Office of Temporary and Disability Assistance | Department of Health

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Local Commissioners Memorandum

Section 1

Transmittal:	18-LCM-18
To:	Social Services District Commissioners
Issuing Division/Office:	OTDA – Integrated Family Assistance Programs DOH – Office of Health Insurance Programs
Date:	September 20, 2018
Subject:	Referral of Persons Residing in Temporary Housing to Health Homes Services
Contact Person(s):	Temporary Assistance Bureau: (518) 474-9344 otda.sm.cees.tabureau@otda.ny.gov
Attachments:	Attachment 1: Health Home - County Information Attachment 2: Health Home Eligibility and Referral Form Attachment 3: Referral Consent Form
Attachment Available Online:	☒

Section 2

I. Purpose

This Local Commissioners Memorandum (LCM) provides social services districts (districts) with information regarding the existence of Medicaid-funded New York State Department of Health (DOH) Designated Health Home services which provide intensive care management services to Medicaid eligible individuals who have chronic conditions and may be higher users of Medicaid services. OTDA and DOH are launching a pilot initiative to establish a closer district interface with Health Home Services. More information on the pilot program follows. OTDA and DOH strongly encourage districts to establish connections with Health Home Services to improve health, housing stability and other outcomes for program participants.

II. Background

A "Health Home" is not a physical place, but rather, services provided based on a care coordination model in which a member's physical health, behavioral health, and social services needs are coordinated by a single Care Manager. This Care Manager works with the member to develop a person-centered plan of care and provides services to promote successful implementation of the plan. The Health Home program works with a network of care management agencies and healthcare providers to serve Medicaid enrolled persons who are deemed eligible for the services. While enrollment in the Health Home program is voluntary on the part of the Medicaid member, this program provides much needed supports to individuals who are eligible and participation should be encouraged.

Health Home programs provide a Care Manager to each eligible individual. These Care Managers identify community-based resources and actively manage an individual's

engagement and follow-up with the services he/she needs. They can obtain priority appointments with healthcare providers in the community and Care Managers are available 24 hours a day, 7 days a week to provide information and emergency consultation services when needed.

There are a total of 33 designated Health Home programs that cover every county in New York State; 13 of which are designated to serve adults and children under 21 years of age, 17 of which serve adults only and 3 which serve children under 21 years of age only. Information about the Health Homes that serve each county can be found on the attachment to this LCM ("Attachment 1") or can be obtained online at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm.

III. Program Implications

Health Home services are Medicaid-funded and available to help TA applicants and recipients who are eligible to receive Medicaid and have certain chronic health conditions. These services are an important resource, especially for homeless individuals, who will particularly benefit from the intensive care management component.

The services offered through Health Homes help facilitate access to medical care, substance abuse, and mental health treatment, as well as assistance with housing placements and other needed services. Services offered by Health Homes include:

- Improving physical and behavioral outcomes by linking individuals to appropriate healthcare providers;
- Providing intensive care management to ensure that members make and keep medical and behavioral health appointments, understand prescription medication protocols and take medications as directed;
- Arranging for transportation services necessary for improving health conditions and for living independently in permanent supportive housing; and,
- Connecting individuals to resources within their own communities and helping them navigate necessary processes to find stable and supportive housing.

To be eligible for Health Home services, an individual must:

- Be Medicaid eligible; <u>and</u>,
- Have one (1) single qualifying condition, which is defined in New York State for adults over the age of 21 as HIV/AIDS or a Serious Mental Illness (SMI) and for children under the age of 21 as HIV/AIDS, Serious Emotional Disorder or Complex Trauma; <u>or</u>
- Have two (2) or more chronic conditions, which may include such things as substance use disorders, mental health disorders or other chronic medical conditions. A listing of eligible chronic conditions can be found online at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_home_chronic_conditions.htm

A pre-screening and referral form ("Attachment 2") and a referral consent form ("Attachment 3") are being attached to this LCM for use by districts to help identify those who may be potentially eligible for Health Home services. Once the district identifies an adult member that may be eligible for the Health Home program, the district can refer the member directly to the Health Home that services the county that the member resides in or receives their treatment in. If an individual is not currently receiving Medicaid but may be Medicaid eligible, he/she should still be referred to a Health Home, as the Health Home staff will assist individuals who need to apply for

or re-certify for Medicaid. See the link under Section II. above or the attachment for Health Home contact information.

Please note: Currently, only adults should be referred for Health Home services. Information on referral to the Health Homes Serving Children Program will be forthcoming.

IV. Pilot Initiative

OTDA and DOH are launching a pilot initiative with several districts from around the State.

In these districts, a Home Health services coordinator will be on-site two to three days per week to determine Health Home eligibility for individuals seeking shelter services. The pilot will focus only on referrals for adults, as there is a different process for children. The district shelter intake worker will use the attached pre-screening and referral form to determine potential eligibility and will refer individuals to the on-site Health Home services coordinator after obtaining necessary client consent. The coordinator will make an eligibility determination and enroll the client as a Health Home services member. At that point, a Care Manager will be assigned and service coordination will begin.

As part of the pilot effort, the Department of Health will provide training and technical assistance to district shelter intake staff, including the use of pre-screening, referral and consent forms. They will arrange for the on-site presence of a Health Home services coordinator. OTDA and DOH will work with the pilot districts and providers to facilitate an effective exchange of information regarding client/member status and to ensure that pilot outcomes are evaluated. OTDA and DOH will share outcome information for the pilot programs in the future as well as recommendations for expanded program interfaces with other districts.

For districts not participating in the pilot initiative, we encourage you and your staff to familiarize yourselves with Health Home Services Providers servicing your district and make referrals as appropriate. See link above under Section II. as well as the attachment. Additionally, district staff can contact the Office of Health Insurance Health Home Programs at: (518) 473-5569 with questions or to obtain additional information. OTDA and DOH will be in regular contact regarding district inquiries. Districts may also contact the Temporary Assistance Bureau within OTDA at: (518) 474-9344.

Districts are reminded of the confidential nature of the information obtained in the screening tool and must ensure that all screening tools and consents are handled like other protected health information they collect.

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