuss the needs of the individual, the potential discharge date, and potential eligibility for Health Home Care Management and HCBS. The HHCM's role is to participate in the discharge planning process and to determine eligibility for HH enrollment and/or HCBS (for children/youth) so that service linkage can occur immediately upon discharge. Coordinating with staff and the individual prior to discharge, aids in ensuring a warm handoff for the individual to minimize the potential for gaps in service connectivity at the time of discharge transition.

Scope

When a CMA/HHCM receives a referral of an individual in an excluded setting identified as potentially eligible for HH and/or HCBS (for children/youth), the HHCM must initiate appropriate activities intended to support collaboration with the individual and the staff of the excluded setting for the purpose of discharge planning and HH enrollment.

Definitions

Excluded settings: For the purpose of this policy, *excluded* settings are those not compatible with Health Home or HCBS enrollment. Examples of excluded settings include but not limited to: nursing homes, inpatient settings such as psychiatric centers; institutions, residential facilities (RTC, RTF). Please refer to the [Guide To Restriction Exception\(RE\) Codes and Health Home Services](#) for a description. For HCBS there are specific allowable settings for the services to be provided which can be found in the [HCBS Settings Rule](#).

Individual or Member: For the purpose of this policy, when *individual* or *member* is used, it includes the individual (adult, child/youth), parent(s), guardian, or legally authorized representative as applicable to the situation.

Procedures

The referral of an adult or child/youth in an excluded setting may be received by a HH/CMA at any time prior to the individual's anticipated discharge date. However, for the purpose of this policy, billing for HHCM activities related to discharge planning is restricted to the **thirty-day** period prior to the individual's discharge.

HHCM activities related to discharge planning and transition must not duplicate usual discharge planning activities performed by the excluded setting. Acceptable HHCM activities include: meeting face to face with the individual; working directly with staff of excluded settings for the purpose of discharge planning (e.g., confirm discharge date; attend discharge planning meetings; discuss discharge plan to establish post discharge needs; etc.), confirming the individual meets all eligibility requirements for HH enrollment or HCBS eligibility (for the Children's Waiver) with documented evidence; obtaining Health Home consent to complete the enrollment process; and so forth.

For children/youth under age 21 in an excluded setting choosing HH enrollment and HCBS:

If the child is identified as potentially eligible for HCBS **and** has

Medicaid in place or will be discharged with institutional Medicaid for a period of time, the HHCM/CMA may complete the HCBS/LOC (Level of Care) Eligibility Determination to ensure that eligibility is in place at the time of discharge, whenever possible.

For children/youth who do not have Medicaid already established, the child/youth would need to be referred to the independent entity, Children and Youth Evaluation Service (C-YES) to establish HCBS/LOC eligibility prior the child/youth's discharge, whenever possible. C-YES will then assist the individual in obtaining Medicaid should they be found HCBS eligible to be able to be enrolled in the HCBS Children's Waiver.

Children/youth who have Medicaid already established and are potentially eligible for HCBS, but decline HH enrollment, should be referred to C-YES for an HCBS/LOC Eligibility Determination.

For children/youth being referred from OMH Licensed Residential Treatment Facilities (RTFs) or OMH State Operated Psychiatric Centers Serving Children (State PCs), please refer to the [HCBS Determination for Children Discharging from OMH Residential Treatment Facility or Psychiatric Center](#) guidance document and attachment, [Patient Resources Administration List](#) .

For a referral from a restricted setting where the child/youth is being discharged and is in need of HCBS, the assigned Health Home/C-YES care manager will contact the restricted setting within 48 hours of being assigned to notify the referring restricted setting of the assignment and must conduct an HCBS/LOC Eligibility Determination within 30days.

Billing

Certain billing rules apply regarding HHCM activities related to discharge planning from an excluded setting, as follows:

- Billing may only occur for appropriate discharge planning activities conducted in the **thirty-days** prior to the individual's discharge from the excluded setting.
- **One** billing instance is allowed for HHCM activities performed during the time the individual is in the excluded setting awaiting discharge.
- The HHCM must maintain documented evidence of all activities conducted to support billing. Such documentation must include proof of eligibility to support HH or HCBS (children/youth) enrollment, and a completed and signed Health Home consent.

Health Home MAPP-HHTS Process

Once a referral has been made and accepted by a HH/CMA, the assigned HHCM will contact the excluded setting who referred the individual to establish a tentative discharge date and the needs of the individual.

After the HHCM meets with the individual, determines that the individual meets HH eligibility or HCBS eligibility (for the Children's Waiver), and obtains appropriate Health Home Consent for enrollment, an enrollment segment can be opened in the MAPP-HHTS.

For Potential Discharges Delayed Beyond the Expected Thirty Day Period

If for some reason discharge cannot occur on the expected date, the HHCM bills for the month that contact was made with the excluded setting in preparation for the discharge prior to obtaining information of a delayed discharge. If HH eligibility or HCBS eligibility (for children/youth) had been determined with HH consent to enroll, then the HHCM will pend the segment until the month of discharge and HH core services begin.

If HH eligibility or HCBS eligibility (for children/youth) has not yet been determined with HH consent to enroll, the HHCM can indicate to the excluded setting to make another referral within 30 days of discharge or continue the individual in assignment or outreach status (which ever status the individual was in when learning of the delayed discharge) without any HH billing.

Training

HHs policies and procedures must include training requirements for staff on conducting activities related to managing referrals of potential Health Home eligible individuals in excluded settings, including timeline limitations, documentation requirements, and acceptable billing practices.

Quality Management

HHs must ensure that quality monitoring related to managing referrals of HH-eligible individuals newly referred from excluded settings are in place in accordance with the standards outlined in the *Health Home Quality Management Program* policy HH0003, which can be accessed on the Health Home Policy and Updates webpage at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_home/policy/greater6.htm#pqm - under: Performance/Quality Management