	Effective Date: April 1, 2024

Category: **E. Billing and Payment**

Title: **2. HML Assessments**

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)

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PURPOSE

This policy is intended to provide a standard set of expectations and procedures for completing and submitting the HML Assessment for all Health Home Members.

POLICY STATEMENTS

It is the policy of Community Health Connections that HML Assessments are completed and submitted to CHC in a timely manner by each Care Management Agency. Further, it is the policy of CHC that responses to HML Assessment questions are based on factual information

with supporting documentation, to align with New York State Department of Health policy and guidance.

Certain HML questions require supporting documentation. Documentation from an external source (i.e., providers, clinicians, etc.) is ideal and therefore preferred to self-report or Care Coordinator observation. In certain circumstances, obtaining documentation from an external source may not be possible, and therefore substantiation of a response from multiple sources is required. See Attachment B for additional information regarding acceptable documentation sources.

SCOPE OF AUTHORITY / COMPETENCY

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

DEFINITIONS

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. Rates, calculated by New York State Department of Health, are based on responses to questions regarding a Member's HIV status, inpatient hospitalizations history, substance abuse treatment history, incarceration history and homelessness status.

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

PROCEDURE

A. HML Assessment Completion

1. HML Assessments drive the rate at which services are to be billed for each Member based upon responses to each Assessment question. The rates will remain in place for up to six (6) months. If circumstances change, the HML Assessment can be updated to reflect those changes. This will trigger a new rate to be calculated and a new six (6) month period will begin.

2. Despite the six (6) month timeframe for Assessment responses, Care Coordinators must complete an HML Assessment each month by attesting that the responses in

the Assessment are accurate and provide the date the Core Service was provided. This process is the only mechanism to trigger billing for Members.

3. HML Assessments must be completed for each Member with an active Enrolled or Diligent Search Efforts status in CareManager.

4. HML assessments will not be completed for any Candidate who is in Client Search status and not yet enrolled in the program or for Members who are in a Pended MAPP segment (e.g., Members who are in Excluded Setting status in CareManager. See Policy C6: Care Coordination: Case Closure and Re-engagement for more on Members who are hospitalized, incarcerated or in Continue Search Status.)

5. For Members in Excluded Setting, an HML Assessment will only be required the month the Member enters the setting and the month the Member is removed from the setting to support Care Transitions. For any complete months in Excluded Setting status, an HML Assessment will not be completed in CareManager. See Policy E1. Billing and Payment: Billable Services and Billing for more information.

6. All HML Assessments must be finalized in the Member's Chart in CareManager no later than the fifth (5th) business day of the following month, unless otherwise notified by Health Home Administration.

7. Each Care Management Agency is responsible for a quality assurance check to ensure that documentation supporting the HML responses was obtained and attached to the electronic health record **and** that if the HML Assessment indicates that a Core Service was provided, that the services provided are in fact billable, as prescribed in Policy E1. Billing and Payment: Billable Services and Billing, and that there is documentation to support the delivery of those services in the electronic health record.

8. The Care Management Agency will submit each month a signed copy of the Billing Attestation Form (See Attachment A) which confirms that the quality assurance check in Section A(3) above has been completed.

B. HML Documentation

1. The HML assessment must be entered and finalized in the Member's chart in CareManager each month. The functionality in CareManager is such that the information from the previous month's HML assessment will pull forward to the current month so that information only needs to be updated each month as the Member's situation changes.

2. Despite information pulling forward each month, staff will always have to state whether a Core Service was provided and record the date of the service. Staff must also attest that the information in the assessment is accurate prior to finalizing the HML Assessment.

3. HML Assessment questions regarding HIV status, homelessness, incarceration, inpatient mental illness stays, inpatient physical health stays and inpatient substance abuse treatment must have supporting documentation verifying the response. The documentation must be attached to the individual's electronic health record. When documentation cannot be obtained Member self-reporting is an acceptable form of verification only if the information is substantiated by at least one other source (i.e., provider, natural supports, etc.) **and** the Plan of Care includes a goal related to that area of concern. The interventions and objectives for that goal should match the intensity of the Member's need. The NYS DOH standards for acceptable documentation on HML is included in Attachment B of this policy.

REFERENCES

New York State Department of Health (December 1, 2016). Billing and Documentation Standards for Health Home: High, Medium and Low (HML) Rates with Clinical and Functional Adjustments.
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_hml_rate_for_adults.pdf)

New York State Department of Health (November 2015). Health Home High, Medium, Low (HML) Billing.
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_hml_rate.pdf)

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

Replaces: Billing and Payment: HML Assessments (December 1, 2016)
Billing and Payment: HML Assessments (June 15, 2018)
Billing and Payment: HML Assessments (March 1, 2022)

ATTACHMENT A: 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

ATTACHMENT B: Acceptable HML Documentation

HIV STATUS

External Documentation Verification:

- Lab results
- Medical Records
- Documented Conversation with collateral service provider or MCO that can confirm lab results or have access to the medical record

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- This documentation of a Care Note and Plan of Care goal will maintain the billing rate for 90 days, until external documentation (above) can be obtained.

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 virologically, testing is recommended within four weeks from a change in ARV, and at least every eight weeks until complete suppressed.

HOMELESSNESS

External Documentation Verification:

- Letter from shelter or other homeless housing program
- Hospital discharge summary

- Eviction notice
- Documentation from local Homeless Management Information System (HMIS)
- Member self-report

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Homelessness and HML Categories:

- *HUD Category 1 (High):* An individual who lacks a fixed, regular and adequate nighttime residence.
- *HUD Category 2 (Medium):* An individual or family who will imminently lose their housing.
- *Date Housed:* If High or Medium (Category 1 or 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

INCARCERATION

External Documentation Verification:

- Release papers
- Documentation from parole or probation
- Documented conversation from collateral contact
- Print-out from Webcrims or other criminal justice database
- Letter from halfway house
- Member self-report

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Incarceration:

- Released from state prison or county jail after sentence is served.
- Member 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 or probation or parole
  - Released on bail awaiting arraignment
  - Other criminal justice status in which the person has an ongoing criminal justice issue requiring care management intervention

INPATIENT STAY FOR PHYSICAL ILLNESS

External Documentation Verification:

- 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
- MCO confirmation of admission

NOTE: Member self-report does **not** meet criteria as sufficient documentation

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing category.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High categorQ y of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Inpatient Stay for Mental Illness:

- Inpatient admission, regardless of duration, that would require significant care coordination post discharge.

INPATIENT STAY FOR MENTAL ILLNESS

External Documentation Verification:

- 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
- MCO confirmation of admission

NOTE: Member self-report does **not** meet criteria as sufficient documentation

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing category.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Inpatient Stay for Mental Illness:

- 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.

INPATIENT STAY FOR SUBSTANCE USE TREATMENT DISORDER

External Documentation Verification:

- 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
- MCO confirmation
- Member self-report

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Inpatient Stay for Substance Abuse Treatment:

- 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.

SUBSTANCE USE DISORDER ACTIVE USE/FUNCTIONAL IMPAIRMENT – HIGH RATE ONLY

External Documentation Verification:

- Based on assessment and information gathered by the Care Coordinator from:
    - substance use providers
    - probation/parole
    - court ordered programs
    - domestic violence providers
    - local DSS
    - other sources.

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- 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.

Definition of SUD Active Use / Functional Impairment:

- Positive lab test for Opioids, Benzodiazepines, Cocaine, Amphetamines, or Barbiturates;
  OR
- Care Coordinator observation (with supervisor sign off) of continued use of drugs (including synthetic drugs) or alcohol with supervisor sign off
  OR
- MCO report of continued use of drugs or alcohol;
  AND
- Demonstration of a functional 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 involvement with 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