ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #4 Health Home Eligibility

Effective Date: 10/31/2014
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Policy: Encompass Health Home will utilize established resources and processes to screen and verify Health Home eligibility for all Participants, according to Managed Care Plans, Department of Health and Medicaid standards.

Procedure:

A. The Department of Health (DOH), Managed Care Plans (MCP), CMAs, Local Department of Social Services/Government Units (LDSS-LGU), SPOAs, Voluntary Foster Care Agencies (VFCA), Schools, other Providers and the Health Home will identify individuals who may be eligible for Health Home Services, based on current relationships, Medicaid claims and encounter data.

B. Individuals will be assigned/referred to the Health Home through the Medicaid Analytics Performance Portal (MAPP) located in the NYS Health Commerce System (HCS).

C. The Health Home will receive and screen assignments/referrals from MAPP and community providers for individuals who may be eligible for Health Home Services.
   1. The MAPP will validate Medicaid status of those assignments/referrals entered through the portal.
   2. The Health Home will verify Medicaid enrollment status/eligibility, MCP enrollment and lack of existing Health Home assignment of all community referrals prior to assigning to a Care Management Agency (CMA).
      i. Those Candidates that meet all other eligibility requirements, and are eligible but are not currently enrolled in Medicaid, may be assigned to a CMA for assistance in renewing/enrolling for Medicaid benefits.

D. Upon assignment, the CMA will assess each Candidate/assigned member for Health Home eligibility prior to and/or during Outreach & Engagement activities.
   1. The CMA will screen and confirm the Candidates diagnoses that qualify them for Health Home Services:
      i. A diagnosis of **2 or more** qualifying chronic health conditions, defined as any of those included in the “Major” categories of the 3M Clinical Risk Groups (See attached);
         a) Documentation of chronic conditions as provided by health care providers. **or**
      ii. A single qualifying chronic condition:
         a) A diagnosis of Serious Mental Illness (SMI) **or**,
         b) Serious Emotional Disturbance (SED)*:
            1) Schizophrenia Spectrum and Other Psychotic Disorders;
            2) Bipolar and Related Disorders;
            3) Depressive Disorders;
            4) Anxiety Disorders;

5) Obsessive-Compulsive and Related Disorders;
6) Trauma-and Stressor-Related Disorders;
7) Dissociative Disorders;
8) Somatic Symptom and Related Disorders;
9) Feeding and Eating Disorders;
10) Gender Dysphoria;
11) Disruptive, Impulse-Control, and Conduct Disorders;
12) Personality Disorders;
13) Paraphilic Disorders;
14) ADHD for children who have utilized any of the following services in the past 3 years:
    i. Psychiatric Inpatient;
    ii. Residential Treatment Facility;
    iii. Day Treatment;
    iv. Community Residence;
    v. Mental Health HCBS & OCFS B2H Waiver;
    vi. OMH Targeted Case Management

c) **Or:** History of Complex Trauma (**See Complex Trauma Policy #27**);
d) **and/or** HIV/AIDS

iii. *To further meet the definition of SED, children must have experienced the following functional limitations over the past 12 months, or on a continuous intermittent basis. Limitations must be **moderate** in at least **two** of the areas, or **severe** in at least **one**:
   a) Ability to care for self (personal hygiene; obtaining and eating food; dressing; avoiding injury, **or;**
   b) Family Life: capacity to live in a family or family like environment; relationships with parents or caregivers, siblings and other relatives; behavior in family setting, **or;**
   c) Social Relationships: establishing and maintaining friendships; interpersonal interactions with peers, neighbors and other adults; social skills; compliance with social norms; play and appropriate use of leisure time, **or;**
   d) Self-Direction/Control: ability to sustain focused attention to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision making ability, **or;**
   e) Ability to learn: school achievement and attendance; receptive and expressive language; relationships with teachers; behavior at school.

iv. The CMA will utilize recent (if available) claims and encounter information via consent from PSYCKES, CONNECTIONS, CANS-NY and/or RHIOS to verify and document qualifying diagnoses and functional limitations.

a) If recent clinical, verifying data is unavailable, the CMA will ask Candidate/Family/Consenter to sign a Release of Information to contact service provider(s), and request medical records and/or assessments from Licensed Practitioners or trained professionals, verifying current qualifying diagnoses.
    1) CMAs will contact the Health Home for assistance in obtaining necessary documentation to verify diagnosis as needed.
b) The CMA will document diagnosis verification in a Care Management progress note, on the Health Home Initial Needs/Eligibility Assessment (See attached), and will update the eligibility section in Netsmart.
    1) All communication and efforts to verify diagnosis will be documented in the care management notes.
    2) All documents obtained to verify diagnosis will be scanned and attached to the record in Netsmart.

v. The CMA will complete an assessment for the presence of significant risk factors of medical, behavioral and/or social risks. This may include, but is not limited to:
    a) A probable risk for adverse events(e.g. death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement);
    b) Lack of or inadequate social/family/housing supports, or serious disruptions in family relationships;
    c) Lack of or inadequate connectivity to healthcare system;
    d) Difficulties with adhering to treatments and/or managing medications;
    e) Recent release from incarceration, detention, psychiatric hospitalization or placement;
    f) Difficulties/Deficits in activities of daily living skills;
    g) Learning or cognition issues; **OR**
    h) Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

vi. The Health Home/Care Management Program will document the presence of significant risk factors on the Health Home Initial Needs/Eligibility Assessment.

2. Care Management Supervisors will review and sign off on the Health Home Initial Needs/Eligibility Assessment to approve eligibility requirements.

E. Candidates/Families with immediate needs, or those in which verifying information is not readily available, will be assigned to Outreach/Care Manager, and billed at the Outreach & Engagement rate for up to 3 months, or until eligibility criteria has been verified and documented.

F. Health Home eligibility/appropriateness for Children will be reassessed quarterly during the quarterly Plan of Care review.

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1. Those Participants that are determined to not meet eligibility after enrollment will be dis-enrolled and referred to alternate Case Management services or SPOA based on need.