



**Department  
of Health**

Medicaid  
Redesign Team

# **Community Mental Health Assessment Billing Procedures**

January 8, 2016

## Overview of Today's Discussion

- ***Identifying Enrolled HARP Members for Purposes of Conducting Community Mental Health Assessments***
- ***Billing Procedures for Community Mental Health Assessments***

# Identifying HARP Members Enrolled in Plan for Purpose of Conducting Community Mental Health / BH HCBS Assessments

- **Prior** to conducting the BH HCBS Eligibility Assessment or the Community Mental Health Assessment (CMHA) for a HARP flagged individual, the Assessor must verify the individual is **enrolled in a HARP through EPACES/EMEDNY**
- The HHTS does not display a member's coverage code or RE code.
- Information on how to check eMedNY can be found at:  
[https://www.emedny.org/selfhelp/ePACES/ePACES\\_Help.pdf](https://www.emedny.org/selfhelp/ePACES/ePACES_Help.pdf) pp. 167-175.
- [https://www.emedny.org/hipaa/QuickRefDocs/ePACES-Enrollment\\_Overview.pdf](https://www.emedny.org/hipaa/QuickRefDocs/ePACES-Enrollment_Overview.pdf)

Provider Name	Provider ID
AMERIGROUP NEW YORK LLC	04004537
AMIDA CARE INC	02191582
HEALTH INSURANCE PLAN OF GREATER NE	04082293
HEALTHFIRST PHSP INC HARP	04003696
METROPLUS HEALTH PLAN INC	04053201
METROPLUS PARTNERSHIP CARE SN	02191362
NEW YORK STATE CATHOLIC HEALTH PLAN	04004486
UNITEDHEALTHCARE OF NEW YORK	04054091
VNS CHOICE SELECT HEALTH SNP	03420871

## Completed Assessments To Date From The Data Feed

Member in HARP Plan or SNP?	Assessment Type	Assessment Month			Grand Total
		October 2015	November 2015	December 2015	
Yes	Eligibility Assessment	5	28	89	122
Yes	Full CMH Assessment	3	5	21	29
<b>Yes Total</b>		8	33	110	151
No	Eligibility Assessment	22	42	52	116
No	Full CMH Assessment	8	11	11	30
<b>No Total</b>		30	53	63	146
<b>Grand Total</b>		38	86	173	297

## Identifying HARP Enrolled Members HARP-specific Restriction Exception (RE) Codes

- A series of HARP specific Restriction Exception (RE) Codes have been established. As HARP members enroll in a HARP program and are assessed, their HARP specific RE code will change:
  - ✓ Initially, HARP eligible members will be identified with the H9.
  - ✓ Members enrolled in a HARP/SNP plan will be identified with the appropriate H1 or H4 RE Code.
  - ✓ The results of the CMHA may trigger the member’s RE code to transition to H2, H3, H5 or H6.
- Eligibility Assessments should only be administered to members **enrolled in a HARP** for the purpose of determining BH HCBS Eligibility.
- Assessments **should not** be conducted to determine HARP eligibility at this time.
- Care managers that choose to use the CMHA for care planning purposes for members that are not enrolled in a HARP may do so, but **payment may not be made for CMHAs performed on members that are NOT enrolled in a HARP or HARP-eligible in an HIV SNP**. Care managers should note the CMHA does not assess for physical health needs and thus may not provide all the information required to develop comprehensive plan of care.

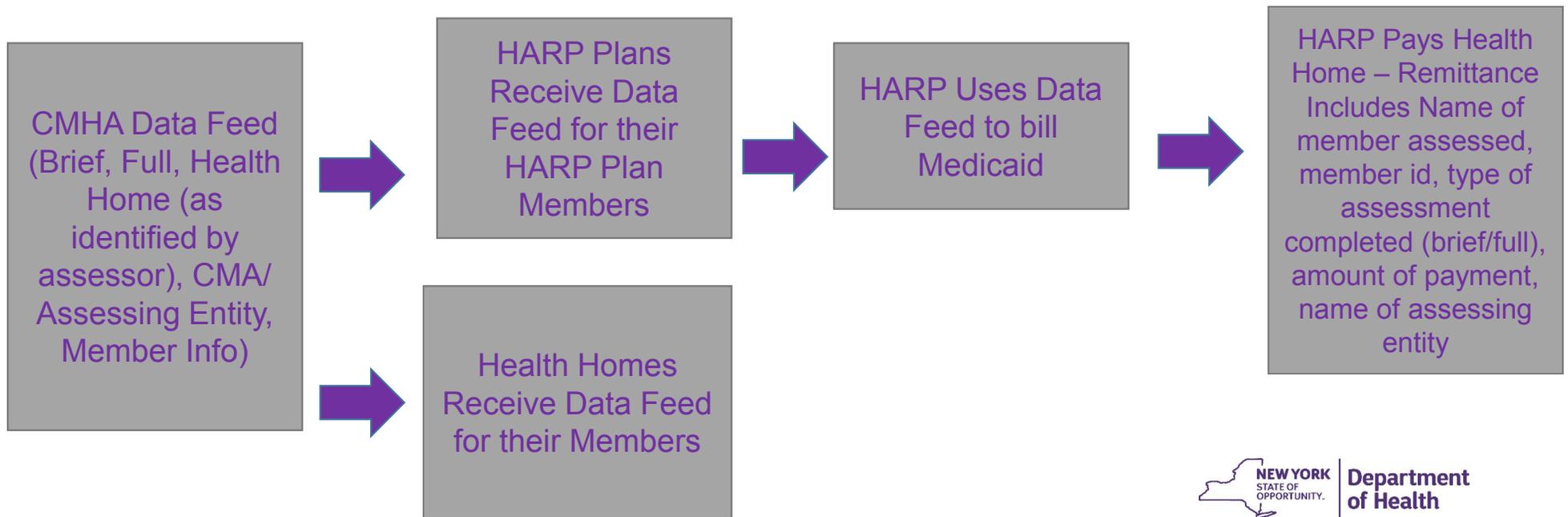
HARP Specific Restriction Exception (RE) Codes	
RE Code	RE Code Description
H1	HARP ENROLLED W/O HCBS
H2	HARP ENROLLED WITH TIER 1 HCBS
H3	HARP ENROLLED WITH TIER 2 HCBS
H4	SNP HARP ELIG W/O HCBS
H5	SNP HARP ELIG With HCBS TIER 1 HCBS
H6	SNP HARP ELIG With HCBS TIER 2 HCBS
H9	HARP ELIG PENDING ENROLLMNT

## Approaches to Billing for Community Mental Health Assessments (CMHA)

- The Department has explored and received feedback on two approaches to billing:
  - 1) Payments that run from the HARP, to the Health Home, and then to the Assessing Entity/Care Management Agency (similar to billing for Health Home PMPM)
  - 2) Payments that run directly between the HARP and the Assessing Entity/Care Management Agency who submits invoice to the HARP
- Both approaches have “pros” and “cons” (depending on your point of view) – including risk for accuracy, data tracking and sharing, timing of payments

## Rules for Billing for Community Mental Health Assessments (CMHA)

- Based on additional feedback from Plans and Health Homes and an evaluation of the pros and cons, the following billing process will be implemented:
  - The HARP will use information from CMHA data feed prepared by the Department to bill Medicaid
  - The HARP will distribute the payment to the Health Home and the Health Home will distribute the payment to the Assessor



# CMH Assessments Data Feed – Pre and Post MAPP

Interim Solution (Pre-Integration of Assessment Data in MAPP) for data feed for billing information related to the CMH Assessments

- ✓ Data extracted from information included on the Brief and Full Assessments that are completed for HARP plan members will be provided to HARP MCPs and will include cumulative data on all assessments that have been completed for HARP plan members
- ✓ Health Homes will receive the assessment data feed for their members
- ✓ The data will be provided to the HARP plan contact and Health Home contact on a bi-weekly basis using the secure file transfer application in the HCS
- Interim solution will be used to test process and inform the development of the process for permanent solution to integrating Brief and Full assessment data in MAPP to allow HARP plans and Health Homes to log into MAPP and download and view the information they need to submit a Medicaid claim/pass down payment to assessors/care managers, respectively, for the Brief or Full assessments and for Health Homes to obtain relevant information for passing payments to Assessors

## Post MAPP

- At a date to be determined, data feed elements from the Brief and Full Assessments will be available in MAPP

## Accurate Data Entries (Manual Input) Critical to Ensure Billings are Accurate

- Data is input manually – assessors need to fill in information accurately in order for process to work efficiently.
- Assessing entities should have procedures in place to ensure that the Health Home information entered into the UAS is correct.
- For example, if Health Home name is incorrect, the Plan will reimburse the wrong Health Home.

## Information Provided on Data Feed to HARP Plans and Health Homes

Data Field	Data Field Description
UUID	Unique number assigned to each record created in the CIM application.
ASSES_APPR_DT	Assessment signoff/finalize date by assessor
MBR_ID	Assessed person's Medicaid ID number
MBR_FIRST_NAME	Assessed person's First Name
MBR_LAST_NAME	Assessed person's Last Name
MBR_BIRTH_DT	Assessed person's Date of Birth
MBR_SSN	Assessed person's Social Security Number
MBR_PLAN_ID	Assessed member's Plan ID per Medicaid DW
PLAN_NAME	Assessed member's Plan per Medicaid DW
ASSESSOR_ORG_ID	Organization ID associated with assessor who signed/finalized
ASSESSOR_ORG_NAME	Organization Name associated with assessor who signed/finalized
ASSESSOR_ORG_TYPE_ID	Organization Type associated with assessor who signed/finalized
ASSES_REF_DT	Assessment Reference Date
ASSES_TYPE_CD	Assessment Type Code
ASSES_TYPE_DESC	Assessment Type Description
ASSES_RSN_CD	Reason Code for the completion of the assessment
ASSES_RSN_DESC	Reason Code Description
ELIG_STATUS_DESC	Explanation for situation when assessment reason is eligibility denial or appeal
PROV_ID	Organization ID of Health Home selected by assessor who signed/finalized
HLTHHOME_ORG_NAME	Organization Name of Health Home selected by assessor who signed/finalized
HLTHHOME_ORG_TYPE_ID	Organization ID of Health Home selected by assessor who signed/finalized
MC_PLAN_ORG_ID	Organization ID of Managed Care Plan selected by assessor who signed/finalized
MC_PLAN_ORG_NAME	Organization Name of Managed Care Plan selected by assessor who signed/finalized
MC_PLAN_ORG_TYPE_ID	Organization ID of Managed Care Plan selected by assessor who signed/finalized
CUR_EXPORT_PRCs_DT	CIM Application extract date for current export
LAST_EXPORT_PRCs_DT	CIM Application extract date from prior export
INS_ROW_PRCs_DT	Date record processed



## Information Provided on Data Feed to HARP Plans and Health Homes

Assessment Type	
Code	Description
1	Eligibility Assessment
2	Full CMH Assessment
Assessment Reason	
1	First assessment
2	Routine reassessment
3	Return assessment
4	Significant change in status reassessment
5	Exit assessment
6	Other
7	Eligibility denial/appeal

# Billing Rules for CMH Assessments

- In cases where it is determined by the Brief Assessment that a HARP enrolled member or HARP-eligible HIV SNP enrolled member is not eligible for BH HCBS, or declines to have a Full Assessment conducted, the HARP or HIV SNP may only bill Medicaid for the Brief Assessment (\$80)
- In cases where both the Brief Assessment and the Full Assessment are conducted on a HARP enrolled member or HARP-eligible HIV SNP enrolled member, the HARP or HIV SNP may only bill Medicaid for the Full Assessment (\$185)
- Data feed captures if the brief assessment was complete but does not capture if the member “passed” the eligibility assessment
- Data feed cannot determine if full assessment will necessarily be complete (i.e., in instances where member declines full assessment – likely rare)
- The Standards document includes a best practice of completing within 30 days – process must be completed within 90 days
  - Plans should wait at least 30 days after the date the eligibility assessment is completed before billing for a brief assessment

# Billing Process for Non-Health Home HARP Members

- Billing process for non-Health Home members is under discussion – will be discussed in more detail at the January 26, 2016 Health Home MCO Work Group
- Consistent with the Standards document, and to leverage the opportunity to connect HARP members not yet enrolled in Health Homes – Plans would contract with HH Care Managers (i.e., care managers that have a contractual relationship to provide HH care management) to perform Brief and Full Assessments and the Behavioral Health Home and Community Based Services Plan of Care (BH HCBS POC) for **Non-Health Home members that have opted out of enrollment by signing the opt-out form.** <https://www.health.ny.gov/forms/doh-5059.pdf>
- One approach under consideration is that billing for CMH assessments and Plans of Care is as follows:
  - ✓ Assessing entities would explain the benefits of Health Home care management to HARP members, and the availability of HCBS services, including POC requirements for HCBS services
  - ✓ If the individual chooses not to join a Health Home, the assessing entity must have the individual sign a Health Home Opt-out form.
  - ✓ Plans will need to contract directly with Qualifying Care Managers to perform assessments
    - ✓ ***Qualifying Care Managers are those that have contracts with the Health Home the Plan would assign such member***
  - ✓ For non-Health Home members that have signed the opt-out form, billing for Brief and Full Assessments and the BH HCBS POC would occur directly between the Plan and the contracted care management agency.
  - ✓ If a non-Health Home individual at any time becomes enrolled into a Health Home, the payment is made to the Health Home.