

Health Homes Billing Matrix FAQs
Updated 06/16/2015

If the policy went into effect May 1st can we still bill outreach for May even if member was assigned, say, in April 1st? Is it outreach per good faith effort but no contact payment once as of May 1st for this month or from original assignment date if that date was prior to May 1st?

Policy is effective 5/1/2015 including good faith effort with no contact. No retroactivity is considered, if outreach had not occurred for members previously rules are now applied per the new guidelines.

If the member changes MCOs or bounces off/back on the roster – does our one payment of good faith effort to outreach w/o contact start over?

Good faith contact effort can be restarted with MCO change. An additional good faith outreach effort can occur if a member has lost Medicaid eligibility for 6 months or more, but has regained eligibility after this window. A maximum of 2 good faith efforts are payable annually to a Health Home Partner for the same member given potential for eligibility loss and MCO change.

If we did due diligence to find someone but couldn't and turn in a refusal but then an MCO comes back to us asking us to try a different phone number or address, does the one time outreach good faith effort start over at that point or are we expected to keep trying knowing that we're not generating any claims?

If the refusal form has been accepted and processed the MCO would not return updated information to the Health Home Partner and requested outreach.

If the refusal form has not been accepted and the MCO responds to the form indicating that alternate contact information is available via a list, portal, or other resource then no subsequent payment is made as it is the expectation of the MCO that these sources be utilized in advance of a refusal form submission.

Please refer to:

[KanCare Serious Mental Illness \(SMI\) Health Homes Program Outreach and Due Diligence](#)

In regards to the good faith effort to contact the member w/o making voice-to-voice or face-to-face contact... We usually try several of the due diligence steps within the first month of assignment, but on different days of the month. Does payment "once" mean one outreach claim/service total or does it mean one month of outreach claims which could contain more than one service coded as health promotional outreach?

Once means one monthly payment, regardless of the number of outreach attempts. We expect that each activity is filed as a claim to the MCOs.

FAQ Scenarios:

I contacted the father of Health Home member, Cassie. Cassie was assigned to me last month. At this point her 30 days of outreach billing are over. I called Cassie's dad today to follow-up with him re: decision to utilize services because he'd asked me to send him more information by mail, which I did, two weeks ago. He still hadn't had time to look it over. He asked for more time and I agreed to allow

for that and then we made a plan to touch base again in a week or two. At this time, how do you want me to bill/document for this contact?

The question implies that an initial contact was made with the parent/guardian of the member. We would classify this scenario as an engaged member. So this would fall under the 90 days of engagement activities. So the first month is reimbursable and an encouraging first step.

Documentation for this first contact should include the name and contact information for the father, the date and time of the outreach, a description of any relevant components of the discussion as well as the follow up to mail the father Health Homes informational material.

Typically, I'd bill/code as health promotion because we're still talking outreach here. However, I'm past my 30 day window so I'm not sure if I need to continue to code that as health promotion or if I now need to code this as non-billable. Please advise.

Appropriate billing should be a determination based upon the amount and scope of the service provided. The MCOs expect that each time activity is performed and documented then a claim will result and the claim coding will be consistent with the note recorded. Multiple services may be coded per claim to appropriately capture the scope of work undertaken by the Health Home staff member.

I'm also concerned at this point that if I bill health promotion for sending Cassie some information specific to quality measures or her conditions, that MCOs would confuse the claim for outreach since the category is the same. I'm not sure how the MCO is supposed to know if that health promotion claim was for outreach that's now past the 30 day mark or if it is for legitimate health education. Any comments?

The MCOs all undertake reviews of the notes and documentation associated with Health Homes service delivery. We ensure appropriate documentation and delivery of services through these oversight mechanisms, and expect that Health Home Partners are documenting services and filing claims in compliance with the standards and requirements as outlined in the SMI Program Manual and the Billing Matrix.