NEW YORK STATE | Department of Health

Initial Appropriateness and CES Tool Training

New York State Office of Health Insurance Programs, Division of Program Development and Management

Bureau of Adult Special Populations

Presenters:

Arianna Antisin, Health Home Program Advisor
Hillel Hirshbein, Health Home Program Director

October 2023

Initial Appropriateness

October 2023

Initial Appropriateness/Need Reporting

- DOH and HH policy has long required CMs to record Initial Appropriateness (at least one Significant Risk Factor) in the case record.
- Unlike information on other Eligibility Criteria (Active Medicaid, Diagnostic Eligibility), there has never been a mechanism to allow CMAs, HH's, and DOH to review/analyze/QA issues of appropriateness other than member level chart review.
- HHs and DOH have identified significant instances of enrollment of members of where appropriateness is either not documented, not justified, or both.
- DOH seeks to reduce enrollment of Medicaid Members who are not appropriate through closer oversight of Appropriateness criterion.

Initial Appropriateness/Need Reporting Policy and Implementation Highlights

- Go-live Date: 12/1/2023
- Within 30 days of signed consent, a provider must submit to MAPP HHTS the member's Initial Appropriateness criteria (only one) on the Consent and Member Program Status Upload file, or they cannot bill for the month following the segment begin date (effective 2/1/24)
- Additionally, anytime a new segment is opened a provider must submit a new initial appropriateness criterion on the Consent and Member Program Status Upload file into MAPP HHTS

  Note: segments created through the MAPP HHTS transfer process are excluded
- At this time, the Department is working on a mechanism for annual reporting for Health Home Serving Children – more to come

Initial Appropriateness/Need Reporting - Continued

Collection/recording of this information is *already* required by policy:

- The only change is that the information is now reported to DOH
- Initial Appropriateness categories will now be more clear and objective
- Systems will require minor configuration changes so that this data, (which are already collected), are now recorded in a reportable field
- Initial Appropriateness will be uploaded into the MAPP HHTS (Health Home Tracking System) from the Electronic Health Record (EHR) via the Consent and Member Program Status Upload file

Initial Appropriateness/Need Categories

Appropriateness Code	Appropriateness Criteria	Program	Comments Required (Y/N)?
10	ADVERSE EVENTS RISK: Current H-code in EMEDNY (HARP Eligible/Enrolled)	Adults	N
11	ADVERSE EVENTS RISK: Current POP flag in PSYCKES	Adults	N
12	ADVERSE EVENTS RISK: Current Quality or HH+ flag in PSYCKES or equivalent from RHIO or MCO	Adults	N
13	ADVERSE EVENTS RISK: Member currently involved with mandated preventive services. Must specify date issued services and provider of service	Children	Y
14	ADVERSE EVENTS RISK: Member recent inpatient/ED/psychiatric hospital/Detox within the last 6 months. Must specify name of institution and date of release	Children	Y
15	ADVERSE EVENTS RISK: Member recent out of home placement (foster care, relative, RTF, RTC, etc.) within the last 6 months. Must specify name of institution and date of release	Children	Y
16	ADVERSE EVENTS RISK: Member recently diagnosed with a terminal illness/condition within the last 6 months. Must specific condition and date diagnosed	Children	Y
17	ADVERSE EVENTS RISK: Member received an initial Disability Determination (SSI or DOH Disability Certificate/letter) within the last 6 months	Children	N
18	ADVERSE EVENTS RISK: Released from Jail/Prison/Juvenile detention, involved with Probation, PINS, Family Court within the last 6 months. Must specify name program and date of release/court/probation	Children	Y
20	HEALTHCARE RISK: Member does not have a healthcare provider or specialist to treat a chronic health condition	Both	N
21	HEALTHCARE RISK: Member has not seen their provider (e.g., PCP, BH, etc.) in the last year	Both	N
22	READMISSION/RECIDIVISM RISK : Released from inpatient Medical, Psych, or Detox within the last 6 months. Must specify name of institution and date of release	Adults	Y

Initial Appropriateness/Need Categories (cont'd)

Appropriateness Code	Appropriateness Criteria	Program	Comments Required (Y/N)?
23	READMISSION/RECIDIVISM RISK : Released from Jail/Prison or other justice program within the last 6 months. Must specify name program and date of release	Adults	Y
24	SOCIAL DETERMINANTS RISK: Current Intimate Partner Violence / Current Family Violence in the home of the member	Both	N
25	SOCIAL DETERMINANTS RISK: Currently cannot access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc.	Both	N
26	SOCIAL DETERMINANTS RISK: Currently homeless (HUD 1, 2, or 4) & for Transitional Age Youth, has no stable living arrangement (living with different friends/family)	Both	N
27	SOCIAL DETERMINANTS RISK: Member has fewer than 2 people identified as a support by the member	Both	N
28	SOCIAL DETERMINANTS RISK: Member has had a recent change in guardianship/caregiver within the last 6 months	Both	N
29	SOCIAL DETERMINANTS RISK: Member is concurrently HH appropriate due to caregiver/guardian enrolled in HH. Must specify caregiver full name and HH/CMA enrolled with	Children	Y
30	SOCIAL DETERMINANTS RISK: Member (or caregiver, if Member is a child) does not have needed benefits (SSI, SNAP, etc.)	Both	N
31	SOCIAL DETERMINANTS RISK: Recent institutionalization or nursing home placement of member's primary support person	Adults	N
32	TREATMENT NON-ADHERENCE RISK: Member/care team member report of non-adherence…Must specify WHICH medication(s) and/or treatment(s) are involved	Both	Y
33	TREATMENT NON-ADHERENCE RISK: PSYCKES flag related to non-adherence or equivalent from RHIO or MCO	Both	N
	Direct Referral from MCO	Both	N
	Direct referral from Adult Protective Services	Adults	N
	Direct referral from Child Protective Services/Preventive Services Program	Children	N

Initial Appropriateness Next Steps

October 2023 – Online 90-minute training sessions rolled out state-wide.

December 2023 – Health Homes must start recording Initial Appropriateness in the their EHRs effective 12/1/23. The MAPP tracking system will start accepting Initial Appropriateness via the Consent and Member Program Status Upload file on 12/9/23. MAPP HHTS December 2023 4.4 release contains this information.

February 2024 – Billing block go-live if Initial Appropriateness not reported within 30 days of consent date

	DOH CES Tool	Initial Appropriateness
HHSA CMAs	YES – excludes HH+ Eligible members	YES
HHSC CMAs	NO	YES
Frequency	At 12 months, and every 6 months thereafter	Within 30 days of signed consent, and upon creation of any new subsequent segment
What does it consist of?	Medicaid, Dx, Significant Risk, Additional Risk, Engagement = RECOMMENDATION	Significant Risk
When does it start	11/1/23	12/1/23
Is there a billing block?	Not yet	Starting 2/1/24
Who does it?	CM (with supervisory review), CMA Supervisor or QA Staff	Whoever completes your eligibility screening at enrollments; data entry can be by whomever creates segments

Continued Eligibility for Services (CES) Tool

October 2023

NEW YORK STATE | Department of Health

HH Recalibration

In order to achieve a budget savings;

Initial Proposal Developed

- Disenroll members who consistently fall into the low-rate code after 9 months
- Members who consistently fall into the medium-rate code bucket for 9+ months stepped down to low-rate code for 3 months before disenrollment

Response to Initial Proposal

- Based on stakeholder feedback the CES Tool workgroup was convened to develop an alternative solution

CES Tool Workgroup

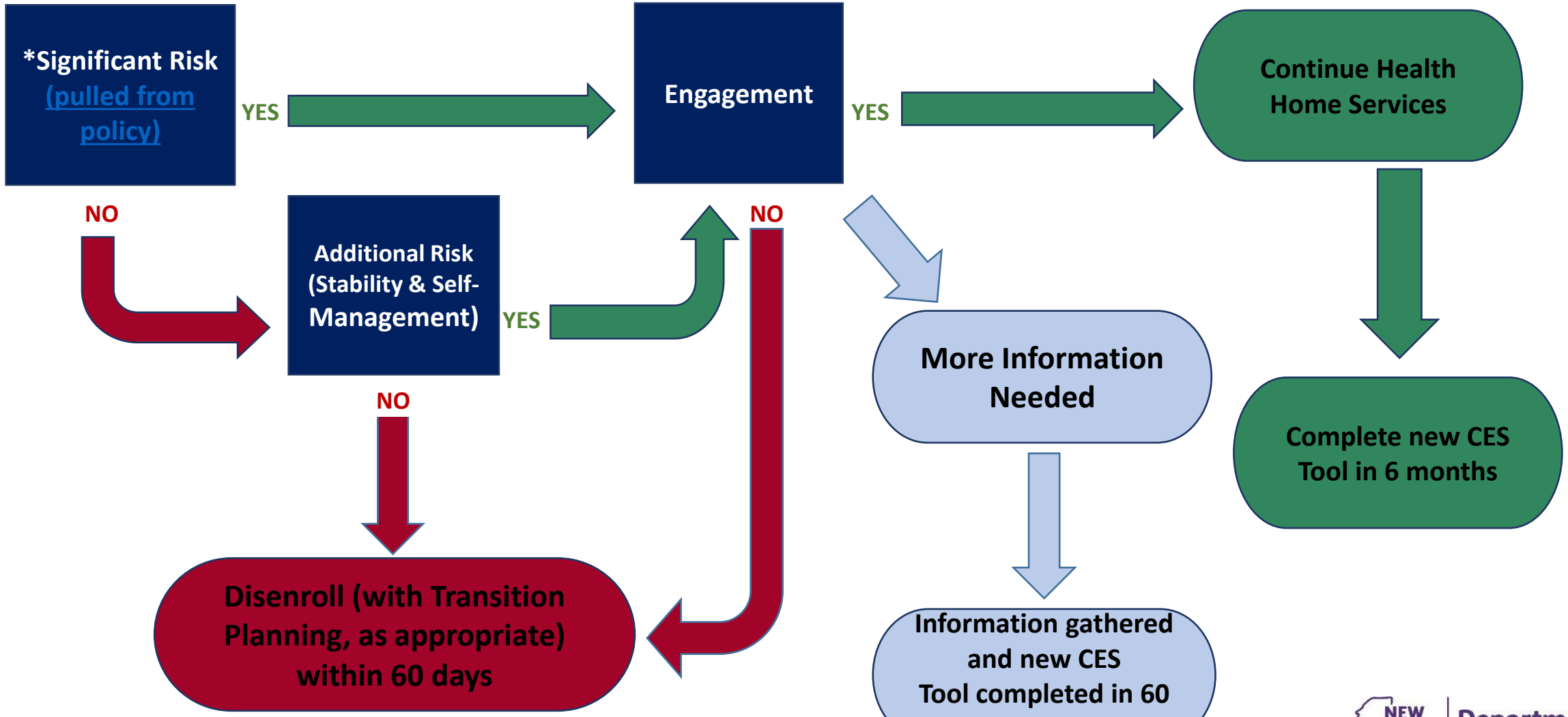
Representatives from the Health Home Coalition, the Care Management Coalition, iHealth, MCOs, HIV SNPs, DOH, and OMH met for 6-weeks to come to consensus on the design of the CES Tool

- Reviewed several tools currently in use by Health Homes across the state
- Developed consensus on what to include in a tool and a policy

Agreed Upon Workgroup Goals:

1. Establish consistent and objective criteria to verify continued Health Home eligibility
2. Ensure use of a person-centered approach
3. Reduce administrative burden as much as possible
4. Align with current Health Home Policy standards

CES Tool Workflow



NEW YORK STATE | Department of Health

Tool Highlights

- Is Medicaid Status active and HH compatible (no disqualifying R/E code)?
- Does member have qualifying diagnosis?
- Does member have a Significant Risk Factor?
- Does the member have Additional Risk Factors?
- Is the member engaged in care?

Please note: The CES Tool is not required to be completed with the member present. The outcome of the tool will determine the next steps.

Tool logic yields 3 possible outcomes which are reported to MAPP HHTS:

- RECOMMEND CONTINUED SERVICES
- RECOMMEND DISENROLLMENT
- MORE INFORMATION NEEDED

Significant Risk Factors

- ADVERSE EVENTS RISK: Current Quality flag in PSYCKES or equivalent from RHIO or MCO
- ADVERSE EVENTS RISK: Current POP flag in PSYCKES
- ADVERSE EVENTS RISK: Current H-code in EMEDNY (HARP Eligible/Enrolled)
- SOCIAL DETERMINANTS RISK: Currently homeless (HUD 1, 2, or 4)
- SOCIAL DETERMINANTS RISK: Member has fewer than 2 people identified as a support by the member
- SOCIAL DETERMINANTS RISK: Member has had a recent change in guardianship
- SOCIAL DETERMINANTS RISK: Recent institutionalization or nursing home placement of member's primary support person
- SOCIAL DETERMINANTS RISK: Member does not have needed benefits (SSI, SNAP, etc.)
- SOCIAL DETERMINANTS RISK: Currently cannot access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc.
- SOCIAL DETERMINANTS RISK: Current Intimate Partner Violence
- HEALTHCARE RISK: Member does not have a healthcare provider or specialist to treat a chronic health condition
- HEALTHCARE RISK: Member has not seen their provider (e.g., PCP, BH, etc.) in the last year
- HEALTHCARE RISK: Member (or guardian) is unable to appropriately navigate the healthcare system for the member's chronic conditions.
- TREATMENT NON-ADHERANCE RISK: Member/care team member report of non-adherence…Must specify WHICH medication(s) and/or treatment(s) are involved.
- TREATMENT NON-ADHERANCE RISK: PSYCKES flag related to non-adherence or equivalent from RHIO or MCO
- RE-ADMISSION/RECIDIVISM RISK: Released from inpatient Medical, Psych, or Detox within the last 90 days. Must specify name of institution and date of release.
- RE-ADMISSION/RECIDIVISM RISK: Released from Jail/Prison or other justice program within the last 90 days. Must specify name program and date of release.
- No Concrete Example of a Significant Risk Factor in record – PROCEED TO ADDITIONAL RISK FACTORS

General Risk Factors

Has member had preventable or unnecessary hospitalizations or ER visits over the last six months? *"Preventable" means they were directly attributable to their lack of adherence to or access to treatments, appointments, or understanding of their Chronic Diagnoses.* *"Unnecessary" means the health care need could or should have been met in an outpatient or urgent care setting instead.*
Is the member's current housing unsafe?
The member has safety concerns in their environment or community, and the member has not been able to follow a safety plan.
Has member been a danger to themselves or others within the last six months? *Examples: Suicidal or homicidal ideation or attempts, violence towards self or others, inclusive of self-harm or arson, subject of a temporary restraining order, etc.*

Stability Risk Factors

If the member has a mental health diagnosis, have they experienced an increase in symptoms, or the need for crisis management responses within the last six months? *Crisis management could be provided through a formal crisis response team, or informally through their HHCM.*
If the member has a SUD diagnosis, has the member met and maintained their SUD goals over the last six months, such as Abstinence, Moderation, or Harm Reduction? *SUD applies to legal and illegal drugs of abuse, alcohol, and/or tobacco if the member has identified a goal related to use of that substance.*
Has the member had stable housing over the last six months? *"Stable" means there have been no evictions, moves, or periods of homelessness.*
If the member is in a relationship with chronic Intimate Partner Violence, have they been able to follow a Safety Plan over the last six months?
If the member is involved in the Criminal Justice System, have they been following the requirements of their Parole/Probation over the last six months?

Skills-Based Risk Factors

Does the member or caregiver understand the frequency of outpatient follow up, schedule and keep their healthcare appointments, and have reliable transportation to get to their healthcare appointments without HHCM assistance?
Does the member or caregiver understand who is on their Care Team and when/why/how to contact them without HHCM assistance?
Does the member or caregiver maintain the member's medication adherence without HHCM assistance?
Is the member or caregiver aware of upcoming recertifications for benefits and can successfully recertify without HHCM assistance? *This could include Medicaid, SNAP, SSI, SSDI, Public Assistance, etc.*
Does the member or caregiver manage the member's day-to-day finances without HHCM assistance? *This could include paying rent, bills, budgeting, etc.*
Does the member or caregiver manage the member's ADLs and IADLs without HHCM assistance?

Engagement in Care

Engagement is a tricky word…this has nothing to do with members in Diligent Search Efforts (DSE). A CES Tool would not be done on pended cases.

Does the member have non-maintenance goals left to accomplish on the POC? *An active (non-maintenance) goal is one that requires actions by the HHCM to elicit progress towards completion of the goal. The members' goal(s) would not be achieved without concrete interventions and support of the HHCM.* *Maintenance goals are goals that the member has met, and although ongoing, do not require any active assistance from the HHCM. Example: "Member will continue to fill their medication monthly".*
Has the member been actively engaged and working with the CM on their HH POC Goals and Tasks in the last six months? *A member is not actively engaged if they are only in touch with the HHCM to say they are busy, or will call them back, or if regularly, Core Services being provided are only being provided through the Care Team because the member is unavailable.* *A member is not working with the HHCM on their HH POC Goals and Tasks if during their contacts they are solely updating the HHCM on their life or persistently addressing something not on the POC.*
Have the member and Care Manager been making progress on their HH POC Goals and Tasks in the last six months? *A member and HHCM are not making progress on the HH POC Goals and Tasks if the same task is being attempted month after month and nothing changes or moves forward.*

If Outcome= Recommend Continued Services

When the outcome is Recommend Continued Services:

- Continue to provide ongoing HHCM services
- Reassess the member in six months

If Outcome = More Information Needed…

- If the completion of the tool results in the “More Information Needed” outcome, it means that the record does not contain sufficient information to make a determination.
- If need/appropriateness is unclear, the CM must further discuss this with the member and other providers such as the MCO, PCP, BH to better determine whether the member still needs HHCM. This must be documented in the member’s chart.
- A new CES Tool must be completed within **60 days** with a definitive outcome of continued services or recommend disenrollment. A second “More Information Needed” result is not acceptable.
- Enforcement using billing exclusion may be implemented in the future.

If Outcome = Recommend Disenrollment

When the outcome is Recommend Disenrollment, the following steps must be taken and documented in member's record:

- Engage with the member and other care team members to determine whether step-up, step-down, graduation, or disenrollment is most appropriate
- The disenrollment process must occur over the subsequent **60 days** following procedures in the Member Disenrollment from the Health Home Program policy HH0007
- If the member disagrees with the decision and plan, they may appeal the decision through the Fair Hearing Process in the Health Home Program policy HH0004

Timeframe for Completion of CES Tool

- New Members enrolled on/after 11/1/23:
  - Complete 12 months post-enrollment
  - Complete every 6 months thereafter
  - Example:

    Hannah is enrolled 11/7/23. Her first CES Tool is due 11/30/24 and her 18-month CES Tool is due by 5/31/25.
- Existing Members
  - Complete at time the member's next annual Reassessment
  - Complete every 6 months thereafter
  - Example:

    Paul's reassessment is due 12/15/23. The CES Tool must be completed no later than 12/31/23. Next CES Tool is due in six months on 6/30/24.

CES Tool Next Steps (for Adult Health Homes ONLY)

October 2023 – Online 90-minute training sessions rolled out state-wide.

November 2023 - CMAs start using the CES Tool either integrated into EHR or as a stand-alone Excel Tool.

December 2023 - EHRs to start submitting CES Tool Outcomes. MAPP-HHTS Dec. 2023 4.4 release on 12/9/23 allows for CES Tool outcome information (for inclusion of data back to November 2023) to be submitted on the Consent and Member Program Status Upload file.

The Consent and Member Program Status Upload file will include new fields to collect the CES Tool Outcome and assessment date.

The system will calculate the CES Tool End Date depending on the assessment outcome.

(These fields will not impact billing in release 4.4)

Interactive Case Examples

Have your phones ready to scan the QR code!

October 2023

Case Study A

Link to interactive form:
https://forms.office.com/g/sh9k9TuP23

October 2023

Case Study A

Taylor is a 31-year-old female. She is diagnosed with Schizoaffective Disorder and has significant functional impairment. Taylor has active Medicaid. Taylor currently resides in an independent apartment. Taylor has been stable over the last year and has obtained employment at the local grocery store. Taylor attends PROS 5 days a week and maintains her appointments. Taylor has worked with HHCM and is now able to schedule her own transportation to appointments and rides the bus to program and work. Taylor currently has all maintenance goals on her POC. These include, maintaining appointments, following up with provider recommendations, getting her yearly physical, and maintaining employment. When HHCM meets with Taylor, she updates her on what has been going on in her life recently and the status of her appointments.

Interactive Case Example: A

Anyone can respond, Anonymous

1. Does the member still have qualifying diagnoses for Health Home?

515 responses

Show correct answer

1/20

Scan the QR code to vote or go to https://forms.office.com/g/sh9k9TuP23

Outcome = Recommend Disenrollment

Case Study B

Link to interactive form:
https://forms.office.com/g/fRR2K8nW8m

October 2023

NEW YORK STATE | Department of Health

Case Study B

Sophie is a 45-year-old female and has active Medicaid. Sophie is diagnosed with Diabetes and Major Depressive Disorder. Over the last year Sophie has had unstable housing due to a past on again off again relationship which involved domestic violence. Sophie has been out of the relationship for the last year and has been stably housed for the last 7 months. The HHCM has helped link her with DV services and has developed a safety plan. HHCM is unsure if she still has contact with her abuser and if she is following her safety plan. The case notes in the chart are unclear.

Interactive Case Example: B

Anyone can respond, Anonymous

1. Does the member still have qualifying diagnoses for Health Home?

Yes	99%
No	0%
Unclear	0%

462 responses

Show correct answer

1/7

Scan the QR code to vote or go to https://forms.office.com/g/fRR2K8nW8m

Outcome = More Information Needed

Case Study C

Link to interactive form:
https://forms.office.com/g/jRi0hMyErA

October 2023

NEW YORK STATE | Department of Health

Case Study C

George is a 42-year-old male who has a diagnosis of Substance Use Disorder and PTSD. George has active Medicaid. George attends all his appointments with his providers regularly and follows up with provider recommendations. George consistently utilizes HHCM to set up his transportation for his appointments and updates his HHCM on the appointments. George hasn't been to the ED or hospitalized in over two years. Up until recently George's housing had been stable. George just received an eviction notice as he has fallen behind on his rent payments after losing his job. George has 1 month to find new housing. HHCM is now helping him work with United Tenants and look for new housing.

Outcome = Recommend Continued Services

Next Steps

October 2023

Please submit questions to the Department by October 27, 2023 by scanning the QR Code or using the link below:

https://forms.office.com/g/PCfnL8UT38

Resources

- Member Disenrollment From the Health Home Program - HH0007
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0007_member_disenrollment_policy.pdf

- Health Home Notices of Determination and Fair Hearing Policy - HH0004

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0004_fair_hearing_nod_policy.pdf