<table>
<tr><td> </td><td>Effective Date: December 1, 2023</td></tr>
<tr><td colspan="2">Category: B. Outreach and Engagement</td></tr>
<tr><td colspan="2">Title: 3. Health Home Engagement and Enrollment</td></tr>
<tr><td colspan="2">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)</td></tr>
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PURPOSE

This policy is intended to provide a standard set of expectations and procedures for conducting engagement activities for potential Health Home Members (referred to as Health Home Candidates) that are aligned with the mission of the Health Home program.

POLICY STATEMENTS

Engagement is the cornerstone to successful enrollment in the Health Home program. Without strong engagement efforts at the time a referral is received, Candidates will likely not be enrolled as Members which will have fiscal impacts for agencies and, more importantly, will prevent those most in need of Health Home services from being enrolled. Concerted engagement efforts at the onset will increase the likelihood that Members will remain engaged in Health Home services and realize the benefits and positive outcomes possible through the services. Given the importance of engagement and enrollments, all efforts made prior to enrollment must be tailored toward the Candidate being referred and the information available at the time of referral and engagement. Even though efforts to locate and engage Candidates are no longer billable or have minimum standard set by NYS DOH, this policy intends to establish some timeframes for communication and minimum engagement efforts that should be put forth by agencies. Agencies are strongly encouraged to use creative approaches to locate and engage Candidates.

SCOPE OF AUTHORITY / COMPETENCY

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

DEFINITIONS

Community Referrals: Referrals for Health Home Candidates from community providers; referrals can be made directly to the Care Management Agency (called Upstream Community Referrals) or to the Lead Health Home to be assigned to a Care Management Agency (called Downstream Community Referrals)

DOH 5055**:** Health Home Patient Information Sharing Consent Form; the State produced form for capturing consent for other providers as well as natural supports

DOH 5234: Notice of Determination for Enrollment in the New York State Health Home Program; used when a Member is newly enrolled in the Health Home program; should be reviewed with the Member with the Welcome Letter/Member Bill of Rights

DOH 5236: Notice of Determination for Denial of Enrollment in the New York State Health Home Program; used when a Candidate is found to be ineligible or inappropriate for Health Home services

Engagement Efforts**:** (also referred to as Client Search) a series of meaningful activities to find and engage Candidates in services; activities may include direct communication with potential Members (face-to-face, telephone, mail, electronic communications) as well as communication with the Candidate’s referral source

Enrollment: Occurs once a Candidate's eligibility and appropriateness has been determined and documented

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

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

NYSDOH: New York State Department of Health; the regulating State entity for Health Homes

PROCEDURE

A. Communication Timeframe Requirements

1. Upon receipt of all community referrals, the referral source must be contacted within two (2) business days of receipt to:
   a. inform the referral source that the referral was received, that and engagement efforts are commencing and
   b. obtain any updated or pertinent information about the Candidate that would assist in engaging the Candidate in services.

2. Engagement activities for all Health Home Candidates may begin immediately upon initial receipt of the Candidate's information but must begin within five (5) business days of assignment to the Care Management Agency (CMA) from the Lead Health Home or from receipt of the Community Referral from an outside provider.

3. Once engagement efforts are ceased, the referral source must be contacted again to inform him/her of the outcome of the efforts (i.e., Candidate enrolled or opted out or successful contact never occurred).

B. Engagement Activities and Duration

1. The purpose of Candidate engagement (referred to as Client Search in CareManager), is to locate the Candidate, explore the needs of the Candidate (identified by self as well as in the referral), explain the services available to him or her through Health Homes, answer any questions, determine eligibility and appropriateness for Health Homes and engage the Candidate in active Care Coordination.

2. Efforts made to engage the Candidate must be tailored toward the Candidate's unique needs and circumstances at the time of referral.

a. Efforts to locate and engage the Candidate must align with the Candidate's current location and needs. For example, if a Community Referral form indicates that the Candidate is inpatient at the time, the first efforts should not be to locate the Candidate at home. Rather, engagement efforts should start with the patient bedside when possible.
b. Conversations about the Care Coordination services should be tailored towards how the services can help mitigate or address any risk factors, barriers and diagnoses indicated in the referral form.

3. At a minimum, at least three (3) meaningful engagement efforts with the Candidate must be attempted in each month the Candidate is in Client Search status. Agencies are strongly encouraged to conduct more than three (3) activities as appropriate and to ensure that all avenues for potential engagement and enrollment are exhausted.

4. The only exception to the minimum of three (3) activities referenced above is if the Candidate verbally opts out of the program before three (3) attempts can be completed.

5. All Candidates will be automatically opted out in CareManager after two (2) consecutive months of being in Client Search status without movement to enrollment. This does not mean that agencies need to pursue engagement of Candidates for two (2) consecutive months. Decisions to close Candidate at the end of month one should be made based on the efforts put forth and the outcomes of those efforts. Candidates can be re-referred to the program and re-opened in CareManager at any point should new, actionable information arise after the case is closed.

C. Documentation Requirements during Engagement

1. All engagement activities must be documented in the Candidate's electronic health record in CareManager. Each engagement activity must be documented separately.

2. Community referrals received either directly by the CMA or from the Lead Health Home must be entered into MAPP prior to beginning any engagement activities. (See Policy B1. Outreach and Engagement: Referrals and Assignment)

3. Prior to enrollment, the Intake Assessment in CareManager must be completed with all Candidates who agree to receive Health Home services. The intake should be used to start to determine Candidate eligibility and appropriateness in the Health Home Program (See Policy B2. Outreach and Engagement: Medicaid and Health Home Eligibility). CMA's must use the Community Health Connections Intake Assessment that is built into the electronic health record system, CareManager.

4. At the time of enrollment, the Initial Appropriateness Screening must be completed in CareManager. The most critical or pressing appropriateness criteria must be select from the list. This information is required to ensure only those who are appropriate for services are enrolled in services. Information collected on the Initial Appropriateness Screening will be sent to NYS DOH. Without this information completed in CareManager billing will be rejected by NYS DOH.

D. Enrollment

1. A Candidate is considered enrolled, and thus a Health Home Member, once the following have occurred.
   a. Medical or mental health documentation is received confirming that the Member is eligible for Health Home services based on diagnoses.
   b. The Intake was completed along with the Initial Appropriateness Screening, and the Member has been deemed appropriate for Health Home services based on his or her risk factors.
   c. The Member consented, via the DOH 5055, to being in the Health Home.
   (See Policy B2. Outreach and Engagement: Medicaid and Health Home Eligibility)

2. The DOH 5055 is required for enrollment into the Health Home Program. Without consent, Care Coordinators cannot share protected health information and thus provide care coordination services. If a Candidate refuses to sign the DOH 5055 s/he will not be enrolled in the program and the DOH 5236: *Notice of Determination for Denial of Enrollment in the New York State Health Home Program* must be sent to the Candidate within five (5) business days of the refusal and determination not to enroll.

3. All enrolled Health Home Members must have documentation in writing from a licensed provider or a Managed Care Organization confirming the Member's eligibility (as referenced in D1a above). Medical records and assessment are examples of acceptable forms of documentation.

4. The only exception to D1 - D3 are Members who are court ordered into Health Home services under an Assisted Outpatient Treatment (AOT) order. These Members, served by only pre-approved Care Management Agencies, may be enrolled without signing the DOH 5055 if the Member continually refuses to sign the DOH 5055. An AOT order would also serve as documentation of the Member's eligibility for Health Home services. An intake assessment must be completed with AOT Members. For more information on AOT, please see Policy F2. Special Programs: Health Home Plus and AOT.

5. Once the criteria in D1 are satisfied the CMA may bill the Per Member Per Month rate for full Health Home Care Management using the first day of the month in which the Core Service was provided as the date of service.

6. Once enrolled in the Health Home program, Members must be provided the Welcome Letter and Bill of Rights and a copy of the DOH 5234: *Notice of Determination for Enrollment in the New York State Health Home Program*. The completed DOH 5234 form must be scanned and attached to the Member's record in CareManager. CMA's may use the Community Health Connections Welcome Letter and Bill of Rights (Attachment A) or may develop their own letter. If a CMA chooses to develop their own Welcome Letter, it should contain the following information, at a minimum.
   - contact information for the Health Home and the Care Management Agency,
   - the Medicaid Help Line number,
   - contact information for after hours emergencies,
   - clearly written instructions on how to file a complaint, incident or request a State fair hearing,
   - other appropriate contact information such as NYSDOH, OTDA and the Member's MCO,
   - the Member's rights and responsibilities as a Health Home Member (Member Bill of Rights), and
   - the Member's signature acknowledging receipt of the above information.

7. Annually, based on time of enrollment into the program, the Care Coordinator must review the Bill of Rights referenced above with the Member. The Health Home Member Acknowledgement Form (Attachment B) should be used to document annual events as they occur.

E. Case Closure during Engagement

1. If staff contact a Candidate and he or she clearly states that Health Home services are not wanted, the Candidate's record in CareManager must be closed by writing a Client Search Note and selecting the 'Client Opts-out of Health Home Services' option. The content of the note should detail the reasons cited by the Candidate for opting out.

2. If a Candidate is interested in Health Home services but is not enrolled in the Health Home program due to ineligibility or inappropriateness, the DOH 5236: *Notice of Determination for Denial of Enrollment in the New York State Health Home Program* must be sent to the Candidate, indicating the reason for the denial. This form must be sent to the Candidate within five (5) business days of the decision not to enroll. The completed form must be scanned and uploaded to the Member's record in

CareManager. This form does not need to be signed by Candidates unless they are challenging the decision regarding the decision not to enroll.

REFERENCES

New York State Department of Health (July 1, 2020) Elimination of Health Home Billing for Outreach. (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/outreach_elimination_guidance.pdf)

New York State Department of Health (November 10, 2017). Health Home Notices of Determination and Fair Health Policy. (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh0004_fair_hearing_nod_policy.pdf)

New York State Department of Health (September 23, 2014). Eligibility Requirements: Identifying Potential Members for Health Home Services. (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_hh_eligibility_policy.pdf)

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)

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Replaces: Outreach and Engagement Policy and Procedure
Outreach and Engagement: Health Home Outreach and Enrollment (May 1, 2017)
Outreach and Engagement: Health Home Outreach and Enrollment (January 15, 2018)
Outreach and Engagement: Health Home Outreach and Enrollment (March 1, 2019)
Outreach and Engagement: Health Home Outreach and Enrollment (July 1, 2020)
Outreach and Engagement: Health Home Outreach and Enrollment (May 22, 2022)

ATTACHMENT A: Member Bill of Rights

Welcome to Community Health Connections!

Community Health Connections (CHC) services are voluntary and use your Medicaid benefits, so there is no cost to you. As a member of CHC, you and your family or caregivers, will have a single contact for your medical and community service needs. This could include behavioral health service, substance abuse services and housing support, etc.

Your Care Coordinator is: ____
Your Care Management Agency is: ____
You can reach your Care Coordinator at: ____

We hope you are happy with your services through CHC. If you have any concerns or questions about CHC you can call 518-271-3301 or 1-855-358-4482. Our office hours are Monday through Friday from 8:00am to 4:00pm.

<u>MEMBER RIGHTS AND RESPONSIBILITIES: Your Rights</u>

As a CHC Member, you have rights. Your rights are written out below.

- The right to receive language translation services or hearing or vision assistance.
- The right to have services delivered with respect and dignity and in way that is free from discrimination.
- The right to confidentiality and privacy of your health information as required by State and Federal law.
- The right to provide input in your Plan of Care which is created by you and your Care Coordinator to help you manage your needs.
- The right to receive a copy of the Plan of Care.
- The right to have your Plan of Care shared with others at your request.
- The right to take an active role in your health care treatment options with your doctor, including the right to select providers.
- The right to receive help from your Care Coordinator in accessing your records from other providers.
- The right to be notified when CHC or other services are changed or ended and why.
- The right to have others involved in your care.
- The right to allow another person to act on your behalf.
- The right to know who your Care Coordinator is and how to contact that person.
- The right to access Care Coordination services anytime by calling: ___________________.

MEMBER RIGHTS AND RESPONSIBILITIES: Your Responsibilities

As a CHC Member, you have responsibilities. Your responsibilities are written out below.

- Return phone calls or other messages from the Care Coordinator.
- Participate in a safe and professional relationship with your Care Coordinator.
- Support a safe and trusting atmosphere when meeting with your Care Coordinator.
- Be involved in the Plan of Care development.
- Tell your Care Coordinator if you decide to stop consent to share confidential information with other specific providers or people.
- Tell your Care Coordinator if you decide to stop participating in Health Home services.
- Tell the right people if you are dissatisfied with your services. This could be your Care Coordinator, the Health Home, your Managed Care Organization (MCO), or the Department of Health.

COMPLAINTS

If you are unhappy with any services, we want to know about it and fix it. Many of your concerns can be addressed with your Care Coordinator directly, either in person or over the phone. If you are not comfortable talking to your Care Coordinator about it, or your Care Coordinator does not solve the problem, please follow the steps below to file a complaint. You can always ask someone you trust to help you file the complaint or file it for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

To file by phone, call us at: ____.

If you want to speak to someone in person, please call to let us know you want to file a complaint in person.

What Happens Next:

When we get your complaint, we will work with you to fix the issue right away over the phone or in person. If we cannot find a solution right away, we will work to have one within 10 business days of when you told us about your concern.

If we are not able to come to a solution that works for everyone involved within ten days, we will send your complaint to the Lead Health Home, Community Health Connections.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters your case will be reviewed by one or more qualified health care professionals.

Community Health Connections will work with your and the Care Management Agency to come up with a solution as soon as possible, but within 10 business days.

If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

FAIR HEARINGS

In some cases you may ask for a Fair Hearing from New York State if you are not satisfied with a decision your local Department of Social Services (DSS) or the State Department of Health, or CHC has made.

How to Request a Fair Hearing:

1) Telephone: Call the state wide toll free number at 1-800-342-3334; OR
2) Fax: Fax the state at 518-473-6735; OR
3) On-Line: Complete and send the online request form at: http://otda.ny.gov/programs/applications/; OR
4) Letter: Fair Hearing Section
New York State Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, New York 12201.

IMPORTANT NUMBERS

Some other important numbers for you to know are listed below.

Your Care Coordinator: ____	
Your Care Management Agency: ____________________________________	
Community Health Connections, Your Health Home	518-271-3301
Your Managed Care Organization (MCO): ____________________________	
New York State Medicaid Helpline	800-541-2831
New York State Department of Health (Main Number)	518-402-0836
New York State Office of Temporary Disability Assistance (OTDA)	800-342-3334

We look forward to serving you!

MEMBER RIGHTS AND RESPONSIBILITIES: Acknowledgement

Signed copy should remain in the Member's file at CHC.

I have read the Community Health Connections Member Rights and Responsibilities, or it has been read to me. I understand the rights and responsibilities and I was given a chance to ask questions about anything that I did not understand.

____ ___________

Member Printed Name **Date**

____

Member Signature

____ ___________

Authorized Representative Printed Name (if applicable) **Date**

____

Authorized Representative Signature

____ ___________

Care Coordinator Printed Name **Date**

____

Care Coordinator Signature

ATTACHMENT B: Health Home Member Acknowledgement Form

Complete this form each time one of the four activities listed below is completed.
More than one activity may be checked if more than one activity was completed during the visit.

Member Name: ____

Date of Acknowledgement: ____

The following annual activities were completed with the Member:
(Note each of these activities must be completed at least once annually)

☐ Health Home Consent Form Reviewed for Accuracy (DOH 5055)
☐ Health Home Member Bill of Rights Reviewed
☐ Comprehensive Assessment Annual Update Completed
☐ SDOH Screening Tool Annual Update Completed

☐ Plan of Care – I actively participated in the creation of my individual Plan of Care and agree with the Plan.

____ ____________________
Member Signature Date

____ ____________________
Care Coordinator Signature Date