Temporary Health Home Billing Procedures effective December 1, 2016

In response to additional time needed by Managed Care Plans to modify their systems to process claims and encounter data to make Health Home payments from resources included in the capitated rate, the following Health Home billing procedures will be implemented. The begin date for enrolling children in Health Homes is December 5, 2016.

Effective December 1, 2016

- Direct billing is eliminated
- High, Medium, and Low rates with clinical and functional indicators will be implemented for service dates on/after December 1, 2016
- The incorporation of Health Home payments into the capitated rate will be delayed until April 1, 2017

Effective December 1, 2016
(for service dates between December 1, 2016 and March 31, 2017)

- For a temporary period of time (i.e., until Managed Care plans are ready to process Health Home claims) Lead Health Homes will bill Medicaid directly for **all** Health Homes services provided to both fee for service **and** managed care members; for both adults and children using the rate codes listed at this link: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/rates_after_dec_2016.xlsx
- Managed care plans and care management agencies ***will not*** submit claims to Medicaid
- The Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) is the system of record for making payments for the Health Home program. Health Homes should only submit claims to Medicaid if the member is properly documented within the MAPP HHTS. (During this time period there will be no Managed Care encounter data.)
- During this time period, the Managed Care Plans, Lead Health Homes and the Department of Health will take the following actions:

Managed Care Plans will:

- Work to immediately resolve and pay any outstanding Health Home payments to Health Homes
- Work with the State and Health Homes to modify their billing systems to be able to process payments to Health Homes in their all payer system in the same manner in which the plan now processes payments to other providers in its network (i.e., using the 837i)
- Work with trade associations to standardize requirements for "clean" Health Home claims across all plans
- Managed Care Plans will configure systems to go live 90 +30 day claims testing period from the date guidance is provided by DOH for HH 837i claiming

Lead Health Homes will:

- Work with their billing vendor and/or modify their system to be able to submit an 837i to Managed Care Plans

The Department of Health will**:**

- Modify MAPP HHTS to include any billing information necessary for Health Homes to submit an 837i and/or provide any billing guidance to Managed Care Plans or Health Homes to ensure smooth process for submitting and processing 837i
- Release guidance to Managed Care Plans regarding moving the Health Home payment into the plan capitation rate.

Contingent upon plan readiness, but no later than April 1, 2017

- For dates of service beginning April 1, 2017, Health Home Payments will be included in the Managed Care Plan's capitated rate
- Like other Managed Care Medicaid providers, Health Homes will submit an 837i directly to the Managed Care Plans to receive payment for Health Home services. Health Homes will continue to bill Medicaid directly for Health Homes services provided to fee for service members.
- Managed Care plans will submit encounter data to the State