Health Home and Managed Care Consolidated Workgroup
Assignment and Referral Sub-committee

Scope of Work

This sub-committee will develop guidelines for making and receiving assignments and referrals within the Health Home system. Both assignment and referrals made from NYS DOH to Managed Care Plans to Health Homes to Care Management Providers AND assignments and referrals made from Care Management providers to Health Homes will be considered by the committee.

Goals to Achieve

- Develop common definitions for assignment and referral that all parties can agree on
  - Currently the definitions of these terms may vary depending on one's perspective within the Health Home.
- Provide an outline for existing assignment and referral processes for (downstream and upstream processes) and address gaps
  - Including encounter / claims data
  - Improving the accuracy of information available through HCS and developing a batch mechanism
- Challenges currently faced and barriers to success will be considered and solutions proposed
  - **Upward Enrollment** - Continue to refine upward enrollment processes including confirming eligibility and obtaining pre-authorization
  - **Eligibility and Enrollment Status -** Develop mechanisms to determine if an individual is currently enrolled with another Health Home provider. Consider mechanisms previously in place to accomplish this task
    - Include processes for determine if someone is not eligible based on the type of insurance they have (e.g., MLTC, Family or Child Health Plus, other exclusions from HH participation)
    - Can / should this process replace the tracking sheet system?
  - **Contracting Issues** - Eligible individuals in managed care plans that do not have a contract with a designated health home or who, based on loyalty, should be assigned to a Health Home that is not active
  - **Volume concerns** - Rate at which assignments are made from Managed Care Plans
    - Coordinating assignments across plans so health homes and care management providers do not receive to many or too few assignments at any one time
  - **Duration of outreach** – how long does an individual remain in outreach? What are some of the challenges Health Home's and Care Management Providers have had with outreach? How can we coordinate better to improve outcomes?

Frequency and duration of meeting

Meet bi-weekly for six months.

Co-chairs

Margaret Leonard MS, RN-BC, FNP
Senior Vice President for Clinical Services
Hudson Health Plan
303 S. Broadway, Suite 321
Tarrytown, NY 10591-5455
T 914.372.2275
F 914.524.7661
mleonard@hudsonhealthplan.org

Kevin Muir
Director of Health Homes
CAMBA
19 Winthrop St
Brooklyn, NY 11225
718-462-8654 ext 30400
FAX: 718.703.7212
kevinm@camba.org