ST. JOSEPH'S HEALTH A Member of Trinity Health ST PETER'S HEALTH PARTNERS A Member of Trinity Health	**Effective Date:** April 1, 2024

Category: **E. Billing and Payment**

Title: **1. Billable Services and Billing**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Community Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

Contents

PURPOSE

To ensure that Community Health Connections Health Home billing information meets the requirements of the New York State Department of Health. To define and put parameters around the activities that constitute billable Health Home services.

POLICY STATEMENTS

It is the policy of Community Health Connections to ensure that services indicated as billable meet the minimum requirements for a billable Health Home service as defined by the New York State Department of Health (NYSDOH). This policy does not supersede NYSDOH Guidance. Care Management Agencies (CMA's) may choose to implement policies that are different from the policies in this document, however CMA's must follow the policies and guidance in this document at a minimum.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Community Health Connections Health Home program.

DEFINITIONS

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

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

Note: the sixth category of Health Home Core Service, "The use of HIT [Health Information Technology]" is <u>not</u> considered a billable service. Detailed explanations of each of the five (5) Health Home Core Services are available in Attachment A: Health Home Core Services

Health Home Candidate: An individual who is in active Client Search (Outreach) status, but who has not yet been enrolled in Health Home services

Health Home Member: An individual who is enrolled in Health Home services

HML Assessment: The monthly assessment conducted on all Health Home Members and Candidates which 1) drives the rate at which services are to be billed for each individual and 2) indicates if a billable service was provided to each individual during the month

NYSDOH: New York State Department of Health; the regulating State entity for Health Homes

PROCEDURE

A. Billable Services for Health Home Candidates

1. Billing is not permitted for any work to outreach and engage Members in Health Home services. Billing may only occur once a Member is enrolled in the program. For information on enrollment, see Policy B3. Outreach and Engagement: Health Home Engagement and Enrollment.

B. Billable Services for Health Home Members

1. Any billable service provided to or on behalf of an enrolled Health Home Member must include one of the five (5) Health Home Core Services. See Attachment A: Health Home Core Services for a detailed description of the services.

2. Billing is completed on a Per Member Per Month basis at the enrolled rate as defined by NYS DOH and the Member's HML Assessment. (For more on HML Assessments see Policy E2. Billing and Payments: HML Assessments.)

3. The enrolled rate will be billed for eligible Members who have received at least one Health Home Core Service in the month. For Health Home Plus (HH+) and AOT Members, additional program requirements must be met to bill at the HH+ / AOT rate. Program requirements for AOT and HH+ are outlined in the following policies.

   Policy F2. Special Programs: Assisted Outpatient Programs (AOT)
   Policy F4. Special Programs: Serious Mental Illness Health Home Plus (SMI HH+)
   Policy F5. Special Programs: HIV Health Home Plus (HIV HH+)

4. Billing for Core Service delivery may not occur if the Member's Plan of Care is not up to date by the end of the billing month. Should attempts to update the Plan of Care with the Member be unsuccessful, CMA's do have the option to update the Plan without the Member present so that billing can occur. In these rare circumstances, the Plan must be reviewed with the Member at the next opportunity. In instances in which a Plan is updated without the Member present, the Care Notes should reflect this situation. Sample text: *Member did not meaningfully participate in the development of the Plan of Care. Every attempt was made to collaborate with Member on the development, however [insert specific circumstances]. Care Coordinator will review POC with Member at next opportunity.*

5. If a Health Home Core Service was provided in accordance with this policy but was not documented in the electronic health record, the service is **not** billable.

6. Regardless of Core Service provision, Care Coordinators are encouraged to conduct at least one (1) face-to-face visit with Member's each month. This frequency of in-person contacts may not be necessary or appropriate for all Member, however. The frequency of face-to-face contacts should be based on the Member's needs as outlined in the Plan of Care.

7. Although rare, it is possible to bill for Health Home Core Services for a month in which the Care Coordinator did not directly interact with the Health Home Member. Such examples may include:
   - Case conferencing with collaterals for the purpose of coordinating care, evaluating goals or obtaining feedback or input regarding the Plan of Care;
   - Interactions with other individuals who are part of the care team for the purpose of coordinating care, discussing Member needs, or consulting about Member goals;
   - Following up on referrals to community, behavioral health or medical service providers; or
   - Advocating for services on behalf of the Member.

8. The delivery of one of the five (5) Health Home Core Services (exclusive of HIT) can be delivered via the following means.

   Electronic Communications (email and text messages)
   - Electronic communications including emails and text messages are considered billable if one of the Health Home Core Services are provided **and** a response is received from the Member, provider, provider's staff member or another individual who is a part of the care team.

   Phone Communication
   - Phone communication is billable if one of the Health Home Core Services are provided by speaking with the Member, provider, provider's staff member or another individual who is a part of the care team.

   - If a voicemail is left and is returned by the Member, provider, provider's staff member or another individual who is a part of the care team.

   Face-to-Face Communication
   - Face-to-face communication with a Health Home Member, provider, provider's staff member or another individual who is a part of the care team or any other collaterals shall be considered billable when a Core Service is provided.

9. The below services are **not** considered billable.
   - Mailing a letter.
   - Emailing a Member without receiving a response.
   - Texting a Member without receiving a response.

- Receiving information from or regarding a Health Home Member, including letters, faxes, voicemails and emails.
- Leaving a voicemail for the Member, provider, provider's staff member or another individual who is a part of the care team.
- Any interaction with or on behalf of a Member that does not provide one of the five (5) Health Home Core Services, regardless of mode of delivery, is not considered billable.
- Contact made solely to "check-in" with the Member when a Health Home Core Service is **not** provided.

The above information on means of delivery of Health Home Core Services is available in Attachment B: Billable Services.

C. Billable Services for Health Home Special Program Members

1. The billing requirements and procedures outlined in this policy apply to those Members in Health Home Special Programs including HARP, AOT and Health Home Plus (HH+).

D. Billing for Members who are Hospitalized or Incarcerated

1. Members who are admitted for an inpatient hospital or rehabilitation program stay or who are incarcerated with an expected discharge/release within six months may continue to be enrolled in the Health Home Program.

2. The six-month timeframe is calculated based on the date of admission or incarceration, with Month 1 being the month the Member was admitted or incarcerated.

3. The CMA is permitted to bill at the enrolled rate for the month the Member enters the setting and the month in which the Member is discharged only if a Core Service, in accordance with Policy C1. Care Coordination: Health Home Services, is provided in each month. This is to support care transitions.

   For Members who are incarcerated, billing during the month of admission will only occur if the Core Services was provided BEFORE the date of incarceration.

   For Members who are incarcerated, billing may occur if the Care Coordinator provided a Core Service to support discharge planning in the 30 days prior to release.

4. If the Member's inpatient stay is longer than six months, the Member must be discharged from the Health Home program, in accordance with Policy C6. Case

Closure and Re-engagement. Upon discharge from the inpatient facility/criminal justice setting, the Member may be re-enrolled in the Health Home.

For more information on Health Home Services provided during hospitalizations and inpatient rehabilitation stays, please see Policy C6. Care Coordination: Case Closure and Re-engagement.

E. Billing and Payment Procedures

1. Each month, each Care Management Agency must submit an HML Assessment for every Health Home Member. All HML assessments will be completed and finalized in the Member's chart in CareManager. (For more information regarding HML Assessments, see Policy E2. Billing and Payment: HML Assessments.)

2. For Members in Excluded Setting, as described in Section D, an HML assessment will only be required the month the Member enters the setting and the month the Member is removed from the setting. For any complete months in Excluded Setting status, an HML Assessment will not be completed in CareManager.

3. Each Care Management Agency is responsible for a quality assurance check to ensure that documentation supporting the HML responses were obtained and attached to the electronic health record **and** that the services provided are in fact billable services, as prescribed in Sections B of this policy, and that there is documentation to support the delivery of those services in the electronic health record.

4. The Care Management Agency will submit, along with the HML monthly submission, a signed copy of the Billing Attestation Form (See Attachment C) which confirms that the quality assurance check in Section E(2) above has been completed.

5. Community Health Connections will bill payors on behalf of each Care Management Agency based on the HML Assessments submitted on a monthly basis.

6. In accordance with contractual obligations, once payments are received, remittance details will be used to pay each Care Management Agency based on billable services.

See Attachment D: CHC Billing and Payment Flow Chart for a detailed workflow regarding billing and payment.

REFERENCES

New York State Department of Health (October 13, 2017). Interim Guidance Addressing Outreach Modifications. (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/outreach_interim_guidance.htm)

New York State Department of Health (October 5, 2015). Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations. (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf)

New York State Department of Health (April 2012). April 2012 Medicaid Update Special Edition, Volume 28, Number 4. (https://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-04_pharmsped_edition.htm)

Approving Official: Senior Vice President, Population Health, Advocacy		**Effective Date: April 1, 2024**
Key Sponsor: Regional Health Home Director		
Reviewed By: Regional Health Home Operations Manager		**Original Date: December 1, 2016** **Reviewed/Revised Date: April 1, 2024**
Search Terms:		***Reviewed, No Revisions** ****Revised without Full Review**

Replaces: Billing and Payment: Billable Services and Billing (December 1, 2016)
Billing and Payment: Billable Services and Billing (June 15, 2018)
Billing and Payment: Billable Services and Billing (December 17, 2018)
Billing and Payment: Billable Services and Billing (April 1, 2019)
Billing and Payment: Billable Services and Billing (March 1, 2022)

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ATTACHMENT A: Health Home Core Services

Comprehensive Care Management

- Completion of comprehensive assessment of preliminary service needs
- Development of individualized Plan of Care, including Member goal, objectives and interventions and include family and other social supports as appropriate.
- Consult with multi-disciplinary team on Member's Plan of Care, needs or goals.
- Consult with Primary Care or any specialists involved in the Member's care.
- Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines.
- Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care & improved health outcomes.
- Prepare client crisis intervention plan.

Care Coordination and Health Promotion Services

- Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.
- Implementation of the individualized Plan of Care (with active Member involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports such as patient education, self-help/recovery and self-management.
- Appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and members or their family members.
- Health education specific to an individual's chronic conditions, development of self-management plans, education regarding the importance of immunizations and screening, providing support for improving social networks and providing health-promoting lifestyle.
- Assist members to participate in the implementation of the Plan of Care and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.
- Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs.
- Advocate for services and assist with scheduling of needed services.
- Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
- Monitor/support/accompany the client to scheduled medical appointments.
- Crisis intervention, revise care plan/goals as required.

Comprehensive Transitional Care

- Follow up with hospitals/ER upon notification of a Member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
- Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to ensure a safe transition/discharge that ensures care needs are in place.
- Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.
- Link Member with community supports to ensure that needed services are provided.
- Follow-up post discharge with Member/family to ensure Member Plan of Care needs/goals are met.

Member and Family Support Services

- Develop/review/revise the individual's Plan of Care with the Member/family to ensure that the Plan reflects individual's preferences, education and support for self-management.
- Consult with Member/family/caretaker on advanced directives and educate Member on rights and health care issues, as needed.
- Meet with Member and family, inviting any other providers to facilitate needed interpretation services.
- Refer Member/family to peer supports, support groups, social services, entitlement programs as needed to help promote health literacy and ability to self-manage care.

Referral to Community and Social Support

- Provide assistance for members to identify, obtain, and maintain eligibility for community based resources, health care, benefits, housing, personal need and legal services.
- Care Coordinator actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
- Collaborate/coordinate with community base providers to support effective utilization of services based on client/family need.

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ATTACHMENT B: Billable Services

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ATTACHMENT C: Billing Attestation Form

Staff Member Name: _____

Care Management Agency: _____

Billing Month: _____

I, _____, or a designee from the Care Management Agency, have reviewed all billing and HML assessments and attest that:

☐ All Members identified as having a billable service for the month have a service that satisfies the CHC policies and procedures regarding billable services.

☐ All billable services provided to Members are documented in the Member's electronic health record.

☐ Documentation supporting the responses to each Member's HML was obtained and recorded in the individual's electronic health record.

_____ _____

Staff Signature Date

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ATTACHMENT D: CHC Billing and Payment Flow Chart