Guide to Edits for the Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program policy #HH0016

Summary: As of August 2024, the *Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program* policy # HH0016 now reflects revised language (indicated by text in red) alongside prior language (indicated by crossed out text in black). This update supersedes the previous policy and guidance issued April 2024 and reflects an implementation date of **September 1, 2024.**

Page and Section	Update Made	Update Specifications Language may be completely new or partially reused from earlier policies. Reference "Former Location of Information" column.	Former Location of Information
Page 1	This document now has the addition of a "Contents" section.	Please refer to policy to see the "Contents" section for update.	New addition to policy document.
Page 5, Confirming Initial Appropriateness	Language has been added for further clarification on the qualifying condition being medical.	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 care, 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.	New addition to policy document.
Page 5, Part II. Appropriateness and Eligibility for Continued Health Home Enrollment	Managed Care Organizations (MCOs) have been removed from the list agencies applicable in this section.	Care Management Agencies (CMAs)/Health Home Care Managers (HHCMs) and Health Homes (HHs) ~~and Managed Care Organizations (MCOs)~~ 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., HARP, HH+, 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.	New addition to policy document.

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Page 5, Requirement for Reporting Initial Appropriateness	The updated link and title of the "Appropriateness Criteria and Codes" has been added. Additional information has been added to clarify that this section does not apply to enrollment segments transferred using the official transfer process available in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).	Once Initial Appropriateness has been confirmed, enrollment can proceed and 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 MAPP HHTS which allows access to HHs, 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 MAPP HHTS via the *Consent and Member Program Status Upload* file. This process requires the selection of **one** of the ~~*Significant Risk Factors*~~ Appropriateness Criteria and Codes in the Initial Appropriateness Criteria chart (refer to Appendix B) that reflects the significant risk that makes the individual eligible for 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 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).	New addition to policy document.
Page 6, Requirement for Reporting Annual Appropriateness (Children)	A new section has been added to provide guidance on the Annual Appropriateness process for Children. Please note: A footnote has been added to this section and is indicated by the	**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	New addition to policy document (future updates to be determined)

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	number two (2).	documentation to validate the chosen appropriateness criteria must be included within the member's case file. [2]This annual requirement will be built in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) at a later date.	
Page 6, Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Health Home Billing	Language has been added to address the effective date for consent going from thirty (30) days to twenty-eight (28) days.	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.	Revision to existing policy language.
Page 7, Continued Health Home Eligibility For Adults (ONLY)	The title of this section has been revised. Language has been added and revised to clarify the timelines for CES Tool due dates when members who are Health Home Plus (HH+), HH+ Eligible, or Adult Home Plus (AH+) step down. The subsection indicated by "**Important:"** has been removed as the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) now protects against this scenario. Language has been added to direct readers to the Medicaid Analytics	~~**For Health Homes Serving Adults (ONLY)**~~ **Continued Health Home Eligibility For Adults (ONLY) – Continued Eligibility for Services (CES) Tool** 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 ~~time the member's next Comprehensive Reassessment is due~~ 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+), HH+ Eligible, or Adult Home Plus (AH+) the CES Tool should NOT be completed. When a member is stepped down from Health Home Plus (HH+), the CES Tool is first be due for completion 12 months following the date of step down from the Health Home Plus level of service. When a member is stepped down from ~~HH+ or AH+, the CES Tool would be due 12 months following the~~	Revision and addition to existing policy language.

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	Performance Portal Health Home Tracking System for rules regarding outcome submission limits following a previous outcome and associated scenarios. Also, an example scenario from the before mentioned link has been added.	~~date of step down, regardless of when their re-assessment is due.~~ Adult Home Plus (AH+) and continues to want Health Home Care Manager (HHCM) services, they are automatically placed into Health Home Plus (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+). ~~**Important:** Multiple CES Tool submissions cannot be used to extend the due date in order to avoid loss of billing. A periodic query should be run to flag members with multiple CES Tools completed to identify whether this may have occurred.~~ 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) calendar~~s~~ 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	

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		user can submit only 'C'.	
Page 9, Policies and Resources	The Appropriateness Criteria and Codes Chart has been added to the Policies and Resources section.	• 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	
Page 12, Appendix B	The Appropriateness Criteria and Codes chart from Appendix B has been removed from this policy and posted on the Health Home Policy and Updates webpage under the *Eligibility* section.	**Please refer to the webpage posting to find the updated Appropriateness Criteria and Codes**	