Adirondack Health Institute

Lead Empower Innovate

POLICY AND PROCEDURE

Title: Health Home Referrals and Assignments

Department: Health Home

Population: Health Home Serving Adults and Children

Date Revised:7/1/2019,7/2/19,5/6/2021,6/1/2022,7/1/2023, 7/1/2024

Health Home Standard: B5, B6, C, F3a, F3b, F5a

Purpose of Policy

To describe the process for making referrals to AHI Health Home and to ensure that all referrals to AHI's Health Home program are processed and assigned to a Health Home Service Provider (HHSP) within a reasonable timeframe, thereby providing the greatest potential for the prospective client/participant to be engaged by a HHSP and provided the essential program services.

Scope

1. This policy must be distributed to all AHI Health Home program staff and all subcontracting Health Home Service Providers. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions, problems, or compliance issues with the policy within ten days of the issue date to the AHI's Health Home Assistant Director.
2. All questions regarding this policy or its implementation may be directed to the Assistant Director, Health Home at AHI Health Home.

Statement of Policy

It is the policy of the Adirondack Health Institute Health Home (AHIHH) to accept referrals of eligible patients from a variety of sources, including but not limited to primary care providers, behavioral health providers, single point of access committees, public health departments, other community-based organizations, and client direct referrals.

Definitions

Care Management Record System: A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

***Community Referral*:** A referral obtained from any number of sources including LGU (Local Government Unit), SPOA (Single Point of Access).

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DOH-5236: Notice of Denial of Enrollment in Health Home

Health Home Service Provider (HHSP): an organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

Legally Authorized Representative: For the purpose of sharing health information, the legally authorized representative is defined as a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information. For children in foster care, the legally authorized representative is the Local Department of Social Services (LDSS) (or VFCA if elected by the LDSS).

***MAPP*:** Medicaid Analytics Performance Portal

***MMCP/MCO*:** Medicaid Managed Care Plan/Managed Care Organization (e.g. CDPHP, Fidelis, MVP, United HealthCare).

Upward Enrollment: A referral obtained by a HHSP that came directly from a source known to the agency.

Background

The Health Home Referrals and Assignments policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the standards for referrals and assignments as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

POLICY

Marketing AHI Health Home Care Management Services

Adirondack Health Institute Health Home (AHIHH) will educate potential referral sources on the Health home program's priority population, eligibility requirements, and services provided. It is noted that the AHI Health Home provides services to both children and adults throughout Clinton, Essex, Franklin, Hamilton, Saratoga, St. Lawrence, Warren, and Washington counties.

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Making Referrals to AHI Health Home

1. Referrals are **not** accepted for persons with Developmental Disabilities receiving case management services from OPWDD, some persons in long-term care settings, and several other restrictions. Please see the Restriction Exception (R/E) codes on the NYSDOH Health Home's website for additional information. Referral can be accepted for those individuals who need support in accessing those services. The HHCM can support the member with getting OPWDD eligibility.
2. Referral sources will refer Medicaid eligible individuals if, based on the information available to them, the referral source believes the following to be true:
    - The person meets the below eligibility criteria:
        i. Two chronic conditions (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, or other chronic conditions), ***OR***:
        ii. HIV/AIDS, **OR:**
        iii. one serious mental illness [adults]/ severe emotional disturbance [children], **OR**:
        iv. complex trauma [children]
        v. Sickle Cell Disease (Adults and Children)

        AND, the person has significant behavioral, medical, or social risk factors which can be addressed through care management and without care management may lead to adverse events (see HH Qualifying Conditions policy).
3. If the referral source is a Health Home Service Provider (HHSP), the HHSP will document the basis for the referral and supporting eligibility criteria as noted above in the client's record within the Care Management Record System. Also see Community Referral Workflow for HHSP's: Health Home Serving Adults (age 21 and over)
4. Referrals may be made directly to AHIHH by calling the toll-free line: 1-866-708-2912 and leaving the name and Medicaid CIN # of the person being referred in addition to the caller's name and phone number. If the caller is not an AHI Health Home Service Provider, the caller will need to provide the information contained within the Adirondack Health Institute Health Home Care Management Community Referral form. This information can be sent via secure e-mail to healthhome@ahihealth.org or can be communicated over the phone. Referrals for children can be made directly though the MAPP (Medicaid Analytics Performance Portal). See section below for more detail: *Health Home Serving Children – Additional Requirements*

How AHI Health Home Processes Referrals and Creates Assignments

1. AHI will retrieve messages from the toll-free line daily, on all day's AHI is open for business, and will perform a "member search" in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (the system provided and maintained by the NYS Department of Health) within 24 business hours of receiving the referral.

2. If the member search reveals that the person being referred has been assigned to another Health Home or is already receiving Health Home services from another AHI HHSP, AHI will notify the referral source immediately. AHI will communicate with all parties as needed to reach a resolution.
3. If the individual referred to AHIHH is not currently engaged in Health Home care management services and believed to meet the criteria for Health Home eligibility, AHIHH will refer the patient to a HHSP within two business days based on factors including but not limited to:
    - Health Home Service Provider's stated capacity
    - Service area in comparison to member's location
    - Specialty or specific area of expertise; member's qualifying Health Home condition and the needs of the member
    - Client preference
    - Health Home Service Providers must assign care managers to each client based upon care manager experience and qualification and defined member characteristics including, but not limited to, acuity, presence of Serious Mental Illness (SMI), Substance Use Disorder (SUD) or co-morbid conditions, and patterns of acute service use. *Also see Health Home Staffing Qualifications policy.*
    - If a preferred provider is identified/requested in the referral assignment, AHIHH will make a best effort to ensure assignment to the individual's preferred provider, if the HHSP is not at maximum capacity or otherwise unable to serve the individual.
    - If the HHSP to whom AHI referred the patient cannot accept the referral, AHIHH will assign the referral to another agency.
    - If no appropriate AHIHH assignment can be made AHIHH will make a referral to another Health Home.
4. Should the Health Home Service Provider accept a referral they later discover they do not have the expertise or experience to serve (based on the preference of the Health Home Candidate, the preference of his/her parent or guardian, or based on other factors), the Health Home Service Provider is to document this in the Care Management Record System within 72 hours of discovery and notify AHIHH via the toll-free line or encrypted email.
5. Once the referral has been accepted by a care management agency, AHIHH will reach out to the referral source and provide the below information:
    i. Care Management Agency name
    ii. Expected date of contact
6. If, after completing the assessment, the HHSP determines that the person referred is not eligible, the HHSP will discontinue providing health home services. If the referral came from AHI, the HHSP will notify AHI by calling the toll-free line.
7. If the prospective Health Home client does not meet the eligibility criteria for Health Home, the HHSP is responsible for sending the client or Parent/Guardian of the client the Notice of Denial of Enrollment in Health Home (DOH-5236).
8. Adult referrals are expected to be contacted within (7) calendar days of receiving the referral.
9. If a HHSP is unable to meet the timeframe above, the HHSP must contact AHIHH to either facilitate a client transfer to another HHSP or another service agency who can serve the candidate.

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Youth who are enrolled in Early Intervention can concurrently enroll in Health Home.

Referral Workflow for HHSP's: **Health Home Serving Adults (age 21 and over)**

1. If a HHSP receives a community referral directly, meaning the referral has not been assigned by the Health Home, HHSP's will enter the members information in the Medicaid Analytics Performance Portal (MAPP) using the quick link: "Create Referral/Segment". *See Attached Desk Guide*. AHIHH will import all referrals into the AHIHH care management record system each business day (Monday through Friday). ***Once the Health Home Outreach segment is created in MAPP that will start the month one of Outreach. For Example: if you enter a member into MAPP for outreach on 7.30.2019 that member's month one of outreach will revert to a 7.1.2019 Start Date.***

2. Note: HHSPs who have not received designation by NYS Office of Mental Health (OMH) to be a Specialty Mental Health Care Management Agency serving Health Home Plus should not enter segments into the MAPP system.

3. In the case of emergent situations where a HHSP needs immediate access to a newly created candidate/member chart the HHSP can either call AHI HH at 1-866-708-2912 and ask for referral coordinator assistance or complete and submit a Care Management Agency Referral Form.

Health Home Serving Children – Additional Requirements

1. All information for individuals under the age of 21 must be entered into the Children's HH Referral Portal within the MAPP HHTS to be referred and/or enrolled into the Health Home Program.
2. To ensure that individuals that make referrals of children to Health Home care management are informed of the outcome and disposition of their referral, care managers are required to contact the referral source (as provided in Referral Portal or from the community) within 48 hours or as soon as practical, to identify themselves as the care manager and their care management agency.
3. Children and adolescents who are parents, pregnant, married or are 18 years or older, are legally able to consent for their own enrollment into a Children's Health Home. They must do this by completing the Health Home Patient Information Sharing Consent form (DOH-5055). Children and adolescents completing the DOH-5055 form do not need a parent, guardian or legally authorized representative to be present to enroll in a Health Home.
4. Health Home Service Providers must assign care managers to each client based upon care manager experience and qualifications and defined member characteristics including, but not limited to, acuity, presence of Severe Emotional Disturbance (SED), Substance Use Disorder (SUD) or co-morbid conditions, and patterns of acute service use.
5. Should a Health Home Service Provider receive a Community Referral or a Referral through the Children's Portal in MAPP that they do not have the expertise or experience to serve, the Health

Home Service Provider must contact AHIHH via the toll-free line or encrypted email, and not accept the referral in the referral portal. AHIHH will re-assign rejections or reject from AHI Health Home, as applicable, within 10 business days of receipt.

6. If the referral is denied due to lack of Medicaid and the referral was made due to Behavioral Health needs, the Health Home Service Provider must consult with the family regarding a referral to the county SPOA.
7. Children's Health Home referrals are expected to be contacted within (2) business days of receiving the referral.
8. If a HHSP is unable to meet the timeframe above, the HHSP must contact AHIHH in order to either facilitate a client transfer to another HHSP or another service agency who can serve the referral.
9. The Health Home Service Provider will assign each child/adolescent a dedicated care manager who is responsible for overall management of the patient's care plan. (see staffing qualification policy)
10. The Health Home care manager is to be clearly identified in the patient record. Each child/adolescent enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the child/adolescent's care.
11. The child/adolescent cannot be enrolled in more than one care management program funded.

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Quality and Performance Improvement
AHI HH will monitor Outreach segments monthly. During Comprehensive annual reviews AHI HH will review each CMA's outreach process to ensure that members are receiving active progress outreach to adequately engage the referred member and inform them of their options regarding Health Home enrollment.

Training
This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of office hours a content specific training will be developed. MAPP specific training for Health Home Service Providers can also be accessed by emailing mapp-customercarecenter@cma.com.

Contact Person: Assistant Director, Health Home

Responsible Person: AHIHH Referral Coordinator and Health Home Service Provider

Reviewed By: Director, Care Management and Health Home

Approved By: Chief Compliance Officer

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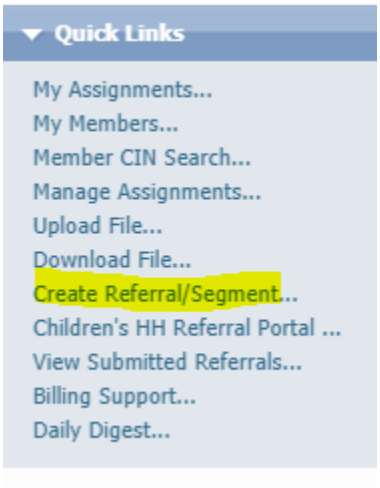
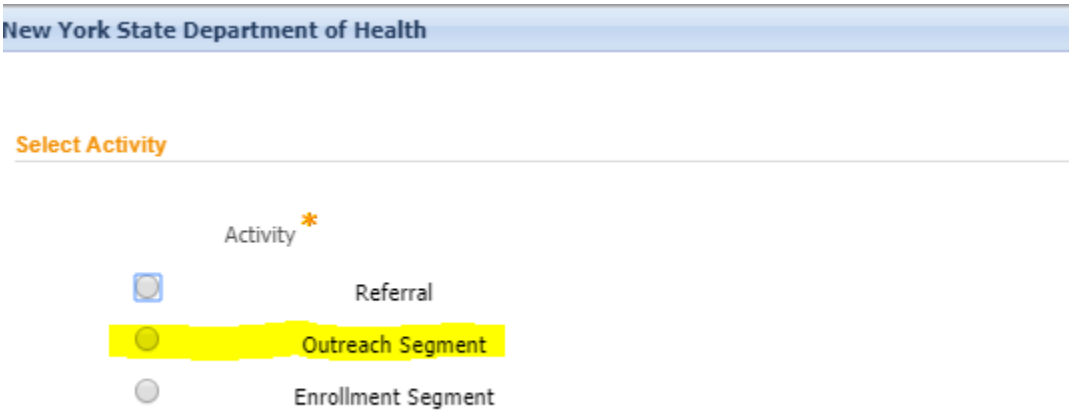
Desk Guide

Creating an Outreach Segment in MAPP – Adults Only



Select Create Referral/Segment



Select Outreach Segment

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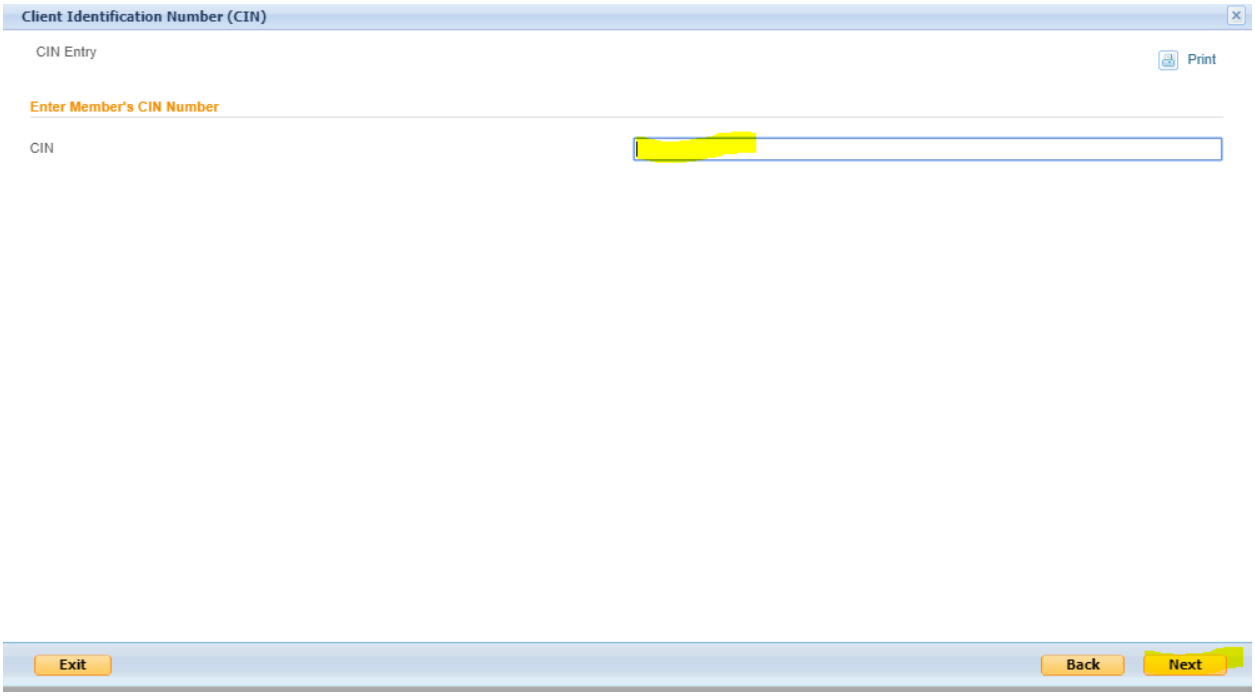

Enter Member CIN# and Click Next

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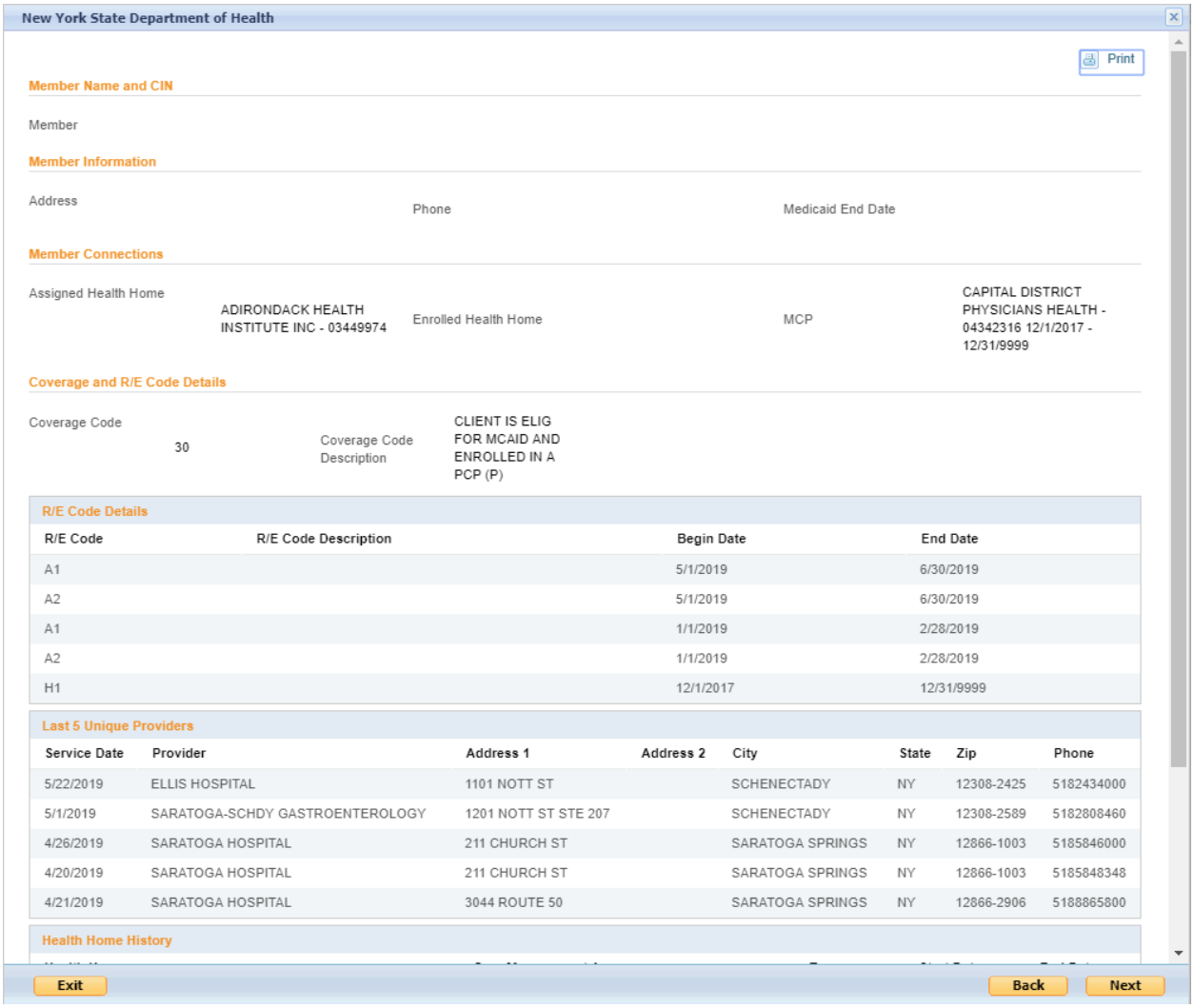

Click Next

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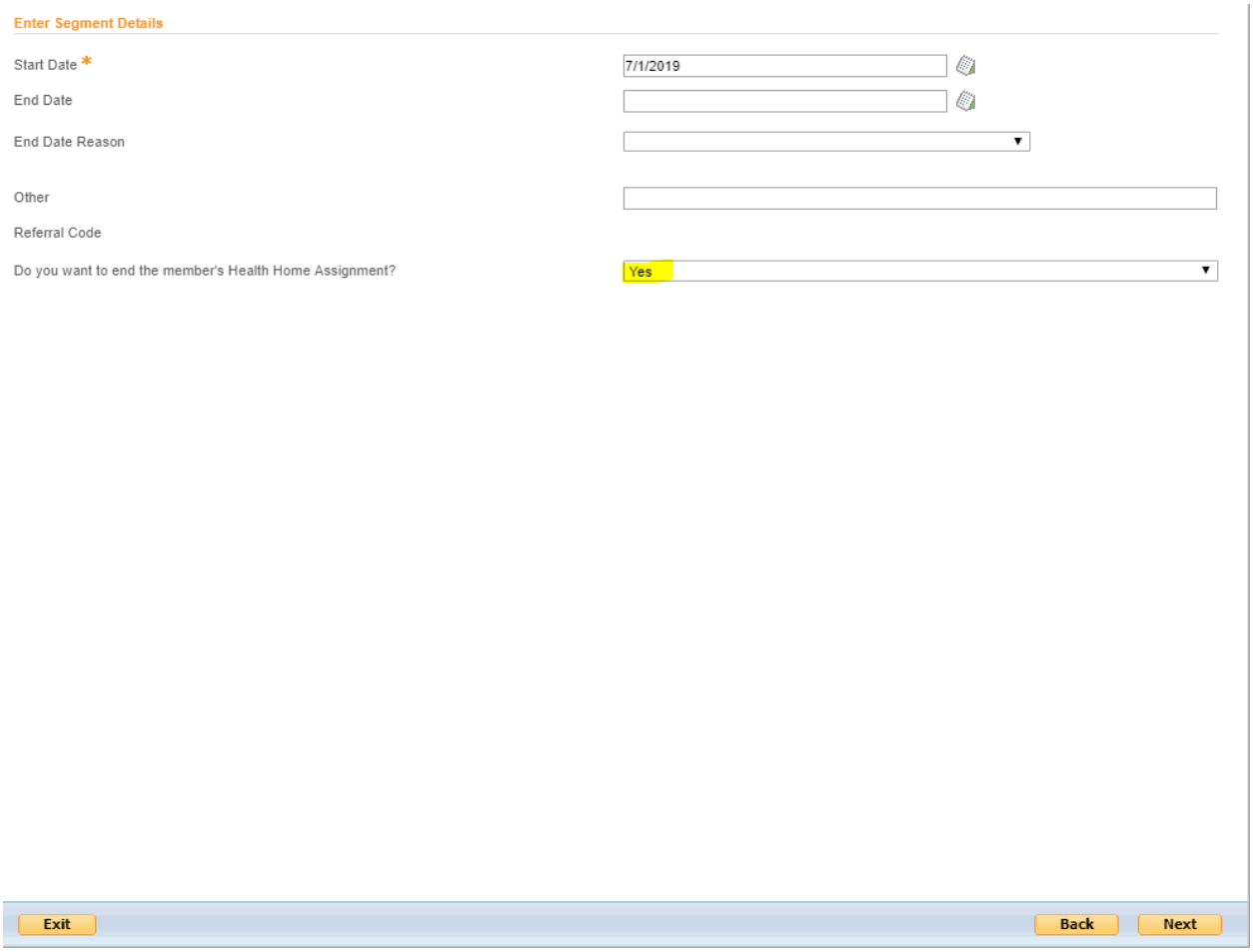

Select Yes and Click Next

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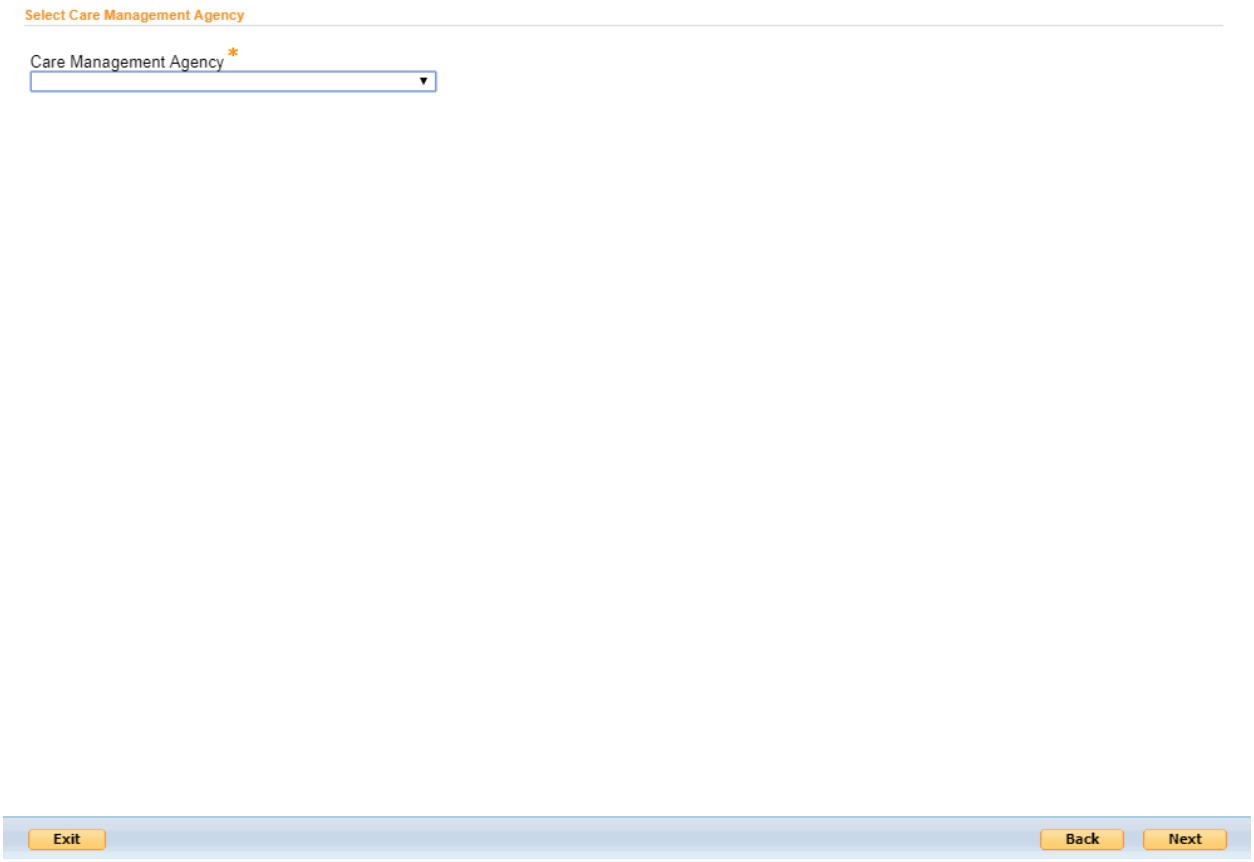

Select your CMA from the dropdown
Click Next

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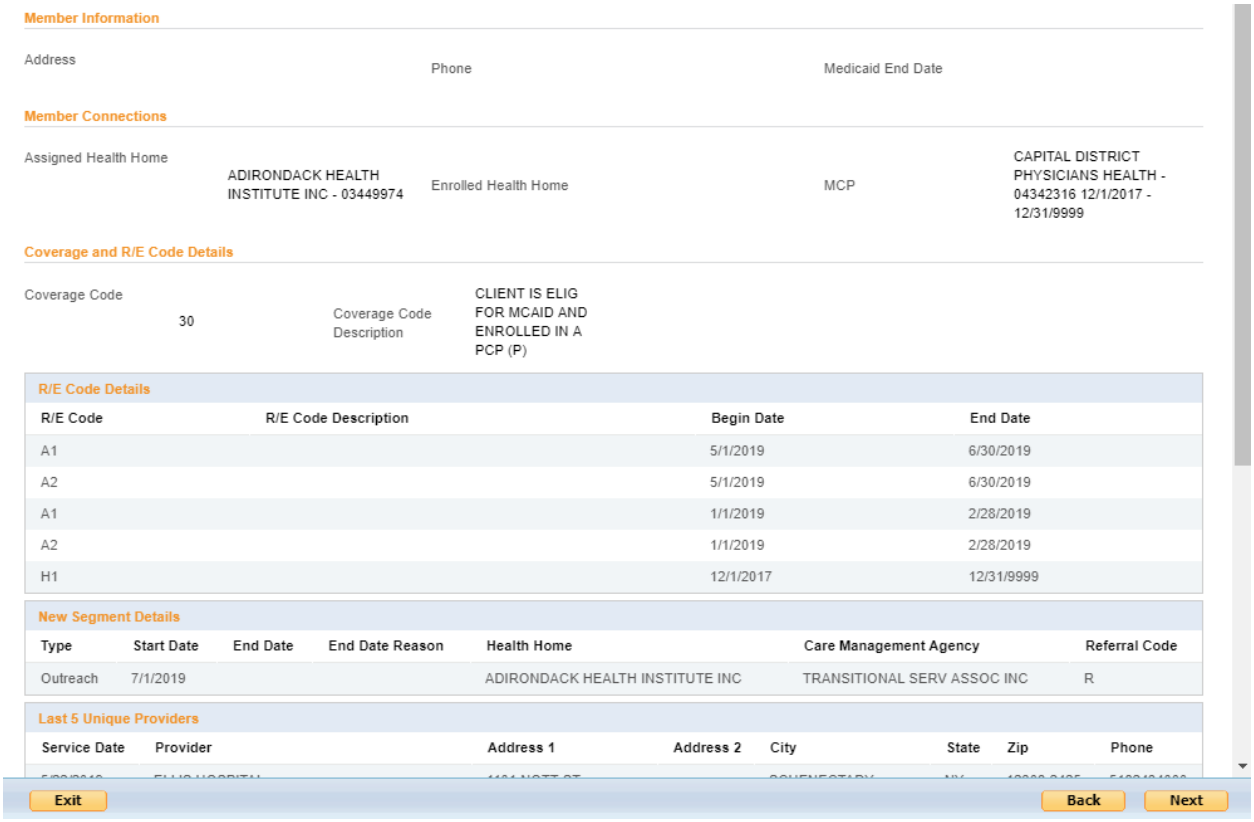

Review and Click Next