THE BRONX HEALTH & HOUSING CONSORTIUM

**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, NYS Office of Health Insurance Programs (OHIP) Data Portal 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:

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|---|---|---|---|
| Bronx Accountable Healthcare Network (BAHN) | Nicole Jordan-Martin *Montefiore Medical Center* | 914-378-6086 | nijordan@montefiore.org |
| Bronx Health Home (BHH) | Virgilina Gonzalez *Bronx-Lebanon Hospital Center* | 718-901-8927 | vgonzale@bronxleb.org |
| NYC Health and Hospitals Corporation (HHC) | Dr. Deborah Rose *HHC* | 212-788-2455 | deborah.rose@nychhc.org |
| Community Care Management Partners (CCMP) | Alyssa Lord *Visiting Nurse Service of New York* | 212-216-9911 | alyssa.lord@vnsny.org |

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:

    1) TCM/MATS/COBRA/CIDP program involvement

    2) CMA (e.g. housing, social services, etc.)

3) Health provider linked to another Health Home (e.g. primary care provider, behavioral health provider, substance abuse program involvement, etc.)

4) Managed Care Organization linked to another Health Home

5) 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, 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.