Eligibility Requirements: Identifying Potential Members for Health Home Services

Individuals previously receiving TCM services through a COBRA HIV or OMH TCM program, receiving substance use case management services through Managed Addiction Treatment Services (MATS) programs, or those formerly receiving services in the Chronic Illness Demonstration Project (CIDP) have been transitioned to Health Home care management.

Currently the State identifies individuals who may be eligible for Health Home services through an analysis of claims and encounter data and provides lists of these individuals to Health Homes for outreach and engagement. Interested individuals are assessed and, if found eligible, assigned to a care manager. These are known as "list assigned "members.

Individuals may also be referred to Health Homes from other providers or entities, including physicians, emergency departments, and community based providers, supportive housing providers, shelters, and family members. These referrals are known as community referrals. Whether a recipient has been list assigned by the State or comes to the Health Home through a community referral, the eligibility of the individual must be verified.

Determining Eligibility for Health Home Services

Step One

Step One is to determine Medicaid eligibility. Medicaid reimbursement for Health Home services can only be provided to individuals who are enrolled in Medicaid. While every effort is made to ensure that Medicaid is active for list assigned members, it is up to the provider to not only verify eligibility but to assure that Medicaid is active for both assigned members and for community referrals in order to ensure Medicaid reimbursement for Health Home services. It is also important to note that a client's Medicaid eligibility may change frequently. The care manager should work with eligible members to assist them in enrolling or renewing members for Medicaid benefits as required. It is important to note that Medicaid coverage may be granted retroactively. Currently, policies for Medicaid enrollment and determination for retroactive coverage vary by county although as enrollment moves to the New York State of Health Marketplace the process for enrolling individuals will be standardized.

Step Two

Step Two is to determine if the member is eligible for Health Home services. To be eligible for Health Home services, an individual must have two chronic conditions or one single qualifying condition. New York State has chosen HIV and Serious Mental Illness (SMI) as single qualifying conditions. Having one chronic condition and being at risk of developing another condition **does not** qualify an individual as Health Home eligible in New York State. In summary, New York State's Health Home eligibility definition is as follows:

- Two (2) or more chronic conditions; or
- One (1) single qualifying condition: HIV/AIDS or a Serious Mental Illness (SMI)

Substance use disorders (SUDS) are considered chronic conditions, but do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition (as described below) to qualify.

Note that the diagnostic eligibility criteria must be verified for both list assigned recipients and for community referrals. The State identifies and list assigns potential members for Health Home services based on diagnosis codes used on claims and encounter data which may not be complete or which may not accurately assess the individual's current condition. Other sources such as medical records or assessments must be used to document diagnostic eligibility. Qualifying chronic conditions are any of those included in the "Major" categories of the 3M™ Clinical Risk Groups (CRGs) as described in the list below. A detailed list of the individual chronic conditions within each of our categories is available at http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_home_policy.htm. Questions regarding eligibility can be directed to the Health Home program at https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action or to the Health Home Provider Link at 518-473-5569.

Major Category: Alcohol and Substance Use Disorder

- Alcohol and Liver Disease
- Chronic Alcohol Abuse
- Cocaine Abuse
- Drug Abuse – Cannabis/NOS/NEC
- Substance Abuse
- Opioid Abuse
- Other Significant Drug Abuse

Major Category: Mental Health

- Bi-Polar Disorder
- Conduct, Impulse Control, and Other Disruptive Behavior Disorders
- Dementing Disease
- Depressive and Other Psychoses
- Eating Disorder
- Major Personality Disorders
- Psychiatric Disease (Except Schizophrenia)
- Schizophrenia

Major Category: Cardiovascular Disease

- Advanced Coronary Artery Disease
- Cerebrovascular Disease
- Congestive Heart Failure
- Hypertension
- Peripheral Vascular Disease

Major Category: Metabolic Disease

- Chronic Renal Failure
- Diabetes

Major Category: Respiratory Disease

- Asthma
- Chronic Obstructive Pulmonary Disease

Major Category: Other

Step Three

Step three is to determine appropriateness for Health Home services. Individuals who are Medicaid eligible **and** have active Medicaid **and** meet diagnostic eligibility criteria are **not**

necessarily appropriate for Health Home care management. An individual can have two chronic conditions and be managing their own care effectively. An individual must be assessed and found to have significant behavioral, medical, or social risk factors to deem them appropriate for Health Home services. Appropriateness for Health Home services must be determined for list assigned members as well as community referrals. While list assigned members have a risk score established by the State (and some community referrals may be on State lists and have a pre-assigned risk score) this score is based on claims and encounter data which may not be current. An assessment must be performed for all presumptively eligible individuals to evaluate whether the person has significant risk factors. Determinants of medical, behavioral, and/or social risk can include:

- Probable risk for adverse events (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 or eating;
- Learning or cognition issues

The November 2012 Medicaid Update Health Home Special Edition requires providers who accept community referrals to establish Medicaid and diagnostic eligibility as well as assess the risk level of clients to determine appropriateness of Health Home services for these referrals. In a Health Home Implementation webinar on March 2014 it was clarified that list assigned members must also be assessed for eligibility and appropriateness in the same way as community referrals and evidence of this assessment will be required to support billing for Health Home services.

Health Homes, Managed Care Organizations, and network care management partners should have policies and procedures that document the responsibilities for establishing and verifying diagnostic eligibility and need criteria, but the Medicaid biller remains ultimately responsible. As described in the New York State Plan Amendment (SPA) recent claims and/or encounter data or other clinical data should be used to verify medical and psychiatric diagnoses. It is expected that documentation of Medicaid eligibility, diagnostic eligibility, and risk assessment be maintained as defined by agreements between the Managed Care Organization, the Health Home, and the network care management agency.

Generally it is the care management agency that determines eligibility for Health Home services. For managed care members, the Managed Care Plans often have more detailed information on a member's diagnosis and care utilization. Managed Care Plans also review list assigned candidates provided by the State and make the final assignment for Health Home services, thus they are well-positioned to determine or assist in determining eligibility.

Note that the Health Home Outreach and Engagement rate (currently paid at 80% of the full per-member-per month rate) can be billed until eligibility criteria have been established and documented, for up to three months. If an individual is determined not to meet diagnostic and risk eligibility criteria, billing for outreach should cease or the member should be disenrolled from the Health Home and the care manager should make a referral to a more appropriate level of care.