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## 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 (adult 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 document, *Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016,* supersedes all previously issued versions of this policy.

## 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.

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

## I. Policy

### 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.

**NOTE FOR HHSC:** To be eligible for the Children's Waiver Home and Community Based Services (HCBS), which in turn meets HH eligibility, the member either must be at risk of institutionalization, or is being discharged from an institution and being referred to the Children's Waiver for the HCBS Eligibility Determination to be conducted. It is the responsibility of the Care Manager to inform and educate the member/family about the HCBS, the potential benefits, and the eligibility process. After being educated regarding the purpose of HCBS (risk of institutionalization) and the eligibility process, if a member/family requests HCBS, the certified Care Manager would conduct the HCBS Eligibility Determination as appropriate. Documentation is made in the member's case record regarding the provided HCBS education and the member/family's decision whether or not to have the HCBS Eligibility Determination conducted, and the reason. Please refer to Children's Home and Community Based Services (HCBS) Waiver Eligibility and Enrollment Policy CW0005. Please refer to Children's Home and Community Based Services (HCBS) Waiver Eligibility and Enrollment Policy CW0005.

### 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; the second part is related to the requirement for *reporting* Initial 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).

## 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 Yearly Appropriateness (Children)

On a yearly basis, at the annual review of the Plan of Care, Yearly Appropriateness is completed no later than one year (365 days) of the previous completion date (regardless of whether it was an IA or YA). The Health Home Serving Children (HHSC) care manager verifies continued eligibility and documents yearly appropriateness in the member's Electronic Health Record (EHR) which, in turn is 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 yearly appropriateness criteria in the Yearly Codes and Criteria Chart (with some codes requiring additional appropriateness detail), that reflects the significant risk that makes the member eligible for continued HHSC enrollment. The Health Home Care Manager

(HHCM) can select a different significant risk factor for appropriateness that differs from the initial or previous yearly appropriateness chosen. Supporting documentation to validate the chosen yearly appropriateness criteria must also 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 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).

**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 thirty (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.

## 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 and continued eligibility requirements
- Initial and Yearly eligibility for children, staff responsible for appropriateness assessments
- Appropriateness criteria - selection and timeline requirements
- Reporting Initial and Yearly 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

- Initial and continued eligibility for adults
- 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
- Yearly Codes and Criteria Chart
- Children's Home and Community Based Services (HCBS) Waiver Eligibility and Enrollment Policy CW0005
- Medicaid Analytics Performance Portal Health Home Tracking System
- Health Home Program Chronic Condition Update with Developmental Disabilities Conditions

### APPENDIX A – Health Home Chronic Conditions List

| Health Home Chronic Conditions |
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| 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 |

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| 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 |

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| 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 |

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| 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 85$^{th}$ 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 |

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| 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