Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program Provider Billing Manual

January 28, 2016

Revised: 6-16-2016

Revised: 2-3-2017

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1. Overview

This provider billing manual (Billing Manual) is designed to be a reference document for providers, Rhode Island Medicaid Managed Care Organizations (MCOs), consumers, family members, primary care providers, other behavioral health care providers, hospitals and other social service providers who are involved in the Integrated Health Home (IHH) and Rhode Island Assertive Community Treatment (ACT) programs. *This manual does not apply to providers billing for Health Home Services in Opioid Treatment Programs (OTP's).*

This manual has been developed by the Rhode Island Executive Office of Health and Human Services (EOHHS), including Medicaid and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), to foster a smooth transfer of program administration to the MCOs, for MCO members on January 1, 2016 and for continued program implementation of this service. This Billing Manual represents a new way of billing for IHH and ACT that members enrolled in an IHH receive. Beginning January 1, 2016, all services will be billed to either the member's MCO or to EOHHS if a member is not enrolled in an MCO but is covered by Medicaid and is "Out of Plan."

2. Definitions

Integrated Health Home (IHH) – The IHH is built upon the evidence-based practices of the patient-centered medical home (PCMH) model. IHH coordinates care for persons with Severe Mental Illness (SMI) and builds linkages with and among behavioral healthcare providers, primary care, specialty medical providers, and other community and social supports, and enhances coordination of medical and behavioral healthcare. The goal of IHH is to more effectively address the complex needs of persons with severe mental illness and co-occurring mental illness and other chronic illnesses. IHH is a service provided to community-based members and collateral providers by a team of professional and paraprofessional mental health staff in accordance with an approved treatment plan for the purpose of ensuring the member's stability, improved medical outcomes and less reliance on more restrictive services, such as the emergency department and inpatient medical-surgical and inpatient psychiatric care. The desired outcome is increased community tenure and improved health outcomes for each of the member's chronic conditions. IHH teams coordinate care and ensure that medically necessary interventions are provided to help the member manage symptoms of their illness. The IHH also helps the members, their providers, and their natural community supports to address the social determinants affecting the member's well-being with the goal of improving the member's overall life situations. Members receive assistance in accessing needed medical, social, educational, vocational, and other services necessary to meeting basic human needs.

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Required Services – IHH providers will be approved by BHDDH. IHHs are required to provide all of the following services: comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, and chronic condition management and population management. These services may be coordinated through health information technology or other mechanisms (i.e. ADT, Current Care, etc.) to facilitate coordination of care with primary care providers and other behavioral healthcare providers.

Team-based Approach - IHH uses a team-based approach to care coordination, mental health and chronic condition management, health promotion and peer/family support. Each team member's unique background and expertise provide a valuable resource for optimizing the care coordination activities that can benefit the members they serve.

Eligible IHH Providers – Only Community Mental Health Organizations (CMHOs), licensed by BHDDH to provide IHH services, may bill for IHH.

Service Delivery - IHH services are based on a team approach for each member, driven by a person-centered, recovery-oriented, strength-based care plan that specifies the duties of the individual team members. Service intensity and service mix among the six required services is likely to vary from month-to-month. A member of the team will maintain contact with the member, the member's family, and/or the members' collateral providers and supports to ensure that the treatment plan is being implemented and to address any barriers to care and support that are identified.

Assertive Community Treatment (ACT) - ACT is a comprehensive set of services designed to meet all of a members' needs in a community setting. A multi-disciplinary team provides the member enrolled in ACT with mental health outpatient services, care coordination, peer support, psychopharmacology, substance use disorder counseling, vocational training, and care management to keep the member with SMI in the member's chosen community setting. Under this initiative, EOHHS projects that 10% of the SMI population deemed eligible for IHH services will meet the threshold ACT services. EOHHS, through a collaboration with the MCOs and BHDDH, will monitor the clients receiving ACT as a percentage of the IHH population during this six-month pilot. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation programs or services—that is the role of the IHH staff layered onto the ACT teams. The ACT team is mobile and delivers integrated clinical treatment, rehabilitation and other supportive services in community locations. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for members. The members served have severe mental illnesses that are complex and have a

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significant effect on functioning. The ACT teams are available to provide these necessary services 24 hours a day, seven days a week, 365 days a year. ACT is well established in research literature in achieving outcomes for individuals with SMI who require greater outreach and management efforts in order to be maintained in the community. This redesign proposes an ACT, with fidelity to the model, for those identified to be in need as established in a standardized level of care/functionality assessment. ACT programs will be reviewed by BHDDH using the Tool for Measurement of Assertive Community Treatment (TMACT) fidelity scale. Members with a DLA score of 3.0 and under will be eligible for ACT. See table below on page 5.

Required Services – ACT programs will be approved by BHDDH. ACT programs are required to provide all of the following services: comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, and chronic condition management and population management. These services may be coordinated through health information technology or other mechanisms (i.e. ADT, CurrentCare, etc.) to facilitate coordination of care with primary care providers and other behavioral healthcare providers. Services also include clinical services.

Team-based Approach - ACT uses a team-based approach to care coordination, mental health and physical health chronic condition management, health promotion and peer/family support. Each team member's unique background and expertise provide a valuable resource for optimizing the care coordination activities that can benefit the members they serve.

Eligible IHH Providers – Only Community Mental Health Organizations (CMHOs), licensed by BHDDH to provide ACT services, may bill for ACT.

Service Delivery - ACT services are based on a team approach for each member, driven by a person-centered, recovery-oriented, strength-based care plan that specifies the duties of the individual team members. Service intensity and service mix among the six required services is likely to vary from month-to-month. A member of the team will maintain contact with the member, the member's family, and/or the members' collateral providers and supports to ensure that the treatment plan is being implemented and to address any barriers to care and support that are identified.

Note: The descriptions of IHH and ACT provided in this billing manual are only a high-level description of the programs. Please refer to the IHH Provider Manual for full details and descriptions of services and requirements included in the IHH and ACT programs.

Members will qualify for IHH and ACT based, in part on their score on the Daily Living Assessment of Functioning (DLA). Based on material disseminated at the DLA training in November 2015, the average DLA scores are interpreted as follows:

5.1-6.0- Mild Impairments, minimal interruption in recovery
4.1-5.0-Moderate Impairments in functioning
3.1-4.0-Serious Impairment in functioning

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2.1-3.0-Severe Impairment in functioning
2.0-Extremely severe impairments in functioning

Along with the established diagnostic categories, BHDDH has established the following guidelines for program assignment:
≤3.0 - ACT
>3.0-5.0 - IHH
>5.0 - Outpatient

The State is establishing an exception process for individuals who may need a higher level of care than indicated by the average DLA score. If a provider identifies a need for IHH or ACT services, but the DLA score falls below the threshold, the provider will submit an “Exception Request” to BHDDH, who will review the request and make a determination on assignment to IHH or ACT. BHDDH and OHHS will monitor this exception process and review for additional modifications as needed.

3. Other Behavioral Health Services Available to Members Receiving IHH and ACT Services

IHH: The menu of IHH services has been designed to complement the direct services that members receive for their behavioral health and chronic medical conditions, (such as outpatient therapy, medication management, intensive outpatient therapy, and primary care/specialty care visits) with their primary care or specialty medical care provider. The work of the IHH team is to ensure coordination among all providers and to address members’ unique needs, especially in times of crisis or high acuity and to facilitate smooth transitions of care for the member, the member’s family and the members’ other supports.

ACT: The ACT program can be provided to any person who has a qualifying diagnosis and a DLA score requiring ACT services as specified by the State. Providers submit the determination via the BHDDH provider portal. Providers and the MCOs will work together to ensure that any newly identified participant is updated on the portal.

The ACT program shall be billed as long as the provider meets the minimum program requirements. The ACT program may not be billed while a person is in an institutionalized setting, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Crisis Stabilization Unit, mental health residential program, substance abuse treatment – ASAM levels IV, III.7, III.5 or long-term residential. Billing will be set up as a per diem payment. However, program enrollment by provider will be monthly except in special circumstances, as defined in Section 6.

4. Initial Enrollment – January 1, 2016

All current members participating in IHH will be attributed to their current IHH provider and appropriately assigned to an MCO or Out of Plan Medicaid (formerly “Medicaid

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Fee-for-Service"), effective January 1, 2016. BHDDH will be the final approval source for the initial IHH roster as of January 1, 2016. BHDDH will forward the approved attributions via the portal to Hewlett Packard Enterprises (HPE). The MCOs will then receive an initial extract with the roster of their members who have been assigned to each of the CMHOs and a weekly extract thereafter for new members assigned to IHH.

Providers must complete the DLA on 95% of their members enrolled on January 1, 2016 and between the dates of November 1, 2015 thru April 30, 2016. In addition, for all members enrolled on January 1 2016, providers must complete an "Enrollment Form" for all attributed members by April 30, 2016. For all members enrolled after January 1, 2016, the provider must complete an enrollment form before enrollment is entered into the portal. The member or the member's authorized representative must sign the form. Providers must provide a bi-annual attestation form to BHDDH to attest that enrollment forms have been completed on all members. The provider must retain the enrollment form in the member's record. The provider must also attach a roster of all IHH and ACT enrollees to each attestation forms. BHDDH, EOHHS, and the MCOs reserve the right to request the enrollment form at any time.

Members will be determined eligible for IHH or ACT services based on the criteria described above in Section 2.

New members will be assigned to IHH or ACT after they have met the diagnostic criteria and the provider has submitted a completed DLA to BHDDH. EOHHS and BHDDH reserve the right to review these documents at any time.

Initial Billing

Providers are responsible for verifying the member's eligibility at the close of the month before submitting the bill for the monthly bundled payment.

5. Enrollment of New Members into IHH/ACT

All prospective IHH members are evaluated by a member of the IHH team based on IHH diagnostic criteria for SMI as promulgated by BHDDH. The member must have one (1) of the DSM V diagnoses consistent with ICD-10as established by BHDDH.

In addition, the provider must complete the DLA and submit the score to BHDDH via the HPE portal. BHDDH will approve the member's enrollment into IHH within two (2) business days of the receipt of the enrollment information from the CMHO. There will be a daily (Monday through Friday) upload to MMIS from BHDDH of all members approved by BHDDH. The State will send a weekly data extract to the MCOs of all new members approved by BHDDH.

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All enrollments should be prospective. The provider should conduct a DLA and attribute the member to ACT or IHH on a prospective basis. Ideally, the provider should complete this assessment and submit this to the portal between the 20-25th of a month, for prospective enrollment the first of the following month. This will allow time for data transfer and to ensure that data can be passed successfully to the MCOs. Questions on data entry into the portal will be addressed in the training with HPE.

For all members enrolled after January 1, 2016 the provider must complete an enrollment form before enrollment is entered into the portal. The member or the member's authorized representative must sign the form. Providers must provide a bi-annual attestation form to BHDDH to attest that enrollment forms have been completed on all members. The provider must retain the attestation form in the member's record. The provider must also attach a roster to each attestation form. BHDDH, EOHHS, and the MCOs reserve the right to request this form at any time.

After January 1, 2016 CMHOs seeking to enroll a client in ACT must submit DSM V diagnoses consistent with ICD 10 diagnosis, the DLA and the ACT enrollment form to the HPE portal. Providers must update and resubmit DLA scores every six (6) months. HPE will send a weekly extract to the health plans of ACT enrolled members.

Level of Care Changes (IHH to ACT or ACT to IHH), should occur monthly. All enrollments should be prospective. The provider should conduct a DLA and attribute the member to ACT or IHH on a prospective basis. Ideally, the provider should complete this assessment and submit this to the portal between the 20-25th of a month, for prospective enrollment the first of the following month. This will allow time for data transfer and to ensure that data can be passed successfully to the MCOs. Questions on data entry into the portal will be addressed in the training with HPE.

Exceptions to the Monthly- Prospective Enrollment Process:

For new clients coming into the program that need to begin services immediately and mid-month, the provider should enter a segment beginning the first day in the month in which they began services. For example, if a client comes in and begins services (after the assessment is completed), on December 15th, the portal entry should begin on December 15th and NOT December 1st. A provider must submit this mid-month assessment to the BHDDH portal within 5 business days of the start of the segment. BHDDH will not approve any retro segments that are more than 5 business days old.

For Emergency Transfer to ACT from IHH Mid-Month: If clinical needs change mid-month and an existing IHH client cannot wait to move to ACT until the start of the prospective month, the provider shall submit the evidence of clinical need to BHDDH though the completion of an Exception Process form. Once this form is approved, the provider shall be instructed to complete data entry into the portal. The portal and billing for each program should reflect the appropriate number of days. For example, if the

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transition was on 10th, then IHH portal segment and billing would be the 1st through the 10th and ACT would be the 11th through the end of the month.

6. Billing for IHH and ACT and Encounter Data Requirements

Billing for IHH

The CMHOs should submit monthly bills for IHH services using a bundled payment methodology that equals the daily rate times the number of days that the member was enrolled. Providers bill the member's MCO or EOHHS-Medicaid for members not enrolled in an MCO. For members not in plan, Providers will use the designated code (H0037). For members in an MCO, please refer to your contract with the MCO for the specific billing code. The monthly rate for this service is $420.22 and the daily rate is $13.82. For RIte Care members only, the provider may need to split billing between EOHHS Medicaid and the MCO, if enrollment into a MCO is for a partial month. A provider should bill the appropriate number of days that a member is enrolled with each entity to that entity, respectively.

The provider must enter the Provider NPI and appropriate taxonomy (251S00000X) for this bundled service**.**

As part of the claim submission, the provider should include codes that match the IHH activities that the client received during the month. The provider must include at least one (1) service level detail on the claims billed at $0.00 in order to get paid for the IHH rate for the full bundled payment. This service may include any code that is currently in the bundle. In addition, EOHHS and BHDDH have established a care management code to allow a provider to account for care management or outreach services performed in a month. For IHH members not enrolled in an MCO, Providers should bill H0036 in 15 minute units for care management involving face-to-face contact with the client only and T1016 in 5 minute units for case management involving telephonic or written contact with the client and/or telephonic, written or face-to-face contact his/her collateral contacts. For members enrolled in an MCO, please refer to your contract for specific codes to be used for these activities. Provider education and support is available for providers that require assistance with claims processing.

BHDDH, EOHHS and the MCO's will review the data contained in the monthly submissions for the IHH clients to validate that the minimum program standards were provided to the IHH members and to provide supportive data to support the IHH quality program. This level of detail should be included in the claims submitted to the MCOs and EOHHS. For RIte Care members that involve split billing, one service at the detail level of the claim is required for each payer.

Billing for ACT

The CMHOs should submit monthly bills for ACT services using a bundled payment methodology that equals the daily rate times the number of days that the member was enrolled. For ACT members not enrolled in an MCO, the Providers bill EOHHS Medicaid using the designated code (H0040). For members enrolled in an MCO, please refer to your contract for specific codes to be used for billing ACT. The monthly rate for this service is $1,267 and the daily rate is $41.65. For RIte Care members only, the provider may need to use split billing between EOHHS and the MCO, if enrollment into a MCO is for a partial month. A provider should bill the appropriate number of days that a member is enrolled with each entity to that entity. The provider may not bill for days when a member is institutionalized, see the Duplication and Exclusion section on page 12. The provider may also need to do this for members that have an inpatient hospitalization or enter an exclusionary setting.

The provider must enter the Provider NPI and appropriate taxonomy (251S00000X) for this bundled service**.**

The provider must provide adequate information at the detail level of the claim billed at $0.00 in order to get paid for the ACT rate for the bundled payment. This detail level may include any code that is currently in the ACT bundle. In addition, a care management code has been established to allow a provider to account for care management for face-to-face encounters or outreach services that make up indirect contacts to the client or collaterals. For members not enrolled in an MCO, Providers should bill H0036 in 15-minute units for care management for face-to-face contact with the client only, and T1016 in 5-minute units for case management involving telephonic or written outreach to the client and face-to-face, telephonic or written outreach to his/her collateral contacts—collateral contacts, allowable in writing, by phone or in person, should never be coded as face-to-face contacts. For members enrolled in an MCO, please refer to your contract for specific codes to be used for these activities.

The expectations for ACT include a minimum of 4 hours per month of direct service or collateral contact involving any of the bundled services per month as documented in the detail lines of the claim. These hours can be comprised of any face-to-face services and interventions, including treatment, care management, care coordination, rehabilitation or support services and written, phone or in person collateral contacts that are provided in the person's life context. Provider education and support are available for providers that require assistance with this.

For the month of January, 2016 the four-hour contact requirement will be waived, however, at least one contact must be made with the client in January to bill for ACT. After February the four-hour contact per month expectation will be enforced. BHDDH, EOHHS and the plans will monitor, DLA scores, use of collateral versus face-to-face contacts as well as performance measures to determine if this flexibility should continue after June of 2016.

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BHDDH, EOHHS and the MCOs will review the data contained in the monthly submissions for the ACT members to validate that the minimum program standards were provided to the ACT members and to provide supportive data to support the ACT quality program. This level of detail should be included in the claims submitted to the State and in the claims submitted to the MCOs. For RIte Care members that involve split billing, one service at the detail level of the claim is required for each payer.

Requirements for Billing for Less than 30 days in a Monthly Cycle (ACT and IHH)

EOHHS recognizes that from time to time, a member's Medicaid eligibility may switch from a MCO to Out of Plan, or that the member may be disenrolled from Medicaid entirely during a month. Under these circumstances, the provider may submit per diem bills to the MCO and/or EOHHS (BHDDH) for the dates that the member was enrolled, using the same methodology of one service or event for the billing period. The provider may bill per diem when a member's enrollment changes during the course of the month, and the provider may bill EOHHS for members not in a plan, or another plan when the members switches mid-month. Per Diem billing is allowed for members not enrolled for the full calendar month.

Quality Metrics

The Quality Metrics for IHH and ACT (See Appendix III for Quality Metrics.) are designed to align incentives for all parties to manage the IHH and ACT participants to achieve positive health outcomes for the member and contain costs of the Total Cost of Care for the member's primary care and behavioral health care.

Each quarter the State will review the quality data from the provider and determine if the provider has met the target measures for that quarter. EOHHS and the MCOs will recoup 10% of payments made in the quarter to any provider that falls short of the target measure for that quarter.

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7. Continuing Authorization

Once enrolled into the IHH or ACT, the CMHOs will continue to bill IHH or ACT on a monthly basis. However, the provider is accountable for having an active treatment plan that is being implemented to meet one or more of the Quality Measures and/or the Quality Monitoring Measures established by EOHHS. (See Appendix III for the Quality Metrics established by EOHHS.)

The CMHO must follow the service authorization and utilization review protocols established by the MCOs to determine continuing medical necessity for the services provided by the CMHOs. Service authorizations are valid for up to six (6) months.

EOHHS, BHDDH and the MCOs reserve the right to conduct joint case reviews.

8. Discharge from IHH and ACT

IHH is a voluntary service; a member may disenroll from IHH at any time. A member's disenrollment from IHH or ACT does not impact their Medicaid eligibility. Members who stop their active participation may also be disenrolled from IHH. However, providers are expected to make ongoing efforts to reach out to and engage the member before disenrolling the member, see Appendix II for BHDDH Requirements for Minimum IHH Participation and Disenrollment. The provider must continue to reach out to members who have become less engaged or not engaged at all for 90 days based on the provider's assessment of the member's risk and needs from the IHH service. A provider may also discharge the member from the IHH if the member moves out of the provider's service area, seeks IHH from another provider, or informs the IHH team that he/she no longer wants to participate. The provider may bill for members as long as there are active outreach efforts and they are included in the bill during the 90-day period.

The provider must maintain active management of their IHH census and determine a member's continuing participation in the IHH program each month. A member's participation may be suspended or the member may be discharged based on the IHH team's assessment of the member's status.

CMHO's will follow the ACT program guidelines for discharge from ACT. Members who have achieved stability in their community setting and whose level of functioning has improved may be seamlessly stepped down to IHH upon clinical review by the ACT team and member consent for less restrictive interventions. See Section 9 for additional details.

9. Duplication of IHH and ACT Services

IHH and ACT Activities When Members are Admitted to Acute Inpatient Care

As was stated in the description of the program model, IHH is a service designed to complement and enhance behavioral health and primary care direct services, such as outpatient therapy, medication management, and chronic care services. There is no inherent conflict or potential for duplication of IHH services with other covered services of a MCO or unbundled Fee-for-Service medical and outpatient behavioral health services.

Similarly, if the member is hospitalized for an acute medical-surgical or behavioral health condition, the IHH team will assign the Hospital Liaison to be responsible for coordinating the discharge planning with the hospital staff to effect a smooth transition of care back to the community. The liaison will also be responsible for ensuring timely follow up to outpatient behavioral health services, primary care and medical-surgical

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services, and will be responsible for establishing a prevention plan to prevent or minimize any subsequent readmissions for medical-surgical and behavioral health problems.

When an IHH member is admitted to an acute medical-surgical or acute inpatient psychiatric hospital unit or detoxification program, the IHH provider may bill the MCO or the State for IHH for one (1) calendar month following the admission with the express purpose of facilitating discharge planning back to the IHH and other community services and supports.

After fifteen (15) days of inpatient care, the provider must notify the MCO or EOHHS that the acute episode may last longer than thirty (30) days. At the twenty-eighth (28th) inpatient day, the provider must request authorization from the MCO or EOHHS for continued involvement of IHH and must describe the IHH service and/or interventions and include a rationale for the value of these interventions to the institutionalized member. The MCO or EOHHS must make a determination for continued involvement in IHH within three (3) business days of the sent date of the second (28th day) notification. For ACT services, providers cannot bill for the days during which the member is hospitalized or institutionalized.

Crisis stabilization and residential treatment are considered community services; members in those programs may also receive IHH services.

Duplication of ACT Services and Billing Exclusions

The only other services that can be billed in conjunction with ACT are Clubhouse and Medication Assisted Therapy (MAT). A provider may not bill for ACT when a member is hospitalized in an acute or long-term setting. The ACT program may not be billed while a person is in an institutionalized setting, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Crisis Stabilization Unit, mental health residential program, substance abuse treatment – ASAM levels IV, III.7, III.5 or long-term residential, or General Outpatient Program (GOP).

Duplication of IHH and ACT for Members in Other Institutional Care Settings

Admission to state-operated facilities including Eleanor Slater, Taveras, or Zambrano Hospitals, or an Out of State facility will result in the member being disenrolled from the Medicaid health plan. Billing for IHH or ACT members under these circumstances will be considered duplicative billing and the claims will be denied by the MCOs and EOHHS. IHH billing will be allowed when an IHH member is admitted for an acute inpatient psychiatric hospitalization to an out of state hospital that is in the MCO provider network or contracted with EOHHS for inpatient psychiatric services.

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IHH or ACT providers cannot bill for a person that is incarcerated unless they are still enrolled and/or Medicaid eligible, before they are placed in a Medicaid-restricted benefit status.

Duplication When Other IHH and ACT Providers Enroll the Member

When a new member is assessed by an IHH provider, the provider must check the HPE portal to see if the member is already attributed to another IHH provider for IHH services. The current IHH provider must disenroll the member at the end of the current month in order for the new IHH provider to enroll the same member at the beginning of the next month. Questions regarding the process of the transfer of members from one IHH to another should be directed to BHDDH, following the usual coordination of care transfers. Any disputes on transition should be referred to BHDDH.

11. Notice Process and Appeals

1. Upon enrollment in IHH and ACT, providers must complete an enrollment form that ensures that a provider has discussed the IHH/ACT program with the member and that the member has consented to participate. This is a voluntary program. Providers must attest that they have completed this action as documented in the medical records before entering an enrollment segment.

2. Upon enrollment or a part of the initial intake process, members are to be given a written copy of the BHDDH and EOHHS process to file a complaint, appeal a decision or request a hearing. The process to file a complaint with the state mental health authority (BHDDH), is written in the Rule and Regulations for the Licensing of Behavioral Healthcare Organizations, Section 19, Concern and Complaint Resolution Procedure. The Appeal Process is written under the Executive Office of Health and Human Services, Medicaid Code of Administrative Rules, Section 0110 Complaints and Hearings.

3. The providers shall provide written notification to the member when the member is discharged from the program or agency or when the member's enrollment in this program has been terminated; and when the member has successfully transitioned to another IHH/ACT provider or another appropriate level of care.

4. Members may appeal their discharge or termination to the as part of the EOHHS Fair Hearing process for enrollment disputes. The IHH/ACT provider must notify members of this right. Members enrolled in MCOs may also appeal through the MCO's complaint, grievance and appeal process. Providers are responsible for interpreting their licensing requirements around incident reporting and following MCO contract requirements on grievances and appeals.
5. If consent is not properly captured and attested to in the member's record, and the provider enrolls and then bills for a member for IHH/ACT, the State reserves the right to recoup any funds paid for the service.

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6. Per BHDDH and EOHHS licensing regulations, provider must maintain all records for any follow up auditing upon the request of the State.

12. Program Integrity

Both the State and the MCOs will engage in periodic audits to review clinical criteria and DLA scores on a sample of members from each provider. The audit may be based on a random sample of members or on a targeted sample of members if there are anomalies in service mix, metrics, staffing or other programmatic characteristics. The State and/or the MCO may outreach to a provider to submit additional information on the level of care determination. If the State or the MCO deny a level of care or seek a modification, and the provider disagrees with this assessment, the provider may appeal to the State for Out of Plan members or the MCOs for MCO members.

13. Other References

The provider and MCOs may refer to the BHDDH IHH manual for more specific requirements for IHH program. These include 24 hour per day/seven day per week access for IHH members, staffing requirements, the list of required services in IHH and integration of IHH with primary care and other behavioral health care providers. This Billing Manual is designed to complement the BHDDH manual and licensing regulations for CMHOs.

This manual also complements existing billing codes for IHH, outpatient and other event codes currently in place for IHH. (See Appendix I for List of New Billing and Procedures Codes)

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Appendix I

List of New Billing and Procedure Codes

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Table of Billing Codes and Rates for Members not enrolled in an MCO

Table 1. Provider Rates for Services Provided by a Community Mental Health Centers for the Treatment of Enrollees in an Integrated Health Home

SEE BELOW

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Code	CATEGORY	Base Rate	MD	PCNS	PhD	LICSW/ LMHC /LMFT	Principle Counselor/ Counselor	LCDP	RN	QMHP
H0037	Integrated Health Home (per diem)	$13.82								
H0040	H0040 ACT High Acuity + IHH (15% pop)	$41.65								
H0036-HN	Integrated Dual Diagnosis Treatment (CPST-SUD) per 15 minutes	$21.25								
H0024	Supported employment, per 15 minutes	$21.25								
90791	Initial Eval	$155.00			$155.00	$131.75	$116.25	$108.50	$ 124.00	
90792	Initial Eval w/ Medical	$294.35	$294.35	$250.20						
90832	30 Minutes Therapy	$70.00			$56.00	$52.50	$49.00	$45.50		
90834	45 minutes Therapy	$96.00			$76.80	$72.00	$67.20	$62.40		
90837	60 Minutes Therapy	$100.00			$80.00	$75.00	$70.00	$65.00		
H2011-U1	Crisis 60 Minutes (ER Eval Only)	$37.50								$150.00
90846	Family Therapy w/out Pt (45 minutes)	$90.00	$90.00	$76.50	$72.00	$67.50	$63.00	$58.50		
90847	Family Therapy (45 minutes)	$96.00	$96.00	$81.60	$76.80	$72.00	$67.20	$62.40		
90853	Group Therapy (45 minutes)	$48.00	$48.00	$40.80	$38.40	$36.00	$33.60	$31.20		
99211	Registered Nurse Visit, per 15 minutes	$7.50							$ 7.50	
99212	Established Patient 10 Minutes	$56.00	$56.00	$47.60						
99213	Established Patient 15 Minutes	$78.00	$78.00	$66.30						
99214	Established Patient 25 Minutes	$118.00	$118.00	$100.30						
99215	Established Patient 40 Minutes	$148.00	$148.00	$125.80						
90833	30 Minutes Therapy	$42.00	$42.00	$35.70						
90838	60 Minutes Therapy	$100.00	$100.00	$85.00						

NOTE: MCO's may use the 90839 code for Crisis 60 Minutes (referencing H2011-U1 above)

NOTE: MCO's may use H2024 for Supportive Employment

NOTE: H0036-HN is not a per diem code, modification was made to define the code as a 15-minute code with a maximum of 4 units per day.

NOTE: 99211 is a 5-minute code, modification was made to define the code as a 5-minute code with a maximum of 9 units per day.

NOTE: H2011-U1 is a 15-minute code, modification was made to define the code as a 15-minute code with a maximum of 4 units per day.

Appendix II

BHDDH Requirements for Minimum IHH participation and Disenrollment

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BHDDH Requirements for Minimum IHH participation and Disenrollment

Discharge Criteria (ACT)

Discharges from the ACT team occur when members and program staff mutually agree to the termination of services or transition to a lower level of care (IHH or GOP). This program is voluntary and member has the right to disenroll at any time. This shall occur when members:

a. Have successfully reached individually established goals for discharge, and when the member and program staff mutually agree to the termination of services.
b. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the member requests discharge, and the program staff mutually agree to the termination of services.
c. Move outside the geographic area of ACT's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT program or another provider wherever the member is moving. The ACT team shall maintain contact with the member until this service transfer is completed.
d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the member.
e. Does not participate in any services for a period of ninety (90) days, despite documented efforts to engage in treatment.

Discharge Criteria (IHH)

Discharges from the IHH occur when members and program staff mutually agree to the termination of services or transfer to a different level of care (ACT or GOP). This shall occur when members:

a. Have successfully reached individually established goals for discharge, and when the member and program staff mutually agree to the termination of services.
b. DLA results indicate need for higher or lower level of care.
c. Move outside the geographic area of IHH's responsibility. In such cases, the IHH team shall arrange for transfer of mental health service responsibility to an IHH program or another provider wherever the member is moving. The IHH team shall maintain contact with the member until this service transfer is completed.
d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the member.
e. Do not participate in any services for a period of ninety (90) days, despite documented efforts to engage in treatment.

Appendix III

Quality Metrics

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Quality Metrics

IHH Year 1 Performance Measures: quarter data collected	Numerator	Denominator	Definition
Quarter 1 Incentive			
Completed DLA	# IHH eligible members during the measurement quarter who have had a completed DLA-20 within the last 6 months	# IHH eligible members during measurement quarter	% of IHH eligible members who have a completed DLA-20
Quarter 2 Incentive			
BMI	#IHH eligible members during the measurement quarter who have a documented BMI in the preceding 12 month period	# IHH eligible adults during measurement year (Note: Follow-up documentation to be included in Y2)	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25

Employment Rate	# IHH eligible members during the measurement quarter who are employed (full or part time) or in the armed forces as of 06/30/2016	#IHH eligible members during the measurement quarter (excluding IHH eligible members whose employment status is "retired" or "unknown")	% of IHH population that report part or full time employment
Discharge for Non-Treatment Adherence	Number of IHH eligible members during measurement quarter discharged for non-compliance or who terminate service prior to completion against clinical advice.	Number of IHH eligible members during measurement quarter (unknown data excluded from both)	% of IHH members during the measurement period discharged for non-treatment adherence
Quarter 3 Incentive			
Annual Physical Exam or Well Visit with PCP	# IHH eligible adults with a claim for an annual physical or well visit during the measurement year	# IHH eligible adults during measurement year	85% of population has Annual Physical Exam with PCP
Admits per 1000 for MH and SUD acute inpatient	#IHH eligible members during the measurement quarter with a psychiatric or substance use inpatient hospital admission (Not ASU/CSU)	Total number of adults in RI X 1000	Need to establish Baseline Measure and Target for Year 1
Patient Satisfaction Survey	Number of estimated attributed members who Strongly Agree or Agree with questions 7-12 of the OEI.	All estimated attributed members responding to the OEI (unknown data excluded from both when 1/3 or more of measures are missing).	Questions 7-12- % Responses Strongly Agree or Agree

Quarter 4 Incentive			
Mental Health Inpatient After Care Follow Up 3 Days	# IHH eligible adults who have a face to face visit with any member of the IHH team within 3 business days of a psychiatric hospital discharge (not including discharge date)	# IHH eligible adults with an inpatient psychiatric hospitalization during measurement year	90% of members who have a MH Inpatient Admission will receive 1 face to face contact by an IHH member within 3 business days of discharge
Mental Health Inpatient After Care Follow Up 7 Days	Number of adults receiving inpatient care	Number of adults who had an encounter with a MH Practitioner or Prescriber within 7 business days of discharge	Follow HEDIS specs for members who received an appointment by an MH Practitioner or Prescriber within 7 business days of discharge
Hospital 30-Day Readmissions All Cause Med, Surg, BH	Number of adults admitted to a hospital for any reason	Number of adults readmitted to a hospital 30 days after discharge from a hospital admission	The percentage of acute inpatient stays that were followed by a readmission within 30 days for any reason in adults ages 18 and older.
Total Cost of Care	Total cost of care for all adults itemized by plan and unenrolled		Identify decrease in total cost of care from SFY15 to SFY16

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Quality Monitoring Metrics

IHH Year 1 Monitoring Measures	Numerator	Denominator	Definition
Stable Housing	Number of estimated attributed members who are living in private, public or residential settings.	All estimated attributed members (unknown data excluded from both).	% of population who report stable housing (Private/Subsidized)
Smoking Cessation	Rate 1: Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user. Rate 2: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.	Rate 1: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. Rate 2: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.	75% of members referred smoking cessation counseling/medication evaluation (NQF Specs)
Acuity Level Transition	1.) # ACT clients in prior month in IHH or FFS in current month 2.) # IHH clients in prior month in ACT or FFS in current month 3.) # FFS clients in prior month in IHH or ACT in current month	Admits and discharges not included	% of members who Transition from High to Moderate or Low Acuity & % of members who Transition from Low or Moderate Acuity to High

ED Visits/1000	Number of ED visits	Number of enrollee months	Rate of ED visits per 1,000 enrollee months among HH Enrollees. A total rate as well as rates for the following age cohorts should be reported: 0-17, 18-64 and 65+. Need to establish Baseline Measure and Target for Year 1.
Inpatient Average Length of Stay	UHC, NHP, & Tufts please provide numerator methodology	UHC, NHP, & Tufts please provide denominator methodology	Average Length of Stay for Inpatient (by Medical, MH, & SUD)
Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	# IHH eligible clients whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year.	# IHH eligible clients with a diagnosis of diabetes (excluding gestational or steroid induced diabetes)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
Screening for Clinical Depression and Follow Up	All patients age 12 and older	# of patients screened for clinical depression on the date of encounter using an age-appropriate standardized depression screening tool, and if positive, a follow up plan is documented on the date of the positive screen.	Percentage of Health Home enrollee age 12 and older screened for clinical depression using an age appropriate standardize depression screening tool, and if positive, a follow up plan is documented on the date of the positive screen.
Controlling High Blood Pressure	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.	The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Single rate is reported.

Care Transition-Timely Transmission of Transition Record	All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Percentage of discharges from an inpatient facility to home or any other site of care which a transition record was transmitted to the facility, home health provider or primary physician/other health professional designated for follow up care within 24 hours of discharge among health home enrollees
Initiation & Engagement of Alcohol and other Drug Dependence Treatment	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).	Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	Percentage of health home enrollees age 13 and older with a new episode of alcohol or other drug dependence who: initiated treatment through an inpatient admission, outpatient visit, IOP, or PHP within 14 days of diagnosis.Initiated treatment and who had 2+ services with a diagnosis of AOD within 30 days of initiation visit.

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Prevention Quality Indicator (PQI 92: Chronic Conditions Composite	Population ages 18 years and older in metropolitan area† or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.	Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI #13 Angina Without Procedure Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.	Number of hospital admissions for chronic conditions per 100,000 member months for health home enrollee age 18 and older.
Inpatient Utilization	Inpatient utilization by discharge date, rather than by admission date and include all discharge that occurred during the measurement year.	Number of enrollee months	Rate of acute inpatient care and services (total, maternity, mental and BH, surgery and medicine) per 1,000 enrollee months among HH enrollees. A total rate as well as rates for the following age cohorts should be reported: 0-17, 18-64 and 65+.

Nursing Facility Utilization			The number of admissions to a nursing facility from the community that results in a short term (less than 101 days) or long term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollment months. A total rate as well as rate for the 18-64 age cohort and 65 and older age cohort should be reported.

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