NEW YORK STATE | Department of Health

Health Homes Serving Children (HHSC)
Additional Guidance Regarding Program Referrals and Enrollment
(Effective March 29, 2017 updated June 1, 2017)

New Standard Regarding HHSC Referral Process

To ensure that individuals that make referrals of children to Health Home care management are informed of the outcome and disposition of their referral, as of the date of this guidance, care managers are required to contact the referral source provided in the Medicaid Analytics Performance Portal Health Home Tracking System (MAPP) Health Home Tracking System (HHTS) referral portal, within 48 hours or as soon as practical, to identify themselves as the care manager and their care management agency. This communication will provide the care manager the opportunity to obtain important information about the child and family, and if appropriate, discuss possibly including the individual in the multi-disciplinary team. For referrals that come from SPOAs, this will provide the care manager the opportunity to discuss county-specific services and other ways the SPOA can assist the care manager in developing comprehensive care plan for the child.

As a reminder, please note current Health Home Serving Children standards require care managers to notify the Health Home referral source, if during HH outreach (prior to enrollment), the member (if appropriate) or the parent/guardian/legally authorized representative refuses Health Home services, and document the refusal prior to closing HH CM services.

New MAPP Referral Required When CIN Number of the Member Changes

As described in the note below there are circumstances which may result in a child receiving a new CIN number. Currently, it is not technically possible to program the MAPP HHTS to automatically update the HHTS to reflect the new Medicaid CIN. If the Medicaid CIN changes for a Health Home enrolled child/adolescent, the care manager will need to dis-enroll the child/adolescent by ending the enrollment segment and then using the child/adolescent's new Medicaid CIN, make a **NEW** referral through the MAPP HHTS Referral Portal.

Note: When a child discharges from foster care their Medicaid CIN may change. When children are discharged from foster care from the Administration of Children's Services (ACS), the CIN changes as the child moves from Upstate WMS back to Downstate WMS. However, in the rest of the state, LDSS generally keep the same CIN upon discharge. Finally, there is always a new CIN when the child in discharged due to adoption, although it takes time to process the new CIN.

(RE) Code 95 OPWDD Waivered Services Look-Alikes

This (RE) code previously precluded a Health Home outreach or enrollment segment from being made. The MAPP HHTS has been recently modified to allow for the creation of Health Home segments for members with the (RE) code 95. However, please note Care Managers ***must*** check with OPWDD to ensure an individual is not receiving Care Management from OPWDD before they can be outreached or enrolled in the Health Home Program. To find a Developmental Disability Regional Office copy and paste the following link in your web browser:
https://opwdd.ny.gov/sites/default/files/documents/OPWDD-DDRO-Eligibilty-Coordinators.pdf

Additionally, there are two known issues relating to members with (RE) code 95:

1. Although the system will allow a user to create an outreach or an enrollment segment for a member with an (RE) code 95, the system will not create/accept a billing instance for a member with (RE) code 95. This means that providers complete the adult HML assessment for members with (RE) code 95 within the MAPP HHTS. Providers should answer the adult HML assessment and calculate what rate the member qualifies for each month for members with (RE) code 95, even though the adult HML information cannot be submitted to the MAPP HHTS, before submitting a Health Home claim to Medicaid. Once this issue Is resolved, DOH will notify the Health Home community.
2. The MAPP HHTS will currently allow a provider to create an assignment with a referral record type (meaning when a provider enters a member under 21 into the Children's Referral Portal and does not create an outreach or enrollment segment), but when system jobs run around midnight, that assignment with a referral record type will disappear. For now, all straight referrals (meaning a member that is entered the system without an outreach or enrollment segment) for members with (RE) code 95 should be handled outside of the system; the Health Home that receives this referral should use the Children's Referral Portal to enter a member with (RE) code 95 into the MAPP HHTS once the member qualifies for either an outreach or an enrollment segment. Once this issue is resolved, DOH will notify the Health Home community.

Reminder of Recent Guidance: The HH list of chronic conditions has been updated to clarify that Intellectual and Developmental Disabilities (IDD) conditions have not yet been approved as eligibility criteria for HH and will be updated upon approval of CMS to include IDD conditions.

Health Home Eligibility and Individuals (Adults and Children) with IDD conditions
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhei_intel_and_dev_disab.pdf

The (RE) code 95 can be assigned to an individual who is not receiving any OPWDD services, therefore, if the individual meets current HH chronic condition eligibility and appropriateness, they can be enrolled in the Health Home program.

Health Home Chronic Conditions Eligibility
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf

Matching Health Home referred members to experienced Health Home Care Management Agencies

As a reminder, Health Homes **MUST** have documented procedures in place, and must ensure, that care managers providing services to members have the experience to meet the needs of the child and must consider, at a minimum, the characteristics of the member, the criteria which made the member eligible for Health Home, the Health Home acuity presence of co-occurring or co-morbid Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), Complex Trauma, medical co-morbid conditions, and patterns of acute service utilization.

UPDATE – Staff Qualification Waiver

The New York State Department of Health (DOH) in collaboration with State Partners, have outlined in the Health Home Serving Children Standards that Care Managers must meet specific staff qualifications. These qualifications are the minimum standard and apply ***only*** to Care Managers that would serve ***"high"*** acuity children as determined by the CANS-NY.

Please Note:

1. Health Homes and Health Home Care Management Agencies that submit a Staff Qualification Waiver Request which is ***not*** granted, the individual in which the request was submitted would still be able to serve children with "medium" and "low" acuity levels, as the waiver is specific to serve children with "high" acuity level determined by the CANS-NY.

2. Health Homes and Health Home Care Management Agencies **MUST** attach a copy of the candidate's **updated resume** as well as list verified relevant degrees and certificates to the Waiver Request Form at the time of submission. The updated resume should reflect what is detailed on the Waiver Request form. A Contact Person for the Health Home and Health Home Care Management Agency must also be listed on the Waiver Request Form along with their title, phone number and e-mail address.

If the Staff Qualification Waiver Request does not have the required information, then the Request will be denied.