The following *Questions and Answers* are provided in response to questions submitted by hospitals related to **DHDTC DAL 17-04**, "*Hospital Referral To Health Homes Requirement*":

1. Is the hospital referral protocol in DHDTC DAL 17-04 mandatory?

Yes. As required by Centers for Medicare and Medicaid Services (CMS), the State must assure that hospitals participating under the State Plan or a waiver of such plan are instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Home providers.

DHDTC DAL 17-04 provides NYS hospitals with the guidance needed to assure the requirement is met, including submission of Attachment B – Letter of Attestation, indicating that policies and procedures were developed and implemented by the due date (90 days from the date of the Letter).

While the NYS Department of Health (the Department) recognizes the impact this requirement may have on some hospitals, policies and procedures must be developed and implemented that clearly define how the hospital will meet this federal requirement.

Hospitals that are a lead Health Home, part of a Health Home network, or part of a Delivery System Reform Incentive Payment (DSRIP) Performing Provider System (PPS) have relationships with Health Homes to support procedures for making referrals directly to Health Homes or Managed Care Organizations (MCO). This connectivity supports the provision of Value Based Payments (VBP) related to the reduction of avoidable Emergency Department utilization.

2. Does the 90-day timeline mean that hospitals must have policies and procedures in place and operationalized?

Yes. The Letter provides notification to hospitals so that appropriate actions could be taken to develop and implement policies and procedures within the 90-day period (from the date of the Letter) so that referrals of eligible individuals could be made to Health Homes.

The Letter of Attestation (Attachment B) to be signed by the CEO and submitted to the Department, includes statements specifically identifying that policies and procedures were developed and implemented by the due date, as follows:

> "I hereby attest that policies and procedures have been developed and maintained in accordance with requirements under federal Affordable Care Act (ACA) Section 1945 [42 U.S.C. 1396w-4] of the Social Security Act, Section (d), as identified in SPA #NY-15-0020 for the following hospital(s):…"

"I further attest that policies and procedures have been reviewed with all appropriate hospital personnel and have been implemented to assure compliance with this requirement."

3. If a hospital does not have an emergency department, are they exempt from this requirement?

New York State's Health Home State Plan Amendment addresses federal and state requirements calling for hospitals to refer Medicaid recipients to Health Homes who seek or need treatment in a hospital emergency department. Therefore, if a hospital does not have within its structure an emergency department/room, then the requirement as stated does not apply.

New York State's approach to Health Home implementation focuses on: reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up; and, improving patient outcomes by addressing primary medical, specialist, and behavioral health care in a comprehensive manner. While the NYS Department of Health (the Department) recognizes that some hospitals do not contain within its structure an emergency room/department, such hospitals do accept and admit patients, and may be part of a larger hospital system or PPS. Several hospitals serve as lead Health Home or may be part of a Health Home network. Discharge planners are in a position of working collaboratively with Health Homes to refer patients, or provide notification if an active Health Home member is identified during his/her inpatient stay. This collaboration can bring Health Home care managers into the hospital's interdisciplinary process, and work with patients post discharge to assure connectivity to care and services needed to maintain optimal health. The Letter issued by the Department, DHDTC DAL 17-04, includes options for hospitals to consider when addressing the discharge planning needs of patients, and the benefits of working with Health Homes.

4. Is there a requirement to refer individuals to Health Homes if they have ambulatory surgery? The letter indicates that it is crucial to refer individuals to health homes if they are under the care of the ED or inpatient hospital staff, but there is no mention of patients who undergo ambulatory procedures.

The hospital referral protocol does not apply to ambulatory surgical patients, but rather, to patients who present for care in the emergency department. Please refer to Q&A #2 for guidance related to hospitals that do not have emergency departments/rooms.

5. Is signed consent by the patient required to make a referral to the health Home program?

Hospitals must obtain consent from individuals to complete a referral to Health Homes *if* the hospital is making a direct referral to the Health Home on behalf of the patient. *Attachment A* provided with the Letter, includes guidance for obtaining patient consent for Health Home referrals. Hospitals can use established processes to obtain consent from patients for the purposes of making a Health Home referral.

6. What if the patient refuses a referral to the Health Home program?

Health Home Program enrollment is voluntary. Therefore, a patient may refuse to consent for a referral to be made. Hospitals should include within its policies and procedures processes for managing and documenting refusals, such as: including information in discharge planning instructions regarding the Health Home program; providing the Health Home brochure with contact information for Health Home(s) within the region where the patient resides or receives any services; and, the patient's Medicaid managed care plan who can assist in making a referral.

7. Is it acceptable to embed Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider Systems (PPS) care managers to assess patients for Health Home eligibility?

Yes. Embedding a PPS case manager to assess Medicaid patients for Health Home or other care coordination services would be appropriate. The PPS case manager would serve as a 'bridge' between the hospital and the Health Home to make timely referrals should a patient appear to meet the criteria for Health Home enrollment.

Policies and procedures should ensure that the workflow includes this MRT initiative. As identified within the Letter, the following link to the DOH Health Home website provides the list of Health Homes within your region (and statewide) for ease of access: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

8. When will Reason Exception (RE) Codes A1 and A2 be available? What information will these RE codes provide?

The Department continues to work toward implementation of these RE codes, and will provide notification when this occurs.

ePaces and EMedNY will show the Health Home RE Codes (A1 and A2) in the same place as the other RE codes. The codes will show the name of the Health Home and/or Care Management Agency however, they will not indicate separately if the individual is assigned, in outreach, or enrolled.

Until these RE codes are available, with patient consent, hospitals can reach out to a Health Home or to the patient's Medicaid managed care organization to access the needed information.

A list of the RE codes and the compatibility with the Health Home Program can be found on the DOH Health Home our website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/restriction_exception_codes.pdf February 2017

9. What are the requirements regarding substance abuse patients?

Substance Use Disorder is a chronic condition, and therefore may be used as one of two chronic conditions required for eligibility under that category. The current list of chronic conditions can be found on the DOH Health Home website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf

10. Does the requirement include both Medicaid managed care and fee-for-service (FFS) beneficiaries?

Yes. DHDTC DAL 17-04 refers to both Medicaid managed care and FFS beneficiaries.

11. As a Health Home who is also part of a hospital system, what is the State's expectation for hospitals to implement notification to Health Homes for *inpatient events?*

A key focus of this requirement is to reduce avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits, provide timely post discharge follow-up, and improve patient outcomes. Ideally, Hospitals and Health Homes should have in place capabilities for notification to Health Homes when an enrolled Health Home member enters the hospital's ED or is admitted into an inpatient bed. For hospitals that are Health Homes or part of a Health Home network, this should be an established partnership that supports connectivity.

For hospitals that do not have this established partnership, the Letter references *consideration* for hospitals to refer eligible patients to Health Homes when admitted into inpatient beds, or notification to Health Homes when an enrolled Health Home member is admitted into an ED or inpatient bed. Though not specifically required by federal law, the Department considers this a 'best practice' and encourages hospitals to integrate this into discharge planning procedures, since as hospitals make referrals to needed post discharge services. By establishing this level of connectivity, Health Home care managers can be actively engaged in the hospital's discharge planning procedures to support timely engagement of services for the individual post discharge.

12. If this requirement does not apply to our location, do we still need to submit something in writing to the Department of Health?

Yes. The Department is monitoring receipt of Letter of Attestation forms from all NYS hospitals to assure this requirement has been met within the 90-day timeframe. Hospitals for whom this requirement does not apply must submit written notification to the Department indicating why the requirement does not apply to their facility. Hospitals can use The Letter of Attestation form (Attachment B) provided to document their response, signed by the CEO, and submitted to the Health Home BML at: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action - Subject "Hospital Referral Requirement – Hospital Letters of Attestation".

13. If a hospital is a Health Home or part of a Health Home network, can they refer a patient directly to its affiliated Health Home without contacting the Managed Care Plan?

When referring a patient to a Health Home the Department encourages hospitals to contact the patient's managed care plan whenever possible as it is important to remember that the Health Home must have a contract with the managed care plan. The managed care plan will work to assure the individual is referred to a Health Home most appropriate for the individual, and that the individual's choice in the selection of Health Homes is honored, where applicable.