ST. JOSEPH'S HEALTH A Member of Trinity Health ST PETER'S HEALTH PARTNERS A Member of Trinity Health	**Effective Date:** April 1, 2024

Category: **B. Outreach and Engagement**

Title: **1. Referrals and Assignments**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Community Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

Contents

PURPOSE

This policy outlines the steps for acceptance of referrals from Community Health Connections Lead Health Home. Further, the policy seeks to establish guidelines surrounding assigning Health Home Candidates and Members to Care Coordinators.

POLICY STATEMENTS

It is the policy of Community Health Connections that potential Members, known as Candidates, will be contacted and outreached or engaged as soon as possible after becoming known to the Health Home and that Health Home Members will be served by a Care Coordinator who can best meet their needs based on the expertise of the Care Management Agency staff.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Community Health Connections Health Home program.

DEFINITIONS

Downstream Community Referrals: Referrals for Health Home Candidates or Members from community providers that are sent directly to the Lead Health Home and then distributed to the Care Management Agencies

Health Home Candidate: An individual who is in active Client Search (Outreach) status, but who has not yet been enrolled in Health Home services

Health Home Member: An individual who is enrolled in Health Home services

Upstream Community Referrals: Referrals for Health Home Candidates or Members from community providers that are sent directly to a Care Management Agency

PROCEDURE

A. Care Management Agency Capacity and Points of Contact

1. At the end of each month, the Lead Health Home will send, via email, an inquiry regarding each CMA's capacity to accept both Downstream Community Referrals for the following month. Each Care Management Agency (CMA) must respond within one (1) to two (2) business days with the number of each that can be accepted the following month.

2. The communication regarding capacity referenced above, as well as any Downstream Community Referrals will be sent electronically to the contact person or persons identified by each CMA. If the contact person or persons who accepts referrals changes, the CMA must notify the Lead Health Home.

B. Downstream Community Referrals

1. Downstream Community Referrals – those sent to the Lead Health Home for distribution to CMAs – will be distributed based on the reported capacity of the CMA (as described in Section A above), counties served by the CMA as well as any identified areas of expertise of the CMA that may align with known Candidate needs. Should the contact person for referrals, counties served or areas of expertise of the CMA change, the Lead Health Home must be notified.

2. Once a referral is sent to a CMA, it is assumed the CMA is accepting the referral for services, unless the Lead Health Home is notified that the CMA is unable to accept the referral. This notification must occur within one (1) business days of receipt of the referral from the Lead Health Home so that the Lead can promptly re-refer the referral to another CMA.

3. Once the referral is accepted, it is the responsibility of the Care Management Agency to enter the Health Home Member or Candidate received via Upstream Community Referral in MAPP via the "Create a Referral" function and open the proper segment (outreach or enrollment).

4. The referral source must be contacted to at least acknowledge receipt of the referral within two (2) business days. When the decision is made and the Member is enrolled or opted out of the Health Home program, the referral source must be notified.

5. As a best practice, outreach with these Health Home Candidates should begin immediately, but must begin within five (5) days business days of receipt of the referral.

6. The approach Outreach Specialists use when outreaching Candidates from a community referral should start with a phone call to the Candidate letting him or her know a referral was received. The discussion with the Candidate should be tailored to the Candidate's diagnoses and risk factors, as indicated in the community referral packet. The first contact with a Candidate received via community referral should not be a letter.

C. Upstream Community Referrals

1. Care Management Agencies may accept referrals from community providers for potentially-eligible Health Home Members, known as Upstream Community

Referrals. Each CMA should establish a protocol for accepting community referrals to ensure they are processed in a timely manner.

2. It is the responsibility of the Care Management Agency to enter the Health Home Member or Candidate received via Upstream Community Referral in MAPP via the "Create a Referral" function and open the proper segment (outreach or enrollment).

3. The referral source for any upstream referrals received must be contacted to at least acknowledge receipt of the referral within two (2) business days. When the decision is made and the Member is enrolled or opted out of the Health Home program, the referral source must be notified.

4. As a best practice, outreach with these Health Home Candidates should begin immediately, but must begin within five (5) days business days of receipt of the referral.

5. The approach Outreach Specialists use when outreaching Candidates from a community referral should start with a phone call to the Candidate letting him or her know a referral was received. The discussion with the Candidate should be tailored to the Candidate's diagnoses and risk factors, as indicated in the community referral packet. The first contact with a Candidate received via community referral should not be a letter.

For more on Health Home eligibility, see Policy B1: Medicaid and Health Home Eligibility
For more on outreach and engagement requirements, see Policy B2: Health Home Engagement and Enrollment

D. Referral Documentation

1. Regardless of the type of the referral (Upstream or Downstream), the physical referral must be uploaded to CareManager in the Documents Tab. If no paper or electronic referral was received, note documentation must indicate how the Candidate came to the attention of the CMA for engagement efforts.

2. Prior to enrolling a Health Home Candidate, Health Home eligibility and appropriateness must be confirmed and documented in the Candidate's electronic health record in CareManager in accordance with the CHC policy and procedures on Medicaid and Health Home Eligibility (See Policy B2. Outreach and Engagement: Medicaid and Health Home Eligibility).

E. Care Coordinator Assignment

1. Care Management Agencies are permitted to assign new Candidates and Members to their own staff as they see fit. As a best practice when assigning Candidates and Members, Care Management Agencies should consider:
    a. The expertise of the Care Coordinator, including but not limited to:
        i. Acuity
        ii. Presence of co-occurring or co-morbid SMI or SUD
        iii. Presence of co-occurring medical conditions
        iv. Patterns of acute service use
    b. The history of the Member with the Care Management Agency
    c. The number of Member's already assigned to Care Coordinator
    d. The language and cultural preferences of the Member and Care Coordinator.

2. While assignment of Candidates and Members to Care Coordinators is left to the discretion of agency leadership, Candidates or Members who are related or in relationships may not be assigned to the same Care Coordinator. Assigning family or those in relationships to the same Care Coordinator creates a potential conflict of interest as the same service is provided simultaneously to two Members and billed for twice. At a minimum, family members or those in a relationship must be served by separate Care Coordinators as a safeguard against potential billing conflicts.

3. When needed, Care Management Agencies should utilize their own internal interpretation services and supports to appropriately and effectively communicate with Members. Should the Care Management Agency not have the resources to provide appropriate language interpretation services, the Lead Health Home must be notified.

4. Members who are on an AOT order, or who qualify for HH+ services, must be assigned to a Care Coordinator who meets the education and experience qualifications and who is supervised by someone who meets the supervision requirements (See Polices F2. AOT; F4. SMI HH+; and F5 HIV HH+ for more on staff qualifications for each special program).

F. Referral and Assignment Restrictions

1. For Care Management Agencies that are also direct service providers, the CMA must ensure that the Care Coordinator providing Health Home services is not the same as the provider who is providing direct care services. Further the Care Coordinator and direct service provider must be under different supervisory structures.

2. Care Coordinators are restricted from assessing a person for whom they have financial interest or other existing relationship that would present a conflict of interest.

REFERENCES

New York State Department of Health (April 2012). April 2012 Medicaid Update Special Edition, Volume 28, Number 4.
(https://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-04_pharmsped_edition.htm)

New York State Department of Health (January 9, 2014). Health Home Provider Manual: Billing Policy and Guidance.
(https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf)

New York State Department of Health (October 5, 2015). Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations.
(https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf)

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Replaces: Care Management Assignment for Health Home Enrollees
Outreach and Engagement: Referrals and Assignments (May 1, 2017)
Outreach and Engagement: Referrals and Assignments (January 15, 2018)
Outreach and Engagement: Referrals and Assignments (January 1, 2020)