Policy Title: Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program
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Approved by:

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Contents

Definitions

Member or Participant –
The individual (both adults and children/youths) enrolled in the Health Home program. The term includes the parent, guardian, legal authorized representative of the member. These terms can be used interchangeably.

Purpose

This policy outlines the steps that must be taken to ensure every individual, adult and child/youth, meets the required eligibility criteria to support Health Home enrollment and continued enrollment in the Health Home program. **Part I** of this policy provides the steps that must be taken to identify and confirm eligibility for Health Home (HH) enrollment (adults

and children/youth). **Part II** of this policy provides steps that must be taken to identify and confirm eligibility for *continued* Health Home (HH) enrollment.

This policy supersedes previous policy outlined in the *Health Home Eligibility Policy - Updated March 2022 (PDF)* and the supplemental document, *Eligibility Requirements: Identifying Potential Members for Health Home Services Appropriateness Criteria (HHSA Only) - September 2020 (PDF) and HHSC Eligibility, Appropriateness, Prioritization and 6 Core Services - (PDF) - March 2022*

Background

Individuals may be referred to Health Homes (HH) from a number of entities including Medicaid Managed Care Organizations (MCO), physicians and other healthcare and behavioral health providers, emergency departments, schools, community-based providers, criminal justice, supportive housing providers, shelters, family members, self-referrals, and others. Regardless of referral source, the eligibility of the individual and their interest in Health Home enrollment must be verified.

For Children (ages 0-21 years old) who ***may*** be eligible for Health Home services, the State has developed the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Referral Portal. The Portal requires the referral source to, "Indicate the chronic conditions which, in your best-informed judgement, you believe make the child you are referring eligible for Health Home." Currently, MCOs, Health Homes, Care Management Agencies, Local Government Units (LGU), Single Point of Access (SPOAs) and Local Department of Social Services (LDSS) and the Administration for Children's Services (ACS)[1] have access to the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Referral Portal. Other entities that want to make a referral who do not have access to the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) can contact one of these entities or reach out directly to a lead Health Home (Find A Health Home By County (ny.gov).

NOTE: In the event a member is deemed no longer eligible for continued Health Home Services, Health Homes and Care Management Agencies should refer to the *Member Disenrollment From the Health Home Program policy - HH0007* to ensure appropriate steps are taken to transition members for disenrollment from the Health Home Program.

I. Policy

[1] In NYC, Voluntary Foster Care Agencies (VFCA)) that contract with ACS will make referrals on behalf of ACS

Part I: Determining Eligibility for Enrollment into the Health Home Program

Determining eligibility for the Health Home Program has three steps: Step One: Verify Medicaid enrollment and compatibility; Step Two: Verify Qualifying Conditions; and Step Three: Confirm appropriateness for enrollment. If any of these requirements are not met, the individual may not be enrolled in the Health Home Program. Health Home Care Managers must document each of these eligibility requirements in the member's record.

Step One: Medicaid

Medicaid reimbursement for Health Home services can only be provided for individuals with active Medicaid, whose Medicaid coverage type is compatible with Health Home services, and who do not have any disqualifying Restriction/Exception codes – refer to the Guide To Coverage Codes and Health Home Services and, the Guide To Restriction Exception (RE) Codes and Health Home Services). The Health Home Care Manager (HHCM) must verify Medicaid eligibility at the time of enrollment. A member's Medicaid eligibility may change frequently therefore, the care manager must continue to verify Medicaid eligibility prior to service provision (either directly or through an automated process embedded within the Health Home's Electronic Health Record (EHR)). The Health Home Care Manager (HHCM) must work with eligible members to assist them in enrolling or renewing their Medicaid benefits as required to continue Health Home enrollment. Medicaid coverage may be granted retroactively.

Step Two: Qualifying Conditions

To be eligible for Health Home services, an individual must have either two chronic conditions (see Appendix A – Health Home Chronic Conditions List) or one single qualifying condition, as follows:

- ✓ HIV/AIDS, or
- ✓ Serious Mental Illness (SMI) (Adults), or
- ✓ Sickle Cell Disease (both Adults and Children), or
- ✓ Serious Emotional Disturbance (SED) (Children), or
- ✓ Complex Trauma (Children).

Having one chronic condition (other than the single qualifying conditions above) and being at risk of developing another condition does not qualify an individual as Health Home eligible in New York State.

Verification of qualifying conditions is required for enrollment or if the member's qualifying conditions change any time thereafter. Certain conditions, which are determined based on functioning within the last 12 months, such as Serious Emotional Disturbance, require annual documentation. Verification of the individual's qualifying condition(s) must be documented in the record. Documentation may be accepted from any one of these sources: Managed Care Organizations, referrals, medical records, or medical assessments, written verification by the individual's treating healthcare provider, the Regional Health Information Organization (RHIO), or the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES).

Qualifying chronic conditions are any of those included in the "Major" categories of the 3MTM Clinical Risk Groups (CRGs) described as follows:

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: Developmental Disability

- Intellectual Disability
- Cerebral Palsy
- Epilepsy
- Neurological Impairment
- Familial Dysautonomia
- Prader-Willi Syndrome
- Autism

For more information related to Developmental Disability, please see Health Home Program Chronic Condition Update with Developmental Disabilities Conditions

Major Category: Metabolic Disease

- Chronic Renal Failure
- Diabetes

Major Category: Respiratory Disease

- Asthma
- Chronic Obstructive Pulmonary Disease

Major Category: Other

Step Three: Initial Appropriateness

Determining Initial Appropriateness is the final and key step in the process to determine that an individual meets eligibility for Health Home Program enrollment. It is a two-step process that must be completed for both adults and children/youth. The first part is related to activities that must be completed to *confirm* Initial Appropriateness (and annual appropriateness for children); the second part is related to the requirement for *reporting* Appropriateness.

Confirming Initial Appropriateness

Many Medicaid enrollees have Health Home qualifying medical conditions but simply meeting Medicaid eligibility and qualifying conditions does not make someone eligible for Health Home enrollment. For example, an individual can have two chronic conditions and be managing their own health and social care needs effectively thereby not requiring Health Home care management assistance. To qualify for enrollment (and ongoing care management services) in the Health Home program, an individual must be assessed and found to have significant behavioral, medical, physical, or social risk factors that require the intensive level of Care Management services provided by the Health Home program.

Selection of risk factors must be well documented in the member's record and must be related to a requirement for comprehensive care management in order for the member to be effectively served. (It should be noted that even if existing enrolled Health Home (HH) members are triggering some of these historical risk factors, if they are currently managing their condition well with existing services and natural supports, they can and should be transitioned to lower levels of care management and disenrolled from the Health Home program).

Requirement for Reporting Initial Appropriateness

Once Initial Appropriateness has been confirmed, enrollment can proceed, and Health Home (HH) consent signed (refer to the *Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents policy #HH0009*). Initial Appropriateness must be recorded in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) which allows access to Health Homes (HHs), Care Management Agencies (CMAs) and the Department to review, analyze and confirm Initial Appropriateness. **Effective December 1, 2023**, Health Homes (adults and children/youth) must ensure that within **thirty (30) days of signed consent twenty-eight (28) days effective 9/7/2024),** Initial Appropriateness is recorded in the Electronic Health Record (EHR) and, in turn uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) via the *Consent and Member Program Status Upload* file. This process requires the selection of **one** of the initial appropriateness criteria in the Appropriateness Criteria and Codes that reflects the significant risk that makes the individual eligible for Health Home (HH) enrollment. If a member meets multiple appropriateness criteria, then when choosing the single criterion for reporting purposes, consideration should be given to the reason that initially supports activities that the Health Home Care Manager (HHCM) will work on that is also important to the member.

> **NOTE:** Recording of Initial Appropriateness applies only to segments with a begin date on or after December 1, 2023. For active members enrolled prior to December 1, 2023, a system upload of Initial Appropriateness will not be required.

After initial enrollment, any time a new enrollment segment is opened for a member, appropriateness must be recorded in the Health Home's EHR and uploaded into Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) via the *Consent and Member Program Status Upload* file. This includes the new segments opened following pended segments such as Diligent Search Efforts (DSE) or Excluded Setting (refer to the Continuity of Care and Re-engagement for Enrolled Health Home Members #HH0006) but does not include enrollment segments transferred using the official transfer process available in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).

Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Health Home Billing

Generally, it is the care management agency that determines eligibility for Health Home services. Information may be obtained from the member's health care providers and Managed Care Organizations (MCOs) to support the eligibility determination as such entities often have more detailed information on a member's diagnosis and care utilization. Health Homes, Managed Care Organizations (MCOs), and Care Management Agencies (CMAs) must have policies and procedures in place for determining and documenting Health Home eligibility.

The Department has built systems into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) to help Health Homes (HHs) ensure that claims do not go through for members who are not eligible for services. The Medicaid biller – the Health Home – remains ultimately responsible for ensuring that only those individuals who are eligible for Health Home services are enrolled into the Health Home program.

Beginning 2/1/2024, if the requirement to upload the Initial Appropriateness via the Consent and Member Program Status Upload file within 30 days of signed consent is not met **(twenty-eight (28) days effective 9/7/2024),** the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) will prevent any billing from occurring.

Part II. Appropriateness and Eligibility for Continued Health Home Enrollment

Care Management Agencies (CMAs)/Health Home Care Managers (HHCMs) and Health Homes (HHs) must routinely review their enrolled Members, adults and children, to determine whether they remain appropriate and eligible for continued Health Home Program enrollment. Can the member manage their condition(s) using existing services and family/natural supports without evidence of risk that supported their Health Home (HH) enrollment? Can the member be graduated or transitioned to a lower level of care management e.g., provided through their Managed Care Organizations (MCO), a Person-Centered Medical Home (PCMH), or Managed Long Term Care (MLTC)? Do they need a more intensive level of care management e.g., Health and Recovery Plans (HARP), Health Home Plus (HH+), Assisted Outpatient Treatment (AOT), or beyond Health Home Care Manager (HHCM) services? Can they be disenrolled from the Health Home (HH) program entirely? (refer to the Member Disenrollment From the Health Home Program HH0007 policy.

Requirement for Reporting Annual Appropriateness (Children)

On an annual basis, at the annual review of the Plan of Care, the Health Home Serving Children (HHSC) care managers must verify continued eligibility within the HHSC program through annual documentation of continuing appropriateness. This documentation is required

to be entered in the member's case file[2]. During the annual verification of appropriateness, the Health Home Care Manager (HHCM) can select a different significant risk factor for appropriateness that differs from the initial or previous annual appropriateness chosen as appropriate. Supporting documentation to validate the chosen appropriateness criteria must be included within the member's case file.

Continued Health Home Eligibility For Adults (ONLY) – Continued Eligibility for Services (CES) Tool

As part of standard, routine Health Home care management activities, members must be evaluated to identify those eligible for disenrollment, which may occur at **any time** during a member's enrollment. Even while conducting routine activities, Health Home Care Managers (HHCMs) may not always be able to assess member eligibility and appropriateness for continued enrollment. Therefore, it is necessary that **periodic standardized screenings** are conducted by all Care Management Agencies (CMAs) through completion of the Continued Eligibility for Services (CES) Tool.

The Continued Eligibility for Services (CES) Tool evaluates members based upon active Medicaid (eligible and compatible with Health Home (HH) services), qualifying diagnosis, significant risk factors, other risk factors, and member engagement in Health Home (HH) care management.

The use of the Continued Eligibility for Services (CES) Tool was implemented for Health Homes Serving Adults (HHSA) effective November 1, 2023, as follows:

- New Members enrolled on/after 11/1/23:
  Complete Continued Eligibility for Services (CES) Tool twelve (12) months post-enrollment and every six (6) months thereafter
- Existing Members
  Complete Continued Eligibility for Services (CES) Tool at twelve (12) months based on the consent date, or the segment start date (whichever is later), and every six (6) months thereafter.

NOTE: For members who are Health Home Plus (HH+), Health Home Plus (HH+), HH+ Eligible, or Adult Home Plus (AH+) the Continued Eligibility for Services (CES) Tool should NOT be completed. When a member is stepped down from Health Home Plus, the Continued Eligibility for Services (CES) Tool is first be due for completion twelve (12) months following the date of step down from the Health Home Plus (HH+) level of service. When a member is stepped down from Adult Home Plus (AH+) and continues to want Health Home Care Manager (HHCM) services, they are automatically placed into HH+ for up to twelve (12) months. Continued Eligibility for Services (CES) Tool
requirements will then resume. The Continued Eligibility for Services (CES) Tool is due twelve (12) months following the date of step down from Health Home Plus (HH+).

The Continued Eligibility for Services (CES) Tool must be completed by the Care Management Agency (CMA) Supervisor or Quality Improvement staff, or if completed by the

[2] This annual requirement will be built in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) at a later date.

Health Home Care Manager (HHCM), the Care Management Agency (CMA) Supervisor must review and confirm the final outcome. Completion of the Continued Eligibility for Services (CES) Tool must be documented in the member's record.

Additionally, if there are concerns related to the completion of the Continued Eligibility for Services (CES) Tool, the Care Management Agency (CMA) Supervisor has the discretion to complete a new Continued Eligibility for Services (CES) Tool for submission into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) if new information pertinent to the continued eligibility for services is identified. This new Continued Eligibility for Services (CES) Tool must be completed within the same time period allotted for the first Continued Eligibility for Services (CES) Tool. The rationale for the completion of a second Continued Eligibility for Services (CES) Tool must also be documented in the member's record.

The date of completion and outcome is recorded in the Electronic Health Record (EHR) and, in turn uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) via the *Consent and Member Program Status Upload* file. The Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) generates an expiration date for the submitted Continued Eligibility for Services (CES) Tool based on the completion date and outcome. This is shared with Health Homes via the *Assessment Download* file.

The outcomes are as follows:

- Recommend Continued Services – complete Continued Eligibility for Services (CES) Tool at next required timeframe – **six** (**6) months**
- Recommend Disenrollment– require that disenrollment be completed within **sixty (60) calendar days**
- More Information Needed –requires further evaluation to include the member and other providers for a conclusive outcome. Another Continued Eligibility for Services (CES) Tool must be completed within **sixty (60) calendars days** (a second 'More Information Needed' result is not acceptable)

Please refer to the Medicaid Analytics Performance Portal Health Home Tracking System for rules regarding outcome submission limits following a previous outcome and associated scenarios.

> **Example:** Continued Eligibility for Services (CES) Tool Outcome 'E' or 'M' is submitted directly following an existing 'E' Continued Eligibility for Services (CES) Tool Outcome, then the system will reject the new 'E' or 'M' Continued Eligibility for Services (CES) Tool Outcome record and the user can submit only 'C'.

Logic built into the Continued Eligibility for Services (CES) Tool results in one of the above outcomes based on responses selected during completion of the tool. Health Homes Serving Adults must ensure that the resulting outcome is implemented in the case work with the member. If the outcome of the Continued Eligibility for Services (CES) Tool recommends Disenrollment from the Health Home (HH) program, Health Homes (HHs) and Care Management Agencies (CMAs)/Health Home Care Managers (HHCMs) must refer to and follow disenrollment procedures within the Member Disenrollment From the Health Home Program policy HH0007.

Health Homes Serving Adults (HHSA) must ensure that policies and procedures are in place that follow guidance and instructions provided in the Continued Eligibility for Services (CES) Tool Guidance document to include: the timeline for completing the Continued Eligibility for Services (CES) Tool, completing the Continued Eligibility for Services (CES) Tool, and recording outcomes in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).

II. Training Requirements

Health Homes Serving Adults (HHSA), Health Homes Serving Children (HHSC), and Care Management Agency (CMA) staff must receive training on protocols related to eligibility for enrollment and continued enrollment in the Health Home Program including, but not limited to:

- Initial eligibility requirements and continued eligibility
- Initial and annual eligibility for children, staff responsible for appropriateness assessments
- Appropriateness criteria - selection and timeline requirements
- Reporting Initial Appropriateness and uploading into Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS)
- Documentation requirements

For Health Homes Serving Adults (HHSA) and Care Management Agency (CMA) staff Only

- Completing Continued Eligibility for Services (CES) Tool, staff responsible, and timeline requirements
- Reporting Continued Eligibility for Services (CES) Tool outcomes and uploading into Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS)
- Documentation requirements

III. Quality Assurance

Through its Quality Management Program (QMP), Health Homes (HHs) must monitor and evaluate patterns related to member eligibility for enrollment and continued enrollment within its own network and establish quality monitoring activities to evaluate practices and address issues identified.

Health Homes (HHs) must work with their network Care Management Agencies (CMAs) to assure a method is in place for reviewing activities surrounding enrollment, continued enrollment and disenrollment of members no longer eligible for Health Home (HH)services.

IV. Policies and Resources

- Appropriateness Criteria and Codes
- Continued Eligibility for Services (CES) Tool (PDF)
- Continued Eligibility for Services (CES) Tool Guidance
- Continuity of Care and Re-engagement for Enrolled Health Home Members #HH0006)

- Member Disenrollment From the Health Home Program policy - HH0007
- Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents policy #HH0009
- Health Home Program Chronic Condition Update with Developmental Disabilities Conditions

APPENDIX A – Health Home Chronic Conditions List

Health Home Chronic Conditions
Acquired Hemiplegia and Diplegia
Acquired Paraplegia Acquired Quadriplegia
Acute Lymphoid Leukemia w/wo Remission
Acute Non-Lymphoid Leukemia w/wo Remission
Alcoholic Liver Disease
Alcoholic Polyneuropathy
Alzheimer's Disease and Other Dementias
Angina and Ischemic Heart Disease
Anomalies of Kidney or Urinary Tract
Apert's Syndrome
Aplastic Anemia/Red Blood Cell Aplasia
Ascites and Portal Hypertension
Asthma
Atrial Fibrillation
Attention Deficit / Hyperactivity Disorder
Benign Prostatic Hyperplasia
Bi-Polar Disorder
Blind Loop and Short Bowel Syndrome
Blindness or Vision Loss
Bone Malignancy
Bone Transplant Status
Brain and Central Nervous System Malignancies
Breast Malignancy
Burns - Extreme
Cardiac Device Status
Cardiac Dysrhythmia and Conduction Disorders
Cardiomyopathy
Cardiovascular Diagnoses requiring ongoing evaluation and treatment
Cataracts
Cerebrovascular Disease w or w/o Infarction or Intracranial Hemorrhage
Chromosomal Anomalies
Chronic Alcohol Abuse and Dependency
Chronic Bronchitis
Chronic Disorders of Arteries and Veins
Chronic Ear Diagnoses except Hearing Loss
Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses

Chronic Eye Diagnoses
Chronic Gastrointestinal Diagnoses
Chronic Genitourinary Diagnoses
Chronic Gynecological Diagnoses
Chronic Hearing Loss
Chronic Hematological and Immune Diagnoses
Chronic Infections Except Tuberculosis
Chronic Joint and Musculoskeletal Diagnoses
Chronic Lymphoid Leukemia w/wo Remission
Chronic Metabolic and Endocrine Diagnoses
Chronic Neuromuscular and Other Neurological Diagnoses
Chronic Neuromuscular and Other Neurological Diagnoses
Chronic Non-Lymphoid Leukemia w/wo Remission
Chronic Obstructive Pulmonary Disease and Bronchiectasis
Chronic Pain
Chronic Pancreatic and/or Liver Disorders (Including Chronic Viral Hepatitis)
Chronic Pulmonary Diagnoses
Chronic Renal Failure
Chronic Skin Ulcer
Chronic Stress and Anxiety Diagnoses
Chronic Thyroid Disease
Chronic Ulcers
Cirrhosis of the Liver
Cleft Lip and/or Palate
Coagulation Disorders
Cocaine Abuse
Colon Malignancy
Complex Cyanotic and Major Cardiac Septal Anomalies
Conduct, Impulse Control, and Other Disruptive Behavior Disorders
Congestive Heart Failure
Connective Tissue Disease and Vasculitis
Coronary Atherosclerosis
Coronary Graft Atherosclerosis
Crystal Arthropathy
Curvature or Anomaly of the Spine
Cystic Fibrosis
Defibrillator Status
Dementing Disease
Depression
Depressive and Other Psychoses
Developmental Language Disorder
Developmental Delay NOS/NEC/Mixed
Diabetes w/wo Complications
Digestive Malignancy
Disc Disease and Other Chronic Back Diagnoses w/wo Myelopathy
Diverticulitis
Drug Abuse Related Diagnoses

Ear, Nose, and Throat Malignancies
Eating Disorder
Endometriosis and Other Significant Chronic Gynecological Diagnoses
Enterostomy Status
Epilepsy
Esophageal Malignancy
Extrapyramidal Diagnoses
Extreme Prematurity - Birthweight NOS
Fitting Artificial Arm or Leg
Gait Abnormalities
Gallbladder Disease
Gastrointestinal Anomalies
Gastrostomy Status
Genitourinary Malignancy
Genitourinary Stoma Status
Glaucoma
Gynecological Malignancies
Hemophilia Factor VIII/IX
History of Coronary Artery Bypass Graft
History of Hip Fracture Age > 64 Years
History of Major Spinal Procedure
History of Transient Ischemic Attack
HIV Disease
Hodgkin's Lymphoma
Hydrocephalus, Encephalopathy, and Other Brain Anomalies
Hyperlipidemia
Hypertension
Hyperthyroid Disease
Immune and Leukocyte Disorders
Inflammatory Bowel Disease
Intestinal Stoma Status
Joint Replacement
Kaposi's Sarcoma
Kidney Malignancy
Leg Varicosities with Ulcers or Inflammation
Liver Malignancy
Lung Malignancy
Macular Degeneration
Major Anomalies of the Kidney and Urinary Tract
Major Congenital Bone, Cartilage, and Muscle Diagnoses
Major Congenital Heart Diagnoses Except Valvular
Major Liver Disease except Alcoholic
Major Organ Transplant Status
Major Personality Disorders
Major Respiratory Anomalies
Malfunction Coronary Bypass Graft
Malignancy NOS/NEC

Mechanical Complication of Cardiac Devices, Implants and Grafts
Melanoma
Migraine
Multiple Myeloma w/wo Remission
Multiple Sclerosis and Other Progressive Neurological Diagnoses
Neoplasm of Uncertain Behavior
Nephritis
Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's
Neurofibromatosis
Neurogenic Bladder
Neurologic Neglect Syndrome
Neutropenia and Agranulocytosis
Non-Hodgkin's Lymphoma
Obesity (BMI at or above 25 for adults and BMI at or above the 85th percentile for children)
Opioid Abuse
Osteoarthritis
Osteoporosis
Other Chronic Ear, Nose, and Throat Diagnoses
Other Malignancies
Pancreatic Malignancy
Health Home Chronic Conditions
Pelvis, Hip, and Femur Deformities
Peripheral Nerve Diagnoses
Peripheral Vascular Disease
Persistent Vegetative State
Phenylketonuria
Pituitary and Metabolic Diagnoses
Plasma Protein Malignancy
Post-Traumatic Stress Disorder
Postural and Other Major Spinal Anomalies
Prematurity - Birthweight < 1000 Grams
Progressive Muscular Dystrophy and Spinal Muscular Atrophy
Prostate Disease and Benign Neoplasms - Male
Prostate Malignancy
Psoriasis
Psychiatric Disease (except Schizophrenia)
Pulmonary Hypertension
Recurrent Urinary Tract Infections
Reduction and Other Major Brain Anomalies
Rheumatoid Arthritis
Schizophrenia
Secondary Malignancy
Secondary Tuberculosis Sickle Cell Anemia
Sickle Cell Disease*
Significant Amputation w/wo Bone Disease
Significant Skin and Subcutaneous Tissue Diagnoses

Spina Bifida w/wo Hydrocephalus
Spinal Stenosis
Spondyloarthropathy and Other Inflammatory Arthropathies
Stomach Malignancy
Tracheostomy Status
Valvular Disorders
Vasculitis
Ventricular Shunt Status
Vesicostomy Status
Vesicoureteral Reflux

*Sickle Cell Disease was added to Health Home policy in March 2022 as a new single qualifying condition