Bassett Healthcare Network
Community Health Navigation

Policy/Procedure:	Health Home Eligibility & Assessment
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I. Policy:

Bassett Community Health Navigation and Partnering Care Management Agencies will ensure potential enrollees' are screened for eligibility and appropriateness based on level of need for Medicaid Health Home Services prior to Health Home Enrollment, as well as throughout the Member's ongoing enrollment in the Program. In addition, Bassett Community Health Navigation and Partnering Care Management Agencies will also ensure Members being enrolled are assigned to a Care Management Agency and qualified staff who can provide the appropriate level and type of Care Management services required by the Member based on their specific eligibility and Care Management needs.

***CHN refers to Community Health Navigators & Partnering Health Home Care Managers**

QUALITY Management and Performance Improvement

Bassett Community Health Navigation and Partnering Care Management Agencies will review a selection of member cases each month for appropriate member attributions. Each case will be assessed for proper Health Home Eligibility Documentation and Health Home appropriateness. CMA's will be notified of any record found to not have adequate eligibility documentation on file and will be expected to resolve the error promptly. Failure to have proper Health Home eligibility documentation in the Care Management Record System may result in voided billing. (See Quality Assurance & Performance Improvement Policy & Medicaid Health Home Billing Policy)

II. Procedures:

A. Initial Eligibility & Enrollment

1. During the Outreach process, CHN must continue to gather information from available sources to make a determination of the Member's eligibility and appropriates for Health Home services and the level of service needed (High-Risk/HARP, HH+, etc.).

a. Individual agency or system specific consents may be necessary to gather information needed to make an appropriate determination for HH enrollment prior to completing DOH-5055

2. The following criteria must be met to be found eligible and appropriate for Health Home Services: (Must meet a., b., and c)

a. Has eligible Chronic Conditions (must meet one of the following categories i, ii or iii):

i. Two Chronic Medical Conditions (See Medicaid HH Eligibility document https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/health_home_chronic_conditions.pdf); **OR** ii. A Serious Mental Illness (must meet both of the following criteria for SMI):

1. Mental Health Diagnosis (one of the following diagnoses/categories):

i). Psychotic Disorders: F21, F22, F23, F20.81, F20.9, F25.0, F25.1, F06.2, F06.0, F06.1, F28, F29 ii). Bipolar Disorders: F31.11, F31.12, F31.14, F31.2, F31.73, F31.74, F31.9,

F31.0, F31.31, F31.32, F31.4, F31.5, F31.75, F31.76, F31.9, F31.81, F34.0, F06.33, F06.34, F31.89 iii). Obsessive-CompulsiveDisorders:F42

iv). Depression: F34.8, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F233.3, F33.41, F33.42, F33.9, F34.1, N94.3, F06.31, F06.32, F06.34, F32.8,F32.9, F34, F32.08

v). Anxiety Disorders: F41.9, F41.0, F41.1, F44.81, F40.0, F43.10

vi). Personality Disorders: F60.0, F60.1, F60.3, F60.04, F60.5, F60.6, F60.9, F60.81, F21

2. Functional Impairment as a result of their qualifying MH Diagnosis (One or more of the following):

i). Marked difficulties in self-care such as personal hygiene, diet, clothing, avoiding injuries, securing health care, or complying with medical advice; or ii). Marked restrictions of activities of daily living such as maintaining a residence, getting and maintaining a job, attending school, using transportation, day-to-day money management, or accessing community service; or iii). Marked difficulties in maintaining social functioning such as establishing and maintaining social relationships, interpersonal interactions with primary partners, children and other family members, friends, or neighbors, social skills, compliance with social norms, or appropriate use of leisure time; or

iv). Frequent deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner in work, home, or school setting.

v). Individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in task, or require assistance in the completion of tasks. **OR**

iii. HIV/AIDS

b. Also has one or more of the following Determinants of Risk (DOR):

i). Probable risk for adverse events (i.e.: death, disability, inpatient or nursing home admission, etc.)

ii). Lack of or inadequate social/family/housing support

iii). Lack of or inadequate connectivity with healthcare system

iv). Non-adherence to treatments or medication(s) or difficulty managing medications (define source)

v). Recent release from incarceration or psychiatric hospitalization

vi). Deficits in activities of daily living such as dressing or eating (should not be only on factor)

vii). Learning or cognition issues

c. Also has appropriate and identifiable level of need for Health Home Care Management services

Note: For additional examples see DOH September 2020 Supplement on HH Appropriateness: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh_appropriateness_criteria.pdf

3. Upon review of available information, CHN/CMA will make a determination of the Person's eligibility for HH Services and proceed as follows depending on the determination:

a. If the Person is found eligible and appropriate for Health Home services:

i. Complete the following documents:

a) DOH-5055: Health Home Patient Information Sharing Consent

Ensure the Person understands the purpose and scope of consent, and include the following on page 3, as applicable:

- Current Care Management Agency Name
- Managed Care Organization
- Local Department of Social Services (LDSS)
- Primary Care Provider
- Specialist Care Providers
- Mental Health Providers
- Local Hospital/ED Provider
- Pharmacy

- Involved Community & Social Service Resources

- Involved Family/Social Supports - If member wants to limit PHI to a specific person or provider, this must be clearly indicated on the form.

b) DOH-5234: Notice of Determination for Enrollment in NYS HH (page 1)
c) Bassett CHN - HIXNY Consent for Sharing of Information
d) Additional documents as applicable (Rights & Responsibilities, Contact Information for 24/7 Navigation, Agency-specific documents, etc.)

ii. Notify Referral Source of Health Home Enrollment

iii. Provide Member with a copy of DOH-5234 (in-person, by mail, or email within 5 days of Enrollment Date)

iv. Complete a Non-Billable Search Note in person's Care Management Record as follows within 3 days of Enrollment:

a) Select Client Search Status: "Enrolled"
b) Complete Note detailing the forms completed and provided to Member, eligibility documentation obtained to support HH eligibility, and any additional relevant information obtained for enrollment/needs/services/etc.

v. Upload the following completed documents to the Member's Record within 3 days of Enrollment:

a) Documentation supporting Health Home eligibility
b) DOH-5055 Consent
c) DOH-5234 Notice of Determination for Enrollment in NYS Health Home
d) HIXNY Consent
e) Additional documents as applicable (Rights & Responsibilities, Contact Information for 24/7 Navigation, Agency-specific documents, etc.) vi.

Enter/update information in the Member's Care Management Record as applicable:

a) Demographics Tab: as needed to correct/provide additional information
b) Program Tab: as needed to reflect the Member's level of service eligibility (HARP-enrolled or HH+ specific category)
c) Consents Tab: Enter Health Home consent (Bassett) and each Data Sharing Consent listed from 5055

b. <u>If Person IS NOT eligible or appropriate Health Home Services</u>, complete the following:

i. Notify the Person of the determination of ineligibility and provide information on other available services and resources which may be appropriate for the person's needs and assist with referrals as applicable.

ii. Notify Referral Source (if applicable) of Determination of Ineligibility iii. Complete the following documents:

a) DOH-5236 Notice of Determination for Denial of Enrollment in Health Home Form (page 1) iv. Provide Member with a copy of DOH-5236 (in-person, by mail, or email within 5 days of Determination of Ineligibility)

v. Complete a Non-Billable Search Note in person's Care Management Record as follows:

a) Select Client Search Status: "Client Opts-Out of HH Services, then select an "Ineligible" Reason which reflects the specific circumstances

b) Complete Note detailing the determination made, reason(s) for ineligibility, notifications/forms, and any referral information provided vi. Upload DOH-5236 and any documentation supporting ineligibility to the Member's Record

4. During Enrollment, CHN will consult with Supervisor/Team Leader as necessary to determine appropriate assignment of the Member to a CHN for ongoing Health Home Care Management services based on the following considerations:
   a. Availability in the CHN's current caseload
   b. The CHN's qualifications, training and experience with the enrolled member's health needs and characteristics, such as:
      i. Acuity of condition
      ii. Presence of co-occurring medical conditions
      iii. Patterns of acute service use iv. HARP or AOT/HH+ status
      v. Age 18-20 or presence of Developmental Disability diagnosis
         a) Requiring staff hired after April 1, 2018 to have Criminal History Record Check and Statewide Central Register Checks
      vi. Potential Conflicts of Interest
         a) A CHN cannot be the same as provider providing direct care services
         b) A CHN cannot assess persons for whom they have financial interest or other existing relationship that would be conflict of interest

B. Comprehensive Assessment

1. After Enrollment (completion/signing of DOH-5055), a Comprehensive Assessment must be completed for each Member within 60 days of Enrollment Date, based on all available information:
   a. Information from Medical Records/EHRs/RHIOs
   b. Contact with Providers, Social and Community Supports

c. Contact with Member utilizing Motivational Interviewing and Person-centered Discussion skills to obtain relevant information

2. Complete the following assessments in the Member's Care Management Record Assessments Tab (within 60 days of enrollment), to identify the person's Medical, Mental Health, Substance Abuse, HIV/AIDS, & Social Service needs, conditions, barriers, goals and preferences* **:
   a. Intake Assessment (Required for all HH Members)
   b. Comprehensive Assessment (Required for all HH Members)
   c. HIV Assessment (Required for all HH Members)
   d. Modified Mini Screen (For those not currently in any Mental Health treatment)
   e. CAGE-AID (For those currently using any non-prescribed substances)
   f. HCBS Eligibility Assessment (For HARP-enrolled Members only – See Requirements for HARP Members Policy for additional detail)
   g. SDOH assessment

*The Comprehensive Assessment process should be concurrent with the development of an Initial Care Plan (also due in 60 days). Information for assessments should be gathered as appropriate over the course of engagement and interaction and must include at least one face-to face meeting with the person. Interviews and completion of required documents may occur over the course of more than one meeting, at the discretion of CHN and/or based upon the needs of enrollee. Members and Providers shall be provided a copy of the Comprehensive Assessments based on Member Preference

**CMA Supervisor/Team Lead or Clinical Supervisor must review and approve Comprehensive Assessments completed for High-Risk Members/experiencing an adverse event, by completing a QA/Supervisory Note in the Member's Record

3. DOH-5055 Consent shall be updated and additional consents obtained as needed based on the information provided in Comprehensive Assessments

4. Upon completion of Comprehensive Assessments, all relevant information must be entered into the person's Care Management Record, as follows:
   a. Consent Forms
      i. Health Home Consent: Bassett Medical Center (If not already entered)
      ii. Data Sharing Consents:

- Each entity listed on the current DOH-5055 ○ Provider: All Providers/Clinics/Services: ○ Social Network Contacts: All social supports
- Electronic HIE Consent for HIXNY (If HIXNY Consent has been signed)

b. Programs (For HARP-eligible or HH+ only))
   i. H1-H8: HARP Enrolled
   ii. HH+: Select HH+ specific category of eligibility

c. Assessments
   i. Ensure all the following are entered and finalized:
   - Intake Assessment
   - Comprehensive Assessment
   - HIV Assessment
   - MMS/Modified Mini Screen (if applicable)
   - CAGE-AID (if applicable) ii. PAM-10 Score/Activation Level (if applicable)
   - SDOH (complete annually)

d. Problems (Identified from Medical Documentation and Comprehensive Assessment)
   i. Chronic Conditions & current health problems ii. All Needs/Barriers/Risk Factors identified in Comprehensive Assessments e. Care Coordination
   i. Social Supports (Those involved in Care Team/Care Plan)
   ii. Provider Referrals (Refer Problems to involved Providers, as applicable to identify what Provider/Service is currently addressing Problem)
   - Primary Care Provider
   - All Specialist Providers
   - All Community Agencies & Resources

** If the Member does not have Social Supports or needed Providers, ensure this is documented in Notes and identified as Barrier in the Member's Care Plan.

f. Notes: Enter Notes for all Contacts that occurred with Member and Care Team to obtain information and complete assessments, and provision of Comprehensive Assessments to Member and Care Team as requested by Member

C. Annual and As Needed Comprehensive Assessment Requirements

1. CHN must complete a new Bassett CHN Health Home Comprehensive Assessment annually (within 12 months of last occurrence), or as needed due to a significant change in condition(s)/care needs, to identify eligibility and care planning needs:

    a. Intake Assessment
    b. Comprehensive Assessment
    c. HIV Assessment
    d. Modified Mini Screen (Only if not currently receiving Mental Health services)
    e. CAGE-AID (Only if currently using substances)
    f. HCBS Eligibility Assessment (For HARP-enrolled Members only)
    g. SDOH (Social Determinates of Health)

*Care Plans must be updated concurrently with completed Annual and As Needed Comprehensive Assessments . In the case of a high-risk member, or if there is evidence of an adverse event, the care management supervisor must review and sign the assessment to ensure that proper steps are being taken to safeguard the member. In these cases, the Plan of Care should be reviewed to set forth goals to mitigate the identified risks.

D. Eligibility for Continued Health Home Enrollment

1. CHN must ensure that the Member continues to be eligible and appropriate for Medicaid Health Home services, and verify the following as necessary, at least annually:
    a. Member remains eligible for/enrolled in Medicaid
    b. Member continues to meet Chronic Health Condition eligibility
    c. Member continues to meet Risk Factor Eligibility

2. If at any time, it is determined that a Member no longer meets Medicaid Health Home eligibility requirements, CHN must disenroll the Member from Health Home services, as per Bassett CHN Transfer of Service & Disenrollment Policy.

Related Forms & Documents:

- ◊ **DOH-5059 Health Home Opt Out Form**
- ◊ **DOH-5055 Health Home Patient Information Sharing Consent**
- ◊ **DOH-5236 Notice of Determination for Health Home Enrollment**
- ◊ **DOH-5234 Notice**
- ◊ **DOH-5230 Functional Assessment Consent**
- ◊ **HIXNY Electronic Data Access Consent Form**
- ◊ **HIXNY Withdrawal of Consent**

- ◊ **Bassett CHN Member Rights and Responsibilities**
- ◊ **Bassett CHN Care Management Record Documentation Guide**
- ◊ **Bassett Appropriateness Criteria Checklist**