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MAPP HHTS Release 4.5

System Changes & Enhancements Effective June 1, 2024

May 1, 2024

Billing Blocks

IA, CEST, and POC Billing Block

This release includes three new billing blocks connected to the timely submission of member information to the system.

The next few slides describe how these billing blocks work within the tracking system. These system rules were developed to reflect the eligibility requirements outlined in the Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program #HH0016.

Each slide contains the name of a supplemental document describing how to access the information in the HHTS. To locate these documents, expand the *Health Home Tracking System* heading on the **Medicaid Analytics Performance Portal (MAPP)** section of the Health Home website.

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Initial Appropriateness (IA) Criteria

- Requirement applied to ***all*** active enrollment segments with a begin date on or after 6/1/24 that ***were not*** created using the system's transfer process
- IA criteria must be submitted to the tracking system using Consent and Member Program Status file within 30 days of EITHER consent to enroll **OR** segment begin date (whichever is most recent)
  - Member actively enrolled 6/1/24 with a consent to enroll date of 6/6/24
  - IA criteria must be submitted to the system by 7/6/24.
  - Provider can bill for 6/1/24 and 7/1/24 *without* IA criteria.
  - Provider cannot bill 8/1/24 *until* IA criteria is submitted to the system. If IA criteria is not submitted in August 2024, provider will never be able to bill for 8/1/24
- The member's BSD record for 8/1/24 service date will contain 'Q' *Does not have Appropriateness Criteria submitted within 30 days of Consent to Enroll* in the **Validation Code** field
- MAPP HHTS Supplemental Document: **Initial Appropriateness in MAPP HHTS**

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Plan of Care

- By 6/1/24 a comprehensive plan of care must be completed and submitted for all actively enrolled Health Home members using Plan of Care Upload file within the POC grace period:
  - Responsible signatory's POC signature date must be within 60 days of EITHER consent to enroll **OR** segment begin date (whichever is most recent) or system will reject BI
- Submitted plans of care will be assigned a **POC End Date**, which signals when the submitted POC expires/when an updated POC must be submitted. Once past the POC grace period, a BI cannot be added to the system unless the BI service date falls between a comprehensive plan of care in the system.
- The following values will be used in the **Validation Code** field on the BSD to message POC billing rules
  - 'W' warning: Last billable service month before POC expires
  - 'R' block: Either POC never submitted or submitted POC expired

- MAPP HHTS Supplemental Document: **Plan of Care in MAPP HHTS (PDF)**

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CEST Outcome Billing Block Rules

- All members enrolled in adult program for a year or more (excluding populations below) with segment begin month of Nov-April must submit CEST outcome to system by **end of April** or they will be blocked from adding **May 2024** billing instances (BI).
- The following month, providers will need to submit a CEST outcome for any member enrolled for over a year with a segment begin month of May or their 6/1/24 billing instance will be blocked. This will continue each month until Nov 2024.
- Members meeting criteria below will be excluded from the CEST billing block. Members must meet the criteria below as of the billing instance service date to be excluded.
  - Adult Home: flagged as *Impacted Adult Home Class Member* as of the BI service date
    - *Billing Support, Enrollment Download, CIN Search, My Members, Assignment Files, Enrolled Member Details Download*
  - AOT: flagged as AOT by weekly feed from OMH as of the BI service date
    - *Billing Support, Enrollment Download, CIN Search, My Members, Assignment Files, Enrolled Member Details Download*
  - Expanded HH+ Population: member has value other than 'A' in **Expanded HH+ population** field on BSD within the past year

When is CEST Outcome Due?

- New field on BSD to list member segment's initial CEST due date based on **Connection Between CEST and Billing Instances in MAPP HHTS** document posted under *Health Home Tracking System*
- **Once a CEST outcome has been submitted to for a member segment, that outcome's CEST End Date (another new field on BSD) dictates when the next CEST outcome is due to the system**
- The **Validation Code** field on BSD will be populated with the CEST related values below as described:
  - 'U' *warning:* last month to bill without CEST outcome (initial CEST hasn't been submitted OR submitted CEST expiring)
  - 'S' *block*: initial CEST was not submitted to system.
  - 'T' *block*: submitted CEST expired and subsequent CEST not submitted
- MAPP HHTS Supplemental Document:
  - **CEST Information in MAPP HHTS (PDF)**
  - **Connection Between CEST and Billing Instances in MAPP HHTS (XLSX)**
    - *this document includes initial CEST due dates and tabs describing when follow up CEST are due to the system once initial CEST is submitted*

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Initial vs Subsequent CEST Outcome

Please note that the CEST due date & billing block dates listed in the first two tabs of the **Connection Between CEST and Billing Instances in MAPP HHTS** document posted to the website only applies to a new segment where an initial CEST has not yet been submitted for that member segment.

Once a CEST Outcome has been submitted to the system for a member segment, the CEST start and end dates dictate when the next CEST is due to the system *(i.e. initial CEST due date no longer apply)*.

Please see example tabs in the **Connection Between CEST and Billing Instances in MAPP HHTS** for examples of an expiring CEST submission and other and other CEST submission scenarios within the tracking system.

When is Follow Up CEST Outcome Due to System?

- Once a CEST Outcome is submitted to the system, it is assigned an end date that dictates how long a provider can continue to bill without submitting to the system a new CEST Outcome.

Ex #	Segment Begin Date	CEST Outcome	CEST Submission Date	CEST Start Date	CEST End Date
1	11/1/2018	C	4/10/2024	3/26/2024	9/22/2024
2	6/1/2023	E	6/30/2024	6/26/2024	8/25/2024
3	3/1/2020	M	5/13/2024	5/5/2024	7/4/2024

- The table below shows the last billing instance the provider can add based on submitted CEST Dates and when billing instances will be blocked without a new **CEST Start Date**.

Ex #	CEST End Date	Last Month to Bill Based on CEST Outcome Submitted to System	Cannot Bill for month ending w/ this date, or any subsequent months, until new CEST submitted w CEST Start date that is equal to or prior to this date
1	9/22/2024	9/1/2024	10/31/2024
2	8/25/2024	8/1/2024	9/30/2024
3	6/13/2025	6/1/2025	8/31/2024

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Submitting IA, CEST, Consent to System

- CEST Outcome, Initial Appropriateness, and Consent to Enroll Date are submitted to the system using the Consent and Member Program Status Upload file**. POC date will no longer be accepted on this file.**
- While **Consent Date** and **IA** can be submitted together in the same record (i.e. file row), all other submissions must be submitted in its own record/file row using the correct **Record Type.**
- CEST records should no longer be modified and you should not submit multiple CEST outcomes for a member with the same **CEST Start Date**. These types of records will be rejected on/after 6/1. The system will allow these types of records in May 2024, but submission of these types of records will result in odd CEST end dates. Data fix ran to correct end dates for duplicative submissions. Prior to 6/1/24, another data fix will be run to correct modified/duplicative submitted records.

Submitted Information	Add, Create	Modify	Delete, Withdraw, Cancel
Consent to Enroll AND Appropriateness Criteria	C	M	W
You can submit consent to enroll and appropriateness criteria on the same record. To add appropriateness criteria to an already submitted consent date record, use the 'M' modify record type. You cannot add an appropriateness criteria code alone unless a consent to enroll record is in the system. Consent and Appropriateness Criteria fields will be included in the Consent Download file.			
Continuing Eligibility Screening Tool Outcome	X		Z
These record types are used to submit the Continuing Eligibility Screening Tool (CEST) Outcome. This information is included in the Assessment Download file, not the Consent Download file.			

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HHSC Billing Changes

Billing Updates for HHCS

- Members enrolled in a children's program must submit on the BSU the number of **Telehealth** and **In Person** interactions they had with the member during the month
- System will be prepared to implement new HFW rate when approved *(member must be flagged as HFW, CMA must be HFW, and must meet min bill req.)*
- There will be new acceptable values for the **Core Service Provided** on BSU for HHSC members who didn't meet CANS-NY acuity minimum requirements but met lower CANS-NY acuity minimum requirements for a billing month:
  - H: *didn't meet HFW req, but meets Complex req 1866*
  - M: *didn't meet HFW or Complex req, but meets Early Development/Intense req 1865*
  - L: *didn't meet HFW, Complex, Early Development/Intense req but meets Low/Standard req 1864*
  - N: *If a member did not receive any level of minimum required services in billing month*
- DOH HHSC policy team will release guidance regarding use of these values

CYES Transfers

Tracking CYES Members in MAPP HHTS

Members receiving CYES care management will be submitted into the MAPP HHTS. This will allow for a new process where all transfers from CYES to HH and HH to CYES care management will occur in the MAPP HHTS using the existing transfer functionality.

All CYES to HH and HH to CYES MUST occur using the MAPP HHTS transfer process. More information will be released soon to explain how and when this new CYES transfer process will begin.

Other File & System Changes

POC File Changes

The logic in the system that required submission of a member's initial plan of care signature date on the Consent and Member Program Status upload file, will be replaced with logic requiring the submission of the complete POC submitted on the POC Upload file.

Additionally, the following changes will be made to POC files:

- Logic used to determine which **Responsible Signatory** code can be submitted will be based on the member's age as of the **POC Effective Date**
- Two new fields on the POC Error file:
  - **Date of PGLAR 1 Signature on POC**
  - **Date of PGLAR 2 Signature on POC**

POC System Changes

Since the system will no longer collect a member's initial plan of care signature date on the Consent and Member Program Status upload file, the following system changes will occur:

- The **POC Date** will no longer be collected at the time the enrollment segment is created or at the creation and acceptance of an enrollment transfer on the screen.
- **POC Date** submitted on the consent file will be removed from the billing logic
- The *Plan of Care* tab on a member's case will display plans of care submitted on the POC Upload file instead of the POC date collected on the Consent and Member Program Status upload file.

New Billing Support Fields on BSU & BSD

New BSU fields were added. These fields are required for HHSC/optional for HHSA

- **In Person Interaction**
- **Telehealth Interaction**

New/updated BSD fields

- **Submitted POC Effective Date** *updated to contain POC date from POC Upload*
- **In Person** *as collected on BSU*
- **Telehealth** *as collected on BSU*
- **Active K1** *'Y' if member has active K1 as of service date*
- **CEST Start Date** *of submitted CEST*
- **CEST Outcome** *of submitted CEST*
- **Consent to Enroll Date** *to help determine when POC and IA*
- **Segment Begin Date** *to help determine when POC, CEST, and IA*
- **Initial CEST Due Date** *per CEST Dates listed on website based on seg begin date. Obsolete once CEST submitted for member segment*

Update: Segments Potentially Incompatible With HH Services

New groups of members with now be included in the Segments Potentially Incompatible with HH Services file:

- Actively enrolled members without POC past 60 days *(either no or expired POC)*
- Members who should have CEST and do not *(either never submitted per due dates or submitted CEST expired)*
- Members with current CEST outcome of 'M' or 'E'

The following CEST fields have been added:

- **Most Recent CEST is E or M**
- **Most Recent CEST Expired**
- **Most Recent CEST Outcome**
- **Most Recent CEST End Date**

a) Member Deceased
b) Member enrolled in ACT at the time of file download
c) Member's current MCP is incompatible with HH services
d) Member has an R/E code that is incompatible with HH services
e) Member's Coverage Code is incompatible with the HH program.
f) Segment has been pended for extended period of time
   i) Segment is pended due to Diligent search over 3 months, OR
   ii) Segment is pended due to other pend reason over 6 months
g) Actively enrolled member does not have an active POC:
   i) for member enrolled in new segment, POC must be submitted within 60 days of EITHER the member's consent to enroll date **or** the member's segment begin date *whichever date is most recent.*
   ii) member has an expired POC and a new POC has not yet been submitted to the system.
h) CEST Outcome: if a member meets one of the CEST related criteria below, they will be included in this file:
   i) Member's current CEST outcome is 'M' or 'E'
   ii) Member is in an active enrollment segment and their most recent CEST Outcome has expired.

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Update HH Claims and Encounter Detail File

The ***HH Claims and Encounter Detail*** file has been updated to:

- Include **all** claims and encounters for members with an active or pended segment with the downloading provider **regardless of the HH/CMA that submitted the claim or encounter**.
- Include **all claims and encounters submitted by the provider**, whether the member is still enrolled with the provider or not.

The ***HH Claims and Encounter Detail*** file will also include **two** new fields:

- Current Segment Status
- Expected Rate Code Description

Provider Summary Download File

Information contained in the Provider Summary Report PDF, is now also available in a download file.

- This file contains a large amount of information pulled from several different places in HHTS, so download times can vary.
- The HHTS will determine the user's role to determine what information is included in the downloaded file. You will only be able to see information as it relates to your own organization.
- For the MCP, a member will only be counted if they are actively associated with the plan as of date of download (per MDW information).
- If a HH operates as both HH and CMA under the same ID, that ID will be listed twice – one line displaying data for members associated with the HH ID (field #1 Provider Category will be populated by 'HH') and another line displaying data for members associated with the CMA ID using the (field #1 Provider Category will be populated by 'CMA').

DOH Health Home Team Contact Information

- MAPP HHTS resources and past presentations can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm
- MAPP HHTS issues and questions should be directed to MAPP Customer Care Center at (518) 649-4335 or MAPP-CustomerCareCenter@cma.com
- Health Home **policy questions** and **Notification of Change (NOC) forms** should be submitted to the DOH Health Home team mailbox found here: https://apps.health.ny.gov/pubpal/builder/email-health-homes
- HHSC questions are directed to the HH Team mailbox: https://apps.health.ny.gov/pubpal/builder/email-health-homes, using the dropdown selection of “Care Management/Health Home Core Services – HHSC ONLY”.

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