Referral and Health Home Assignment Process for Children Example "Use Cases"

May 11, 2015

Purpose of Today's Webinar

- Background: The April 29, 2015 Webinar "Tailoring the Health Home Model to Serve Children: Design and Implementation Updates" provided general information regarding the process being developed to refer and assign children to Health Homes

- Today's Webinar provides additional information and example "use cases" that demonstrates how the referral and assignment process will be operationalized in the Medicaid Analytics Performance Portal (MAPP)

- Use cases are "draft" and under development in the MAPP Build

Agenda

- Brief overview of MAPP
  - The Referral and Health Home Assignment Process for children will be accessed and automated in the Medicaid Analytics Performance Portal (MAPP)
  - Access to MAPP to make referrals and assignments
    - Short term and long term Plan
- Examples of "Use Cases" to demonstrate the MAPP Health Home Referral and Assignment Process for Children
  - Community Referrals
  - Direct Referrals

Medicaid Analytics Performance Portal (MAPP)
Long Term Vision (Developed in Phases through 2016)
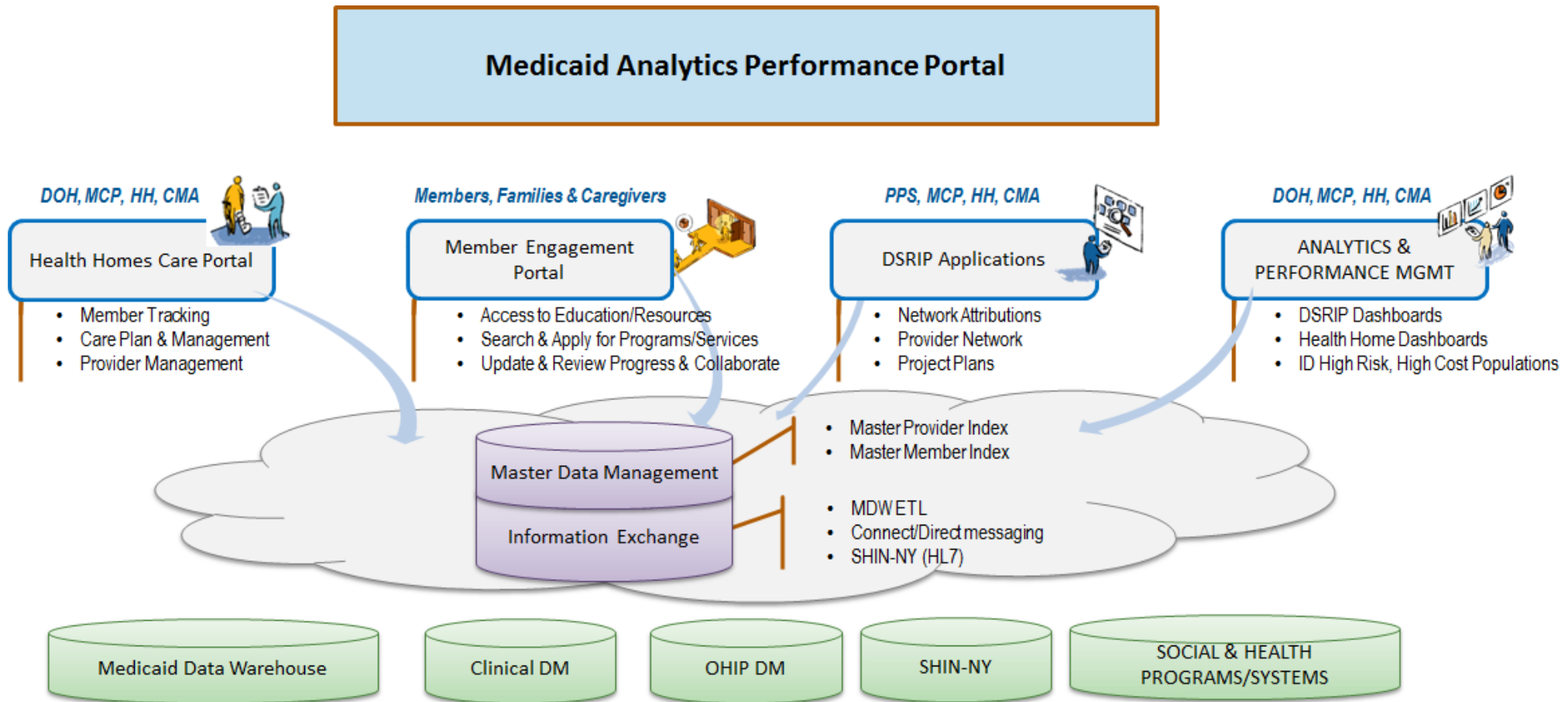
Medicaid Analytics Performance Portal (MAPP)

- MAPP supports both Health Homes and Delivery System Reform Incentive Program (DSRIP) management and technology needs

- A team of experts (DOH-HH Team, NYSTEC, Salient, IBM, Currier, McCabe & Associates, State UAS, State Agency Partners) have been working to launch the first phase of the MAPP design

- Over several phases of development that will run through 2016, MAPP functionality will grow and expand to be a comprehensive performance management system (data management and analytics, and robust dashboard capabilities)

- MAPP will provide transparent data and tools to Health Homes, Plans, Care Managers, and eventually to consumers and other providers to support and provide effective and comprehensive care management to the Health Home population and to manage performance

- At "Go Live" **August 15, 2015**, MAPP will:
  - Replace the current Health Home Tracking System, which is accessed now by Health Homes and Plans to track members (e.g., management of Assignment lists and assignments, outreach, enrollment, billing information)
  - Provide new and improved functionality
  - Extend access to MAPP to downstream care managers

MAPP Functionality at "Go Live"

- Identification of Health Home eligible population

- Assigning eligible individuals to Health Homes, Referrals of potential members (for adults, different process for children – today's Webinar)

- Outreach of Care Management Agencies (CMA) and Health Homes to potential members

- Enrolling an individual into a Health Home once outreach is complete

- Billing Support (Members' MCO, HH, and CMA and Diagnosis information)

- Transfer of individuals between Health Homes

- Ability to check on member's connection to Health Home

- Member Batch lookup and export

- Dashboards to assist Care Managers, Plans and Health Homes to manage performance, identify and evaluate best practices

MAPP Functionality for Children's Health Homes

- CANS-NY Assessment tool will be integrated into MAPP
- Billing, rate information and CANS-NY algorithms (High, Medium, Low)
- ***Today's Discussion: Referral Portal for Children (under 21)***
    - ***Community Referrals by Plans, LGU/SPOAs, LDSS, and eventually others, for Assignment***
    - ***Direct Referrals by Health Homes and Care Managers for Assignment***
- Consent Management
    - Consent to Refer
    - Consent to Enroll
    - Consent to Share Information (Protected Services)

Referral and Health Home Assignments Process for Children will be Housed in MAPP

- The requirement to obtain consent from the parent/guardian to make a referral or enroll a child in a Health Home makes using Department generated Health Home assignment lists for children impractical

- Referrals for assignment and enrollment will be made through the MAPP Referral Portal for Children (members under 21)

- MAPP will accommodate *"Community"* Referrals for Assignment and Enrollment and *"Direct"* Referrals for Assignment and Enrollment

- Today the State will present draft use cases for referral and assignment algorithms it has developed with the MAPP builders – ***the design algorithms need to be finalized this week, please provide any feedback to*** hhsc@health.ny.gov ***no later than Wednesday, May 13, 2015***

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User Access to MAPP to Make Referrals will Expand Over Time

- ***Community Referrals***: Typically made by entities or providers that are not Health Homes or Care Managers
  - **Initial Users** (October 1, 2015, effective date for beginning to enroll children in Health Home)**:** LDSS, LGU/SPOA and Plans will have access to the MAPP referral portal to make a community referral to Health Home for children only
  - **Future Phases**: Over time, the State will expand access to the MAPP Referral portal by identifying and authorizing other entities that are natural points of contact in the systems of care that impact children to make referrals through the MAPP Referral portal (School Districts, county probation departments, pediatricians, emergency rooms, Early Intervention initial care coordinators, etc.)
- ***Direct Referrals***: Made by Health Homes and Care Management Agencies (CMAs)/Voluntary Foster Care Agencies (VFCA)

Training and MAPP Access

- Training for access to and use of the MAPP Referral Portal will occur in the Summer of 2015

- Users will be required to obtain a Health Commerce System (HCS) ID in order to access the MAPP referral portal

Use Case #1:
Referral Portal: Community Referral Made by LGU/SPOA or Managed Care Plan (MCP)
(for Children *not* in Foster Care)

- LGU/SPOAs or Managed Care Plans that enter MAPP to make a referral will be required to:

  1. Accept the "Terms and Conditions" [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Trauma, HIV)]

  2. Identify if the child is in Foster Care (only a LDSS or Voluntary Foster Care Agency (VFCA) may make a Health Home referral for a child in Foster Care)

  3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)

  4. Provide the Medicaid CIN # for the individual being referred

  5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home

  6. Provide parent/guardian, legally authorized representative or individual's contact information

  7. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

  8. Indicates whether the child is receiving Child Welfare Preventive Services (if known, may provide National Provider Identifier (NPI))

  9. Referrer receives notification referral submitted

Use Case #1:
Referral Portal: Community Referral Made by LGU/SPOA or Managed Care Plan (MCP)
(for Children *not* in Foster Care)

- MAPP uses information obtained from the MAPP Referral Portal and loyalty algorithm (i.e., which providers the child has utilized and which of those providers are reflected in the network of designated Health Homes to serve children)

- If member is Fee For Service (FFS):
  - System creates a pending referral for the Health Home determined by the loyalty algorithm
  - Health Home accepts referral and makes an assignment to a care management agency, or
  - Health Home rejects referral and suggests an alternative assignment

Use Case #1:
Referral Portal: Community Referral Made by LGU/SPOA or Managed Care Plan (MCP)
(for Children *not* in Foster Care)

- If member is enrolled in a Managed Care Plan (MCP):
    - System creates pending referral for the member's MCP and identifies a recommended Health Home determined by the loyalty algorithm
    - System identifies Health Homes that have a contractual relationship with the member's MCP
    - MCP selects Health Home
    - Health Home is notified of assignment
    - Health Home accepts – assigns member to care management agency
    - Health Home rejects assignment – Managed Care Plan makes alternative assignment

Use Case #2:
Referral Portal: Community Referral Made by LDSS
For Children in Foster Care
Only LDSS or VFCA may make Referral for Children in Foster Care

- LDSS' that enter the MAPP to make a referral will:

  1. Accept the "Terms and Conditions" [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Trauma, HIV)]

  2. Identify if the child is in Foster Care (only a LDSS or VFCA may make a Health Home referral for a child in Foster Care)

  3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)

     - The LDSS is the legally authorized representative

  4. Provide the Medicaid CIN # for the individual being referred

  5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home

  6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

  7. Provide legally authorized representative or individual's contact information (i.e., the LDSS)

  8. Selects VFCA to be the CMA

  9. Referrer receives notification referral submitted

- Once the referral is submitted in MAPP:
  - The MAPP System creates a pending referral for the VFCA selected in the MAPP Referral Portal by the LDSS
  - VFCA accepts referral and selects Health Home it has contractual relationship with AND, if the child is enrolled in a Plan, a Health Home the Plan contracts with or
    - VFCA rejects referral and suggests an alternative VFCA
  - If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members

Use Case #2a:
Referral Portal: Community Referral Made by LDSS
For Children in Foster Care and Managed Care Plan
Only LDSS or VFCA may make Referral for Children in Foster Care

- Children in Foster Care that are placed with VFCA will be enrolled in Managed Care Plans in 2017 – MAPP Referral Portal for Children is being built to accommodate that transition

- All Plans will be required to contract with at least one Health Home that contracts with a VCFA

- Generally the MAPP Referral Portal will only provide the VFCA Health Home options where there is alignment (contractual relationships) between the VFCA and Health Homes, and the Managed Care Plan and the Health Homes
  - Exceptions to this approach accommodate the following circumstances:
    - a) The LDSS needs to make a placement that regionally relocates the child and assigns the child to VFCA in appropriate region.
      - ✓ The VFCA indicates in MAPP the Health Home placement is out of the Plan network due to placement which requires child to be regionally relocated and enrolls child in a Health Home in new region.
      - ✓ The LDSS ensures the child is dis-enrolled from current Plan and enrolled in a Plan that has relationship with the HH located in the new region.
    - b) The LDSS determines that the VFCA/HH/Plan aligned choices are not in the best interests of the child (i.e., capacity)
      - ✓ The VFCA may enroll the child in a Health Home which results in an unaligned Plan/Health Home relationship but must indicate/affirm in MAPP that within 15 days the LDSS will dis-enroll and enroll the child in a Plan that is aligned with that Health Home.
  - Out of network payments may be required by the Plan during the process of dis-enrolling and enrolling a member from one plan to another.

Use Case #3:
Referral Portal: Direct Referrals Made by Health Home or Care Management Agency
Process for Making a Referral for Children *Not* in Foster Care

- Health Homes and Care Management Agencies making direct referrals in MAPP for a child **that is NOT in Foster Care** will provide the following information:

    1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Trauma, HIV)]

    2. Identify if the child is in Foster Care (only a LDSS or VFCA may make a Health Home referral for a child in Foster Care)

    3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)

    4. Provide the Medicaid CIN # for the individual being referred

    5. Identify all chronic conditions that the Referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility

    6. Provide parent/guardian, legally authorized representative or individual's contact information

    7. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

    8. ***Health Home or Care Management Agency (CMA) indicates they have been engaged and in communication with the child and wants to enroll the child in the Health Home or has already obtained consent to enroll***

    9. Health Home or CMA enters the child in an outreach segment (i.e., consent to enroll has not yet been obtained) or in an enrollment segment (i.e., consent to enroll in Health Home has been obtained)

    * If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members

Use Case #4: Referral Portal: Direct Referral Made by VFCA Process for Making a Referral for Children in Foster Care

- VFCA users making a referral for a child that is in Foster Care to a Health Home will be required to provide the following information:

  1. Accept Terms and Conditions [provides brief overview of Health Home program and eligibility requirements (Medicaid member and two chronic conditions, Serious Emotional Disturbance (SED), Trauma, HIV)]

  2. Identify if the child is in Foster Care (only a LDSS or VFCA may make a Health Home referral for a child in Foster Care)

  3. Affirm and indicate they have obtained consent to make the referral from the child's parent, guardian, legally authorized representative, or self (individual's 18 -21 years of age or minors that are married, pregnant, or a parent may provide consent on their own behalf)
     - The LDSS is the legally authorized representative

  4. Provide the Medicaid CIN # for the individual being referred

  5. Identify all chronic conditions that the referrer believes make the child eligible for Health Home and appropriateness meeting Health Home eligibility

  6. Indicate whether the parent/guardian is currently enrolled in a Health Home (if yes, may provide CIN number of parent/guardian)

  7. Provide legally authorized representative or individual's contact information

  8. Identify that the VFCA is acting as the CMA

  9. ***VFCA users acting as the CMA indicates they have been engaged and in communication with the child and wants to enroll the child in the Health Home or has already obtained consent to enroll***

  10. VFCA enters the child in an outreach segment (i.e., consent to enroll has not yet been obtained) or in an enrollment segment (i.e., consent to enroll in Health Home has been obtained)

  * If the member is enrolled in a MCP, the member will be reflected in the Plan's list of Health Home assigned members

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Information that will be Programmed into MAPP to Operationalize the Referral and Assignment Process for Children

- To operationalize the MAAP Referral and Assignment Process for Children the following inputs/relationships will be programmed into MAPP
  - ✓ Designated Children's Health Homes
  - ✓ Care management agencies and Voluntary Foster Care Providers that have contracts with Designated Children's Health Homes
  - ✓ Network providers of Children's Designated Health Homes
  - ✓ Plans that have contracts with Designated Health Homes
  - ✓ Voluntary Foster Care Agencies that have chosen to provide Health Home care management
  - ✓ List of LDSS'
  - ✓ List of LGUs/SPOAs
- After the Children's Health Home Designation Process, the Department will be working with appropriate parties to obtain this information

Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569

- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

Appendix
Current and Proposed Health Home Eligibility Criteria

Current Health Home Eligibility Criteria and Proposal to Modify Health Home Eligibility Criteria (Modifications in *Bold*)

Person must be enrolled in Medicaid and have:
- Two or more chronic conditions or
- One single qualifying condition of
  - ✓ HIV/AIDS or
  - ✓ Serious Mental Illness (SMI) / Serious Emotional Disturbance (SED)
- ***Trauma at risk for another condition (Requires CMS Approval)***

Chronic Conditions Include:
  - ✓ Alcohol and Substance Abuse
  - ✓ Mental Health Condition
  - ✓ Cardiovascular Disease (e.g., Hypertension)
  - ✓ Metabolic Disease (e.g., Diabetes)
  - ✓ Respiratory Disease (e.g., Asthma)
  - ✓ Obesity BMI >25 ***(BMI at or above 25 for adults, and at or above 85th percentile for children)***
  - ✓ Other chronic conditions (see DOH website for list of chronic conditions) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf

Health Home Eligibility Criteria

Appropriateness Criteria for Health Home Eligibility

Appropriateness Criteria: Individuals meeting the Health Home eligibility criteria must be appropriate for Health Home care management. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- ✓ At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues, or
- ✓ Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

SED Definition for Health Home - SED is a single qualifying chronic condition for Health Home and is defined as a child or adolescent (under the age of 21) that has a designated mental illness diagnosis in the following Diagnostic and Statistical Manual (DSM) categories* as defined by the most recent version of the DSM of Mental Health Disorders *AND* has experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

SED Definition for Health Home - DSM Qualifying Mental Health Categories*

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Personality Disorders
- Paraphilic Disorders

*Any diagnosis in these categories can be used when evaluating a child for SED. *However, any diagnosis that is secondary to another medical condition is excluded.*

Functional Limitations Requirements for SED Definition of Health Home

To meet definition of SED for Health Home the child must have experienced the following functional limitations due to emotional disturbance over the past 12 months (from the date of assessment) on a continuous or intermittent basis

- Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents, siblings and other relatives; behavior in family setting); or
- Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Health Home Eligibility Criteria

Trauma at Risk for Another Chronic Condition

Trauma is defined as exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure which involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence, and physical and sexual abuse.

A child or adolescent who has experienced trauma would be defined to be **at risk for another chronic condition if they have one or more functional limitations** that interfere with their ability to function in family, school, or community activities, or they have been placed outside the home.

> **Functional limitations** are defined as difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in family relationships necessary for normal childhood growth and development.

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