Medicaid Redesign Team (MRT) Pilot Scattered-Site Housing Program

Toolkit and Lessons Learned
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Project Renewal
Services for the Underserved
Supportive Housing Network of New York

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INTRODUCTION

The Bronx Health and Housing Consortium (“the Consortium”) is a collaborative network of providers in the Bronx with the shared goal of streamlining client access to health care and quality housing. The Consortium has over 40 formal member organizations from across health care, housing, social service, and managed care as well as the partnership of City and State government agencies. Consortium members agree upon the premise that shared understanding among housing and health care providers is necessary to support high cost/high need clients who require intensive, coordinated services to achieve improved health outcomes. Yet these resources are costly and scarce.

The recent implementation of health reform and the establishment of the Health Home Program to focus on high cost Medicaid populations puts into stark relief that the homeless and precariously housed populations are a significant driver of inappropriate health care utilization and high Medicaid costs. The New York State Department of Health (NYSDOH) Medicaid Redesign Team (MRT) recognized this need for housing and launched the Supportive Housing Health Home Pilot Project. The new MRT Pilot Project provides rental subsidies for scattered-site supportive housing units available to Health Home members—Medicaid recipients with high Medicaid spending and chronic conditions. This differs from other MRT housing programs, which require specific diagnoses (behavioral health and/or substance use disorder) and the 2010E application process through HRA. The NYSDOH has also allowed people who have both Medicaid and Medicare to be eligible for MRT housing, even though financial savings primarily will be realized by the Medicare program, since Medicare is the primary payer. The application process is managed directly by the State-contracted housing providers.

A committee of the Bronx Health & Housing Consortium comprised of housing, health, research, and managed care representatives met during 2015 to discuss the targeting of these scarce MRT Pilot Program housing units to people most in need with the greatest potential for reduced avoidable hospital utilization. This document is intended to serve as a toolkit for organizations with similar housing programs and for those seeking to make referrals into this program.
WHY TARGET?

The reasons to consider targeting these units carefully are:

- There are very few units available in the Bronx—fewer than 40 (20 BronxWorks and <20 Fortune Society)

- This Pilot Program requires only Health Home membership/eligibility, which is based on high Medicaid utilization rather than the usual NY/NY Supportive Housing requirement of significant behavioral health and/or substance abuse diagnoses. These flexible requirements create supportive housing for people with health issues who need housing and do not meet current supportive housing criteria. Thus, we agreed to focus on people who do not meet the criteria for other existing supportive housing programs.

- We believe that the State Medicaid program will consider further funding if this Pilot successfully shows financial savings and improved health outcomes. NYSDOH has indicated that reducing avoidable Emergency Department (ED) and inpatient stays as well as improving quality of life and health through increased engagement with outpatient primary care and specialty doctors will be considered as measures of success. But without financial savings, these housing units will be difficult to fund. Assuming that supportive housing costs an average of $25,000/year in NYC, the average savings needs to be higher. Therefore, it is critical to prioritize these units for the highest utilizers who, when stably housed and connected to care, have the potential for the greatest reduction in avoidable hospital utilization and costs.

- Although this is a small program, our collaboration and experience will be important to any program expansion or similar program development. With demand for housing far outpacing the availability, it is imperative that we are strategic and intentional in placing people into the most appropriate housing for their needs.
WHOM TO TARGET?

The Committee agreed that these units should be targeted for:

1. **People for whom housing will likely and primarily result in lower Medicaid costs.**

   Ideal candidates have annual, potentially avoidable Medicaid expenses of over $60,000, are homeless or unstably housed, have no other source of housing support, and are able to live relatively independently in scattered-site housing — can manage Activities of Daily Living (ADLs) independently or with limited support, have ability to pay bills or make arrangements to pay bills, etc.

2. **People for whom housing will likely and primarily result in a measurably higher quality of life and improvement in health outcomes, but whose Medicaid costs may not decrease.**

   While cost savings and reduction of avoidable hospital utilization is an important goal, it is necessary to recognize that for some homeless people who have serious illnesses, getting housed and better connected to care can help improve their health and quality of life but may not account for significant cost savings. In fact, some treatments like transplants and cancer treatments require the patient to have stable housing. In these cases, obtaining permanent housing will enable them to receive the medical treatments that would dramatically improve their health but could potentially increase their health care costs. Consistent with the goals of Health Homes and DSRIP to improve health outcomes, this Committee believes that these people should also be prioritized for available MRT supportive housing, even if stable housing and being better connected to care does not reduce their health care costs.

We assume that a balance in favor of reducing costs overall is important to the future funding of the program. Because these units are scattered-site, in both cases, an appropriate level of functionality is needed in order for the MRT housing recipients to be successful.
HOW TO TARGET?

The targeting process begins when the referring agency, such as a Health Home, Managed Care Organization (MCO), hospital, housing provider, community based organization (CBO), or other potential referral source identifies someone who is enrolled in or eligible for a Health Home, who requires housing, is not eligible for existing housing programs, and whom they have identified as a high utilizer. The referral source then contacts the MRT housing provider to discuss the referral process, as each MRT housing provider’s process is different. MRT Pilot supportive housing providers should develop a referral system for their housing, including clear requirements for eligibility and designated application forms.

How to target people for whom housing will likely reduce Medicaid costs

As mentioned previously, ideal candidates for MRT pilot housing units are enrolled in a Health Home, have potentially avoidable Medicaid expenses of over $60,000 annually, are homeless or unstably housed, have no other source of housing placement, and are able to live relatively independently in scattered-site housing. In general, the steps for a referring agency are as follows:

1. **Enroll Client in a Health Home**

   MRT pilot housing units are specifically for members of Health Homes. If the person is not yet enrolled in a Health Home and the referring agency is not a Health Home, they will have to submit a bottom-up referral to whichever Health Home is most appropriate for the client. This is usually based on where they are currently receiving care but clients have the right to enroll in whichever Health Home they choose. Although Health Home enrollment is completely voluntary, in order to qualify for MRT housing, the person must be enrolled in a Health Home.

   Different Health Homes have different forms and processes for accepting bottom-up referrals. A sample form is found in Attachment D. In some cases, the MRT housing provider may also provide care management services through one or more health home and may require that anyone living in their housing units receive care management through their agency. This could affect which health home the client is able to join in order to be eligible for the MRT pilot housing unit. If someone is already in one Health Home and needs
or wants to switch to another in order to qualify for this housing, the Bronx Health Homes have agreed to use a process found in Attachment E.

2. **Determine Need for Housing**

   Because these MRT pilot housing units are so scarce, it is critically important to target them for people who are homeless or unstably housed and for whom housing insecurity is a primary reason for their frequent hospital utilization and/or a primary barrier to getting well. Health Homes can determine housing status using members’ responses to the question “Are you homeless?” on the FACT-GP questionnaire, which is required by NYSDOH to be completed for every enrolled Health Home member. This is based on client self-report so additional documentation of housing status and history may be required. Hospital staff often can identify people who are homeless and visit the ED and inpatient units often. MCOs receive information from the NYC Department of Homeless Services (DHS) about which members are homeless, defined as having recent experience in the DHS shelter system. All MRT housing providers have access to the DHS database CARES, so as long as the referring agency has a State-sanctioned agreement to share data with the MRT housing provider, the housing provider can look up the client in CARES to determine any history in the DHS shelter system.

3. **Obtain Medicaid Utilization and Costs**

   There are several sources to obtain Medicaid utilization information and how the referring agency obtains this data depends upon the sources to which they have access. When calculating avoidable Medicaid expenses, spending such as the cost of ongoing medications is not included because these expenses will likely continue when a person is stably housed. The focus should be on **avoidable** utilization. The following are some possible sources of Medicaid utilization data.

   The Medicaid Data Warehouse is the best source of Medicaid expenditures, because they collect all payment data. The referral agency will need to complete and submit two forms, the HIPAA compliant Authorization to Release Protected Medicaid Member Information to a Third Party (Attachment A) and accompanying cover letter (Attachment B). Instructions for completion of these forms are included in the attachments. Due to a lag in
billing, the initial Medicaid Spending Report will typically not include the most recent 3 months of claims. The referring agency needs to take this into account.

Managed Care Organizations also have Medicaid data for their plan members but only for claims made through their plan and for the time period that the person was a member enrolled in their plan. If the referral agency is an MCO, they may use their own data to identify high Medicaid utilizers who are homeless and whose annual potentially avoidable Medicaid expenditures are over $60,000. If the referring agency is a Health Home, they may be able to get utilization information from the client’s MCO as long as the Health Home is contracted to share data with that MCO.

The Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES) is a HIPAA-compliant, web-based portfolio with data on the NYS Medicaid population. PSYCKES gets data from the NYS Medicaid claims database for consumers who receive behavioral health services or psychotropic medication paid for by Medicaid, and provides health records, such as a history of illnesses or injuries, outpatient services, hospital services, medications, and more. Access to Medicaid data in PSYCKES requires registration through an on-line Security Management System and an OMH-issued security token.

Hospitals and other potential referral sources can also identify high Medicaid utilizers who are unstably housed. Hospitals have access to their own medical records for any patient who ever received care at that hospital. The limitation here is that the hospital will not have any records for care a person received from a different hospital.

The Bronx Regional Health Information Organization (RHIO) is another source of utilization information across several hospital systems. One limitation is that the RHIO only has records for participating hospitals so if the person received care from a hospital that is not a member of the RHIO, that utilization will not be available. In order to access data in the RHIO, the referring agency must be a participating member of the RHIO and the patient must sign a specific consent form to allow their data to be shared.
4. **Submit Forms and Utilization Data to MRT Housing Provider**

When the utilization information is obtained, these forms and the referral form used by the MRT provider are sent by the referring agency (Health Home, MCO, CBO, etc.) to the MRT housing provider as part of the application process. The MRT referral form typically includes elements such as name, housing status, diagnoses, psychosocial evaluation, income, and frequency and nature of ED visits and/or inpatient hospitalization in the last 12 months. A sample referral form used by BronxWorks is provided in Attachment C.

5. **Client Interview**

When applicants meet the initial eligibility criteria, an interview is held to determine whether they are suitable for the housing. The timing of the interview is often related to the availability of units. We have found it best to interview a potential client close to the time they could actually move into a unit, rather than interviewing, accepting, and waiting months while so many circumstances could change.

MRT housing providers use a variety of interview forms to interview potential clients. The interview is designed to determine the client’s needs and how well they can succeed in this housing. For instance, a client with mobility issues may not be suitable for a 4th floor apartment in a walk-up building. Questions may include questions about employment history, benefits and medical and behavioral health.

Note—Some MRT housing providers work with specific Health Homes. Once someone is accepted into the MRT housing program, there may be a need to reattribute the client to the Health Home that the housing provider works with in order to streamline care management.

6. **Consent and Lease Forms**

Once someone is accepted into the program, consent and lease forms may be required.
How to target people for whom housing will primarily increase quality of life and improve health outcomes, but whose Medicaid costs may not decrease

The application process described above is also available to people whose unstably housed situation has a serious, detrimental effect on their health: the “medically homeless”. Examples include people who need housing in order to meet organ transplant or Hepatitis C treatment requirements or people whose illness limits their ability to seek housing and for whom moving between the street, various couches, and shelters negatively impacts their health. For these people, stable, permanent housing is necessary for them to receive the medical care they need but receiving that care may increase rather than decrease their health care costs. In these cases, the referral process will be the same as detailed above but the MRT provider will put greater consideration into the person’s need for housing over their avoidable Medicaid utilization. In order to generate overall cost savings, this group will need to be balanced by savings from those with more avoidable utilization.

The MRT Pilot may also be used creatively to help people avoid homelessness by preventing evictions and keeping them in their apartments, as imminent homelessness would be detrimental to their health. The program can also be used as a preventive measure to house people leaving the justice system who meet the program criteria.
HOW TO EVALUATE SUCCESS OVER TIME?

NYSDOH has issued an RFP for a formal evaluation. We are also interested in using our own data to better understand the effect of this targeting.

1. **Reduced avoidable hospital utilization**: Measuring and comparing Medicaid (and Medicare where relevant) costs over time for this group and a control group is the best way to determine whether and how much savings was generated. However, we do not have the capacity to perform this type of analysis. Instead, we will perform a ‘before and after’ analysis of Medicaid expenditures, especially for ED visits, admissions, and lengths of stay, using the move-in date as the point of reference. It is our suggestion that MRT Programs request the Medicaid Spending Report 3 months after the individual is placed into permanent housing and quantify the Medicaid spending 12 months prior to placement.

   We assume that for high utilizers, changing the pattern of care is not immediate and that outpatient care may increase appropriately. For example, anecdotally, we know that people with high substance use histories who are actively using do not quickly change this pattern. However, they may be more likely to address other medical problems once stably housed.

2. **Reduced health care costs**: The Medicaid data can be used to assess overall cost differences before and after housing.

3. **Increased engagement in preventable and outpatient care**: We will also note increased engagement with outpatient primary and specialized care providers over time.

4. **Improved health outcomes and quality of life**: We are using instruments such as the Quality of Life Assessment, General Anxiety Disorder GAD-7, and PHQ-9 to determine whether and how participants are noting changes to their health and lives. A special challenge for us is measuring success for those whose health is deteriorating. Although stable supportive housing is providing an opportunity for healthier living, their underlying medical condition, such as End Stage Renal Disease, cancer, or sickle cell disease may be deteriorating and resulting in major illness or even death. In these cases, we need to focus on quality of life and palliative measures. We need to find a means review the characteristics of those who succeed in this program as well as those who do not succeed in order to improve it.
WHAT CHALLENGES DO THESE PROGRAMS FACE?

The MRT Supportive Housing Pilot Program has been in operation for over a year and the following are some of the challenges that have come up so far.

Identifying Suitable Units

As this is a scattered-site program, supportive housing providers need to identify units in the community in order to create a timely process from application to interview to move-in. Although there is no subsidized rate or maximum rent at the moment, units cannot rent for much more than $1,000 or so to meet the budget. Given the rental climate in New York City, this has proven to be challenging. These units need to be easily accessible for those with mobility impairment (ground floor apartments or elevator buildings are preferable) and contain private space and clean cooking and bathroom facilities. These units must be managed by landlords who are willing to make timely repairs, open to working with social service teams, and generally attentive to clients' needs for clean and safe housing.

The MRT staff is also often required to provide ongoing support to clients to sustain the units. MRT providers may need to be involved as the continual liaison between the client and management company to advocate for repairs. One way of being successful is to follow up with the management companies monthly to confirm rent was received and accounted for. Some clients require setting up direct payment systems. For example, people who receive SSI/SSD may have their rent withdrawn automatically from banks.

The difficulty in finding affordable and appropriate units needs to be discussed with NYSDOH if the program is expanded. We need to continue to lobby for more units, including congregate site units for people who need a higher level of support, like daily medication management and access to 24 hour security onsite. Several people have been rejected from this program because they need the more intensive support of congregate housing. Without the behavioral or substance abuse diagnoses required for most supportive housing, they remain homeless. There is also a need to expand what can be funded through the MRT programs. People who obtain MRT housing often also require basic apartment supplies (furniture, cooking and cleaning supplies, bathroom accessories) that are not provided within the MRT program.

Need for Staff Training
Early feedback from MRT supportive housing providers indicates the need for more staff training because this population is sicker than the usual supportive housing cohort and also has other serious conditions. Specialized training about diseases such as Hepatitis C and sickle cell as well as palliative care will help care managers to better support their clients.

**Medicaid Recertification and Managed Care**

We recognize that unstably housed high Medicaid utilizers often fail to recertify their Medicaid status and fall in and out of coverage. To address this need, hospitals, MCOs, supportive housing providers, shelters and others need to be mindful of their clients’ recertification dates and work with them to recertify successfully. This population also changes its MCOs so we need to rely upon Medicaid as the best source of health expenditures. The Medicaid Spending Report is most important and reliable means of obtaining this information.

**Accessing Housing History Information**

Hospitals and MCOs need access to the CARES database in order to check whether someone has been in the shelter system and whether they are eligible for NY/NY supportive housing. This knowledge helps select people with no other housing option and provide appropriate support.

**Working with Other Stakeholders**

Since the hospitals/rehab are the best place to engage people for housing, the MCOs may need to authorize slightly longer stays in order to allow hospital staff and/or MCO staff to work on housing placement. This requires better coordination among MCOs, hospitals/rehab staff, Health Homes, housing providers, city agencies, shelters, etc. Often these agencies need to work together to supply all information needed to assist with the psycho-social evaluations, and other information necessary to obtain housing and benefits needed to maintain housing. Communication flows between the MCO, Health Homes and Housing Providers require multiple consents that are a barrier to housing people quickly. The Blue Cross/Blue Shield Health Plus program used a conference call among the member, Health Home care manager and Housing agency to expedite consent and this is a good example to follow.
Attachments

Attachment A: Instructions for Completing Attachments B and C

Attachment B: Authorization to Release Protected Medicaid Member Information to a Third Party

Attachment C: Medicaid Spending Cover Letter

Attachment D: Sample MRT Housing Referral Form

Attachment E: Sample Bottom-up Referral Tool

Attachment F: Consortium Guidelines for Clients Enrolled in another Bronx-Based Health Home
Instructions for Completing Attachments B and C

Attachment B: Authorization to Release Protected Medicaid Member Information to a Third Party

This Authorization form is required by the NYSDOH to request a Medicaid Spending Report from the Medicaid Data Warehouse.

- On the Authorization form, the client's information goes on top.
- **Persons/organizations authorized to receive or use the information:** Your name/Organization and Organization's address
- **Purpose/use of information:** to determine eligibility for MRT scattered site housing
- “Will anyone be financially compensated for the info?”: make sure to check “no”.
- Please have the client sign and date the bottom of the form.
- Once the report is received from the NYSDOH Medicaid Data Warehouse, the referring agency should send it directly to the MRT housing provider along with all other application forms.

Attachment C: Cover Letter for Medicaid Spending Report

On the cover letter, fill in date and client's information. You must indicate the dates of service requested in the report or they will send it back. Please note that it is preferable to request 1 year of spending that ends 3 months prior to the report date, to capture a lag in billing. For example, if you want the spending for the calendar year 2015, send the request at the end of March 2016 so all the December 2015 billing is included. Your signature/contact goes at the bottom.
ATTACHMENT B

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

AUTHORIZATION TO RELEASE PROTECTED MEDICAID MEMBER INFORMATION TO A THIRD PARTY

Medicaid Member Name (required): ____________________________________________

Date of Birth (required): _______ / _______ / ________

At least one of the following identification numbers is required, preferably both.

Client Identification Number (CIN): ____________________ Social Security Number (SSN): _______ - _______ - ________

By signing this form, I understand that I am allowing the New York State Department of Health to use or disclose all of
my payment information as indicated below. This may include data on certain conditions such as HIV/AIDS, Mental
Health and Alcohol and Substance Abuse.

Persons/organizations authorized to receive or use the information:

Name: ________________________________________________________________

Address: ______________________________________________________________

City: _____________________________ State: _______ Zip: ______________

Phone Number: (_____) __________ - ________

1. Purpose of the use/disclosure: __________________________________________

2. Will the person/program requesting the authorization receive financial or in-kind compensation in exchange for using
or disclosing the health information described above?  Yes ______ No ______

3. I understand that my health care and the payments for my health care will not be affected if I do not sign this form
except in some situations when information is needed for the health plan’s eligibility or enrollment determinations
relating to the individual.

4. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and
that I may get a copy of this form after I sign it.

5. I may revoke this authorization at any time by notifying the Department of Health in writing at the address below, but,
if I do, it will not have any effect on actions that the Department took before they received the revocation. If not
previously revoked, this authorization will expire upon completion of this request or one year from the date this form
is signed, whichever comes first.

6. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the
information is not a health plan, health care provider or clearinghouse, the released information may no longer be
protected by federal privacy regulations, and therefore the recipient of the confidential data may re-disclose the
confidential data.

_____________________________ __________________________
Signature of Medicaid Member or Agent Date

If not member, name of person signing for member Authority to sign on behalf of member

Please return to: Medicaid Data Warehouse - CDRs
NYSDOH – MISCNY
ESP  P1-11 S  Dock J
Albany NY 12237
To Whom It May Concern,

We are requesting the Medicaid claims data for the following Medicaid member in order to determine eligibility for our MRT Scattered Site Housing program:

Name:
CIN:
SSN:
Dates of service the report will cover:

Please send the claim detail with a total, not by invoice type.

We are funded through the Department of Health Medicaid Redesign Team to house individuals who are high utilizers of the Medicaid system, are currently unstably housed, and who have chronic medical conditions. Access to the Medicaid claims data will also provide us with the necessary data to measure program outcomes in terms of reduced utilization and improved health outcomes.

If you have any questions please contact us at the information below.

Thank you,

REFERRAL SOURCE NAME
AND CONTACT INFO
Stable Homes to Health Program
Referral Form

Date: ___________
Clients Name: ___________________________ Current Address: ___________________________
Client Phone: ___________________________ ___________________________

Referral Source
Name: ___________________________ Email: ___________________________
Phone: ___________________________ Capacity of Relationship: ___________________________

Known Medical Conditions:
__________________________________________________________________________________________
__________________________________________________________________________________________

In the past 12 months:
Emergency Department visits: __________ Inpatients Stays: __________
Known Medicaid Spending: __________

Factors Contributing to High Utilization: (i.e. Homelessness, specific medical conditions, barriers to treatment, access to transportation)
__________________________________________________________________________________________
__________________________________________________________________________________________

Active Medicaid? Yes/No _______ Currently enrolled in a Health Home? Yes/No _______
If yes, contact person and phone: ___________________________

Please give a brief synopsis of why you believe this individual to be most appropriate for MRT Housing:
__________________________________________________________________________________________
__________________________________________________________________________________________

Is this person eligible for other housing? (Y/N) _______

Attachments

Exhausted Housing Resources

NY/NY III- Category A _______
Category E _______
Category F _______

HASA _______
NYCHA _______
HPD _______

All referrals can be sent to Keona Serrano at: kserrano@bronxworks.org or via fax to (646) 731-3438
Targeted Population for Stable Homes to Health Scattered Site

_______ Health Home Enrolled/Eligible

_______ Heavy Medicaid user- $80k+ in medical claims in the past 12 months

_______ Active Medicaid

_______ Chronic medical conditions (i.e. diabetes, respiratory diseases, heart disease, high blood pressure)

_______ Currently unstably housed or homeless, with no other housing options/availability

_______ Stable income (i.e. SSI/SSD, VA benefits)

_______ Individuals willing to have weekly face to face/phone contact

_______ Ability to live independently (cook, clean, grocery shop) with supports in place
### Health Home Bottom-Up Referral Screening Tool

**Referral Type:**
- [ ] Incarcerated
- [ ] Parole
- [ ] Inpatient
- [ ] Clinic
- [ ] CBO
- [ ] Other: ____________________

**Client Name:** ________________________________________

**DOB:** ___________  **State:** ________  **Zip Code:** ________

**Address:** ________________________________________

**City:** _______________  **State:** ________

**Tel:** ________________  **Cell:** ________________

**Alternate Tel** (Identify specifically):

**Medicaid ID:** __________________

**Primary Language:** __________  **Can you read and write in English?**  Yes [ ]  No [ ]  **If no, what language:** ____________________

**Managed Care Plan** (if applicable):
- [ ] Fee for Service
- [ ] Affinity
- [ ] Amidacare
- [ ] Emblem (HIP)
- [ ] Fidelis (NYS Catholic)
- [ ] Healthfirst
- [ ] Healthplus/Amerigroup
- [ ] MetroPlus
- [ ] United
- [ ] VNS Choice
- [ ] WellCare
- [ ] Other: ____________________

### STEP 1: ASSESS ELIGIBILITY

**Do you have any of the following chronic conditions?** (check all that apply)

- [ ] HAVE
- [ ] AT-RISK
  - [ ] Mental health condition: ____________________ (if known)
  - [ ] Substance abuse disorder: ____________________ (if known)
  - [ ] Asthma
  - [ ] Diabetes
  - [ ] Heart disease
  - [ ] Being overweight (BMI over 25)
  - [ ] HIV/AIDS
  - [ ] Hypertension
  - [ ] Other: ____________________

**Do you have a severe and persistent mental illness (SPMI)?**  Yes [ ]  No [ ]

### STEP 2: ASSESS APPROPRIATENESS FOR HEALTH HOME

- [ ] Probable risk for adverse event, e.g. death, disability, inpatient or nursing home admission;
- [ ] Lack of or inadequate social/family/housing support;
- [ ] Lack of or inadequate connectivity with healthcare system;
- [ ] Non-adherence to treatments or medication(s) or difficulty managing medications;
- [ ] Recent release from incarceration or psychiatric hospitalization;
- [ ] Deficits in activities of daily living such as dressing, eating, etc.;
- [ ] Learning or cognitive issues.

**How many times have you been to the ER or Hospitalized in the last year?**
- [ ] ER: _______
- [ ] Hospitalized: _______

**For what?** ____________________  **Where?** ____________________

### STEP 3: ELIGIBLE FOR HEALTH HOME SERVICES

1. [ ] Active Medicaid
2. [ ] Clinically Eligible (Step 1)
   - [ ] Two or more chronic conditions
   - [ ] HIV/AIDS
   - [ ] One serious mental illness
3. [ ] Appropriate for Health Home (Step 2)
4. [ ] If in managed care, a member of a Bronx Health Home participating plan (Affinity, Amidacare, Emblem, Fidelis, Healthfirst, HealthPlus Amerigroup, Metroplus, United, VNS Choice, and WellCare)

If the person meets the above eligibility criteria, fax the Bottom-up Referral Form to 718-514-7461 Bronx Lebanon Health Home

**Agency:** ____________________  **Worker:** ____________________  **Signature:** ____________________  **Date:**

*Updated May 2014*
HEALTH HOME GUIDELINES
CLIENTS ENROLLED IN ANOTHER BRONX-BASED HEALTH HOME

In some cases, an individual may enroll in more than one Health Home or be assigned to one Health Home, but enroll with another Health Home. To prevent the enrollment of members in multiple programs, Health Homes should check all bottom-up/community referrals in the Health Commerce Systems MAPP Health Home Tracking System, before submitting the record to DOH. If a Health Home attempts to enroll a client and discovers that they are already enrolled in or assigned to another Health Home, the following steps should be followed to determine where the client will ultimately be enrolled.

1. Notify the point person at the other health home to confirm the assignment or enrollment. The Health Home contacts are as follows:

<table>
<thead>
<tr>
<th>Bronx Accountable Healthcare Network (BAHN)</th>
<th>Jackie Santiago Montefiore Medical Center</th>
<th>914-378-6171</th>
<th><a href="mailto:jacsanti@montefiore.org">jacsanti@montefiore.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronx Health Home (BHH)</td>
<td>Isaac Dapkins, MD Bronx-Lebanon Hospital Center</td>
<td>718-960-2048</td>
<td><a href="mailto:idapkins@bronxleb.org">idapkins@bronxleb.org</a></td>
</tr>
<tr>
<td>NYC Health + Hospitals</td>
<td>Vijaya Dasary NYC Health + Hospitals</td>
<td>212-323-2501</td>
<td><a href="mailto:Vijaya.dasary@nychhc.org">Vijaya.dasary@nychhc.org</a></td>
</tr>
<tr>
<td>Community Care Management Partners (CCMP)</td>
<td>Phil Opatz CCMP</td>
<td>212-290-6467</td>
<td><a href="mailto:phil.opatz@ccmhealthhome.org">phil.opatz@ccmhealthhome.org</a></td>
</tr>
</tbody>
</table>

2. Ask client if they are aware of being enrolled in another Health Home and attempt to ascertain their engagement with that Health Home.

3. Ask if the client has a particular preference for one of the two Health Homes. If client has expressed a preference for one Health Home, that information should also be discussed and agreed with the client. **The overriding principle is that the client’s preference is the deciding factor and client enrollment is strictly voluntary.**

4. If the client has no preference, factors to consider when reviewing which Health Home is most appropriate to provide care coordination include, in order of priority:
   a. TCM/MATS/COBRA/CIDP program involvement
   b. CMA (e.g. housing, social services, etc.)
   c. Health provider linked to another Health Home (e.g. primary care provider, behavioral health provider, substance abuse program involvement, etc.)
   d. Managed Care Organization linked to another Health Home
   e. Geography/access
5. When necessary, Health Home contacts can facilitate a conversation between the programs or providers in their respective networks who are engaged with the client to discuss the case further.

6. If both Health Homes feel that they are equally involved in care coordination with the client, then a case conference is recommended with representation from each of the Health Homes, CMAs, the client, and the client’s advocate, if available, to review the services and permit the client to determine their preference.

7. If client is moving from one Health Home to another, the first Health Home (Health Home 1) should dis-enroll the client through NYS DOH process, thus permitting the other Health Home (Health Home 2) to add the client to their roster.

**NYS DOH Process for Health Home Transfer:**

- Health Home 1 submits a **Change Record**, ending the enrollment segment for that month and populating the “Segment End Date Reason Code” field with code 01 – Transfer to another Health Home.
- Health Home 2 submits an **Add Record** for the following month when service was ended with Health Home 1. The Referral Code field should be populated with code ‘T’ to indicate this member was transferred from another Health Home.

**Definitions**

**CMA – Care Management Agency:** A CMA is a healthcare management company that provides services and interventions to help federal and state healthcare programs and commercial insurers serving enrolled members achieve optimal health.

**TCM – Targeted Case Management:** Targeted Case Management (TCM) refers to case management for specific Medicaid beneficiary groups or for individuals who reside in state-designated geographic areas.

**COBRA – Case Management** [Consolidated Omnibus Budget Reconciliation Act of 1985] It allows those people living with HIV/AIDS or those people who are at risk for obtaining HIV to receive case management services by having their health coverage (almost always Medicaid) pay for those services.

**MATS – Managed Addiction Treatment Service:** MATS is a Medicaid reform initiative created by the NYS Office of Alcohol and Substance Abuse with partnerships with localities throughout the state. The goal of MATS, via case management, is to assure access to and enhance the cost-effectiveness of needed treatment, rehabilitation and other social services to voluntarily participating individuals.

**CIDP – Chronic Illness Demonstration Project**—State DoH funded grant project to show efficacy of case management for complex Medicaid patients.

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