



Department of Health

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Executive Deputy Commissioner

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Dear Chief Executive Officer:

As a provider with a critical role in serving Medicaid members with chronic conditions and implementing key Medicaid Redesign Team (MRT) initiatives, you are being notified by the New York State Department of Health (the Department) of federal and state requirements that call for hospitals to refer **Medicaid** recipients to Health Homes. The Department recognizes the impact this requirement will have on the current operating procedures of hospitals and, as described later in this letter, the Department intends to support hospitals by updating systems, providing guidance, and making itself available to individual hospitals to address specific questions.

The State included language regarding the requirement for Hospitals to refer eligible individuals to Health Homes in the Health Home State Plan Amendment (SPA) for Individuals with Chronic Behavioral and Medical Health Conditions (SPA #NY-13-0018). To further strengthen the expectation of States with regard to hospital referrals, the Centers for Medicare and Medicaid Services (CMS) then required the State to submit the following assurance: “The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be 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.” This new language can be found in SPA #NY-15-0020 at the following link: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/spa15-20.pdf

Compliance

To monitor compliance with hospital Health Home referral requirements, it is possible that CMS may perform a compliance review to determine whether the State is adhering to these requirements. As such, all hospitals must develop and maintain policies and procedures for implementing this protocol. Policies must include methods the hospital has implemented for referring individuals to Health Homes when they seek or receive medical treatment in an emergency room.

Hospitals must submit to the Department a Letter of Attestation (see [Attachment B](#)) signed by the Chief Executive Officer (CEO) confirming development of the required policies and procedures no later than 90 days from the date of this letter via the Department of Health’s Health Home BML using the following link: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action - Subject “Hospital Referral Requirement – Hospital Letters of Attestation”.

The Department may request submission of a hospital’s policies and procedures related to this protocol in the future, at which time the hospital must produce a copy within the time frame requested.

Health Home Program and Eligibility Criteria

Health Homes provide comprehensive care management for New York State Medicaid beneficiaries with two or more chronic conditions, HIV/AIDS, or serious mental illness (SMI). Health Home care managers work with the Health Home's network of providers (behavioral and physical health providers including hospitals), health plans, and community-based providers (i.e., a multi-disciplinary team) to provide comprehensive, person-centered care planning. Health Homes are responsible for comprehensive transitional care, including discharge planning from a hospital.

Hospital staff must use their best judgment and information gathered during the encounter with the Medicaid member to identify and refer individuals who appear to meet eligibility criteria for Health Home enrollment.

To be eligible for the Health Home program, an individual must:

- Be Medicaid eligible/have active Medicaid, and
- Have two or more qualifying chronic conditions, or
- Have one single qualifying condition of HIV/AIDS or serious mental illness (SMI)

In addition, Medicaid members who are enrolled in Health and Recovery Plans (HARP) are also eligible for Health Home services. A HARP is a product line of some Managed Care Plans that serve adults with significant behavioral health needs. ePACES-eMedNY includes information on whether a member is enrolled in a HARP. For additional information regarding Health Home eligibility criteria and qualifying chronic conditions see:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_hh_eligibility_policy.pdf

Effective December 8, 2016 the Health Home program was expanded to begin enrolling children (Medicaid members under 21 years of age). On that date, Health Home eligibility criteria was expanded to include the single qualifying criteria of serious emotional disturbances (SED) and complex trauma. For additional information regarding these qualifying conditions please see:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/index.htm

Determining if a Member is Currently Assigned or Enrolled with a Health Home

To assist hospitals in determining if an individual is Health Home eligible (or enrolled), the Department has developed new restriction exception (RE) codes for Health Home eligibility. The process to release these new RE codes via ePACES-eMedNY is in progress. This information will include Health Home eligibility, the name of the Health Home and the care management agency (if the individual is assigned to, in outreach or enrollment with a Health Home), and the Provider NPI.

Making Health Home Referrals

There is at least one Health Home serving each county of New York State. For a comprehensive list of Health Homes, their service area, and contact for making referrals, please see:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

The attached document, **Attachment A – Hospital Requirements for Making Referrals to Health Homes: Referral Procedures and Determining if a Medicaid Member is Currently**

Eligible or Enrolled in a Health Home provides information and guidance on the process for referring potentially eligible individuals to Health Homes.

Hospital and Health Home Relationships and Delivery System Reform Incentive Payment (DSRIP) Performing Provider System (PPS)

In addition to their natural connectivity to the community through providing services to Medicaid members, including those who may be eligible for or enrolled in a Health Home, hospitals may also be connected to Health Homes because they are a lead Health Home, part of the network of a Health Home, or part of a Delivery System Reform Incentive Payment (DSRIP) Performing Provider System (PPS). Note that based upon these relationships, your hospital may already have procedures in place for making Health Home referrals.

Comprehensive procedures to make Health Home referrals (and to notify Health Homes when a Health Home member presents in the hospital emergency room or is admitted for inpatient care) that are systematically followed by hospitals will become even more vital as DSRIP continues to be implemented across the State. PPS payments through DSRIP are directly based on the achievement of an ambitious set of transformation goals, primarily related to the reduction of potentially avoidable hospital admissions. Health Homes are in the unique position of providing care management services to the high-utilizing, chronically-ill population of Medicaid members who drive more than 50% of those avoidable admissions and likely meet Health Home eligibility criteria.

The following examples of DSRIP projects illustrate how important it is for hospitals to connect to, establish, and implement comprehensive Health Home referral procedures:

- DSRIP Project 2.b.iv, rewards PPS for implementing a care transition intervention model to reduce 30-day re-admissions for chronic health conditions. Since Health Homes provide care management to chronically ill patients, implementing a hospital referral program as part of a transition intervention model will be important to succeeding in the project and being awarded performance payments.
- DSRIP Project 2.c.i, rewards PPS for developing a community based health navigation service to assist patients in accessing healthcare services efficiently. A hospital-to-Health Home referral service would be a natural and significant element of any successful care navigation service, as it will direct eligible patients to the care management services specifically designed for their benefit.

Additional Considerations for Hospitals

In the coming months, the Department will be reviewing State discharge planning regulations at 10 NYCRR Section 405.9 once recent proposed amendments to federal discharge planning regulations have been adopted, and will propose requirements for hospitals to adopt notification and discharge protocols to establish linkages to Health Homes, for Health Home-eligible Medicaid members.

In anticipation of these regulatory amendments, the Department is asking hospitals to consider adopting policies and procedures to notify Health Homes when an enrolled Health Home member enters a hospital emergency department or is admitted into a hospital inpatient bed, including inpatient Psychiatric Units of Article 28 facilities. In addition, the Department is asking hospitals to consider including as part of its discharge planning process, referrals to Health Homes or, for Health Home enrolled members, involvement of the patient's Health Home care manager.

While these practices are not currently mandated by state or federal regulations, they will support the reduction of health care costs, specifically preventable hospital admissions and re-admission and avoidable emergency department visits, and will help to provide timely post discharge follow up care, improving patient outcomes. Timely notification also supports a coordinated effort between hospitals and Health Homes/Health Home Care Management agencies to provide comprehensive transitional care.

Regulation supporting these practices can be found in 10 NYCRR Section 405 as follows:

10 NYCRR Section 405.19(c)(5):

The emergency service, in conjunction with the discharge planning program of the hospital, shall develop and implement written policies and procedures, including written patient criteria and guidelines, for transfer of those patients for whom the hospital does not have the capability to care. Such policies and procedures shall specify the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services, but not in need of inpatient hospital care.

10 NYCRR Section 405.9 (f)(1):

The hospital shall ensure that each patient has a discharge plan which meets the patient's post-hospital needs. No patient who requires continuing health care services in accordance with such patient discharge plan may be discharged until such services are secured or determined by the hospital to be reasonably available to the patient.

Hospitals that have questions regarding the requirements for making Health Home referrals or the notification process may submit questions through the Health Home website at: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action - Subject "Hospital Referral Requirement – Questions".

We thank you for your continued support as we implement this initiative.

Sincerely,



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Office of Health Insurance Programs
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Ruth Leslie, Director
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