Bassett Healthcare Network
Community Health Navigation

Policy Title: Standards and Requirements for Referrals, Eligibility Verification, Outreach and Enrollment into Health Home Care Management Services

Policy Number: BCHN002

Original Date: 10/17/2022 **Last Revised:** 5/14/2024 **Effective Date:** 10/1/2026

Approved By: Miranda Blakeslee

Applicable to: Health Homes Serving Adults (HHSA)

Purpose: The purpose of this policy is to establish standards and procedures for the timely and appropriate management of referrals, eligibility verification, outreach, engagement, and enrollment of individuals into Health Home Care Management Services. Bassett Community Health Navigation Health Home (BCHNHH), as the Lead Health Home, will maintain processes to ensure that individuals referred for Health Home Care Management Services are appropriately reviewed, assigned, engaged, and enrolled in accordance with New York State Department of Health (NYS DOH) Health Home requirements.

This policy establishes requirements for receipt and review of Health Home referrals; referral assignment to Care Management Agencies (CMAs); verification of Medicaid eligibility and compatibility; verification of qualifying chronic condition(s); determination and documentation of Initial Appropriateness; outreach and engagement; Health Home consent and information sharing; enrollment and required documentation; referrals received from excluded settings; MAPP Health Home Tracking System (HHTS) requirements; and quality monitoring of referral, eligibility, outreach, and enrollment activities. Enrollment occurs only when the individual meets applicable eligibility requirements and voluntarily elects to participate in Health Home services.

Contents

Definitions

Health Home (HH): The Lead Health Home responsible for oversight of Health Home Care Management Services and its network of Care Management Agencies.

Care Management Agency (CMA): An entity contracted with the Lead Health Home to provide Health Home Care Management Services, including outreach, engagement, assessment, care planning, and ongoing care management.

Health Home Care Manager (HHCM)/Care Manager (CM): The individual responsible for performing Health Home Care Management activities on behalf of a CMA.

Individual/Member: For purposes of this policy, an individual or member includes the individual and, when applicable, the individual's parent, guardian, or legally authorized representative.

Community Referral: A referral to Health Home Care Management Services received from a source other than an excluded setting.

Excluded Setting: A setting that is not compatible with Health Home enrollment, including, but not limited to, nursing homes, inpatient settings such as psychiatric centers, institutions, and residential treatment settings.

Initial Appropriateness: The determination that the individual has significant behavioral, medical, physical, or social risk factors requiring the level of comprehensive care management provided through the Health Home Program.

MAPP HHTS: The Medicaid Analytics Performance Portal Health Home Tracking System used to manage Health Home referrals, assignments, enrollment segments, appropriateness reporting, and other Health Home program functions.

Policy

HH will maintain a standardized process for receiving, reviewing, assigning, and monitoring referrals for Health Home Care Management Services.

All referrals, regardless of referral source, must be reviewed to determine whether the individual may meet Health Home eligibility requirements and whether the individual is interested in receiving Health Home services.

An individual may not be enrolled in the Health Home Program unless all applicable eligibility requirements have been met and documented. Health Home eligibility requires:

- Active Medicaid coverage that is compatible with Health Home services and does not contain a disqualifying Restriction/Exception (R/E) code.
- Two qualifying chronic conditions or one applicable single qualifying condition.
- Initial Appropriateness demonstrating significant behavioral, medical, physical, or social risk requiring Health Home care management.

HH and its network CMAs are responsible for maintaining documentation supporting eligibility determinations. The Lead Health Home remains ultimately responsible for ensuring that only eligible individuals are enrolled and billed.

Health Home enrollment is voluntary. Appropriate Health Home consent must be obtained and maintained before enrollment and billing. Current NYS DOH consent and PHI requirements must be followed.

Outreach and engagement activities performed prior to enrollment are not reimbursable Health Home services. BCHN operational outreach standards may exceed NYS DOH minimum requirements and are identified as BCHN requirements within the Procedure section.

Individuals referred from excluded settings must be managed under applicable NYS DOH excluded-setting requirements and must not be handled solely under the standard community-referral process.

HH and its network CMAs will maintain a standardized enrollment process to ensure that individuals who meet Health Home eligibility requirements are appropriately engaged, informed of Health Home Care Management Services, and enrolled in accordance with NYS DOH requirements. Enrollment will include verification and documentation of Medicaid eligibility, qualifying condition(s), Initial Appropriateness, required Health Home consent, and other applicable enrollment requirements prior to billing.

Enrollment in Health Home Care Management Services is voluntary and must be based on the individual's informed agreement to participate. The Care Manager is responsible for completing the required enrollment activities and documentation, establishing the member's Health Home enrollment in the applicable systems, and transitioning the member into ongoing care management services. The HH will oversee the enrollment process to ensure compliance with applicable NYS DOH requirements, BCHN policies and procedures, and documentation standards.

Procedure

Referral Sources

BCHNHH may receive referrals from, but is not limited to, the following sources:

Hospitals and Medical Facilities

Hospitals, emergency departments, and other medical facilities may refer individuals who may be eligible for Health Home Care Management services.

The Lead Health Home may utilize available Emergency Department (ED) admission and discharge information, including applicable ED dashboards, to identify individuals who may be appropriate for Health Home Care Management referral and outreach.

When permitted by applicable information-sharing and confidentiality requirements, CMAs may contact providers who currently or previously served the individual within the past twelve (12) months to request assistance with outreach.

Providers may assist with outreach by explaining Health Home services to the individual, encouraging the individual to contact the CMA, or assisting in arranging communication or a meeting with CMA staff.

Information identifying an individual's participation in an OASAS-certified treatment program is protected under **42 CFR Part 2** and must not be disclosed or acknowledged in a manner prohibited by applicable requirements.

Partnering Care Management Agencies (CMAs)

Partnering CMAs may identify and refer individuals who may be appropriate for Health Home Care Management services.

CMAs must provide or obtain the information necessary to support referral review and outreach in accordance with BCHNHH requirements.

CMAs must comply with applicable privacy and confidentiality requirements when receiving, using, or sharing Protected Health Information (PHI) for referral, outreach, and enrollment activities.

Information identifying an individual's participation in an OASAS-certified treatment program must not be disclosed or acknowledged in violation of **42 CFR Part 2**, unless otherwise permitted or the required consent has been obtained.

Community-Based Organizations (CBOs)

CBOs may refer individuals who may be appropriate for Health Home Care Management services.

Referrals received from CBOs will be submitted to the Lead Health Home for tracking, review, and processing.

Medicaid Managed Care Organizations (MCOs)

MCOs may refer or assign individuals to Health Home services and may have information that can assist with Health Home outreach and enrollment.

Information that may be available to support outreach includes:

- Individual contact information, including address and telephone number.
- Prior Medicaid service-use information.
- Names and contact information for providers who previously treated or currently serve the individual and who may be able to assist with outreach.
- Primary care, mental health, hospital inpatient, and emergency department provider information, when available and permitted to be shared.

Information relating to an individual's participation in an OASAS-certified treatment program is subject to **42 CFR Part 2** and must not be accessed, disclosed, or acknowledged in a manner prohibited by those requirements.

Information sharing between MCOs, Health Homes, NYS DOH, and other participating entities must occur pursuant to applicable **Business Associate Agreements (BAAs), Data Exchange and Use Agreements (DEAAs), or other required agreements**.

Other Health Homes

Other Health Homes may refer individuals to BCHNHH when the individual may be appropriate for Health Home Care Management services.

Referrals involving an individual's transition between Health Homes must be processed in accordance with applicable Health Home requirements and Lead Health Home procedures.

State, County, and Community Referral Sources

- Single Point of Access (SPOA) Liaisons.
- Correctional facilities.
- Probation/parole.
- Mental health providers and systems.
- Addiction recovery providers and systems.
- Department of Social Services (DSS).
- Schools.
- Supportive housing providers and shelters.
- Family members.
- Self-referrals.
- Other authorized referral sources.

Excluded Settings

Excluded settings may refer individuals to BCHNHH prior to the individual's anticipated discharge. Referrals from excluded settings are subject to specific Health Home requirements related to discharge planning, eligibility, enrollment, documentation, and billing. The process for managing referrals received from excluded settings is addressed in the **Excluded Setting Referrals** section of this policy.

Referral Submission

BCHNHH will accept referrals through approved referral mechanisms. Referral processing requirements may vary based on the source and method of referral. The following referral processes apply:

Direct MAPP HHTS Referrals

Referrals received directly through the MAPP HHTS Referral Portal will be reviewed by the Lead Health Home for completeness, and available information necessary to determine eligibility considerations, and appropriate CMA assignment.

The Lead Health Home will review the referral, determine whether the individual may already be enrolled with another Health Home or CMA, identify potential eligibility or assignment barriers, and determine an appropriate CMA based on the information available at the time of referral.

Following acceptance and assignment, the referral and required member information will be transmitted through the designated Health Home information systems to the assigned CMA for processing as well as, Care Manager assignment.

Community/Bottom-Up Referrals

Community or "bottom-up" referrals received from community organizations, providers, individuals, family members, or other approved referral sources will be reviewed by BCHNHH to determine whether the referral contains sufficient information to initiate the referral and assignment process.

BCHNHH will review available information to identify the individual, assess potential Health Home eligibility, determine whether the individual is currently enrolled with another Health Home or CMA, identify potential barriers to enrollment, and determine an appropriate CMA for assignment.

When additional information is necessary to process the referral, BCHNHH will coordinate with the referral source, as appropriate, to obtain the information necessary to support timely processing and assignment.

Online Referrals

Online referrals submitted through a BCHNHH-approved referral mechanism will be reviewed by BCHNHH, and processed in accordance with the referral pathway applicable to the referral source.

The Lead Health Home will review the referral for completeness, eligibility information, existing Health Home enrollment, potential barriers, and appropriate CMA assignment. Once the referral is accepted for processing, the referral will be transmitted through the designated Health Home system, or secure process to the assigned CMA.

Paper, Fax, or Other Approved Referrals

Referrals received by paper, fax, secure email, or another BCHNHH-approved referral method will be reviewed and processed by BCHNHH in accordance with the requirements applicable to the referral source and referral type.

When a referral is received directly by a CMA rather than through the Lead Health Home, the CMA will follow BCHNHH procedures for notifying or transmitting the referral to the Lead Health Home, as applicable, to support appropriate review, assignment, and documentation.

Referral Processing Requirements

Regardless of the referral mechanism, BCHNHH will ensure that referral processing supports:

- Identification of the individual.
- Review of available eligibility information.
- Identification of existing Health Home or CMA enrollment.
- Identification of potential eligibility or enrollment barriers.
- Determination of appropriate CMA assignment.
- Documentation of referral disposition.
- Secure transmission of the referral and required information to the assigned CMA.
- Timely assignment and initiation of outreach in accordance with this policy.

System-specific instructions for MAPP HHTS, Netsmart, or other systems may be maintained in separate operational procedures or job aids. System workflows will be updated as necessary to reflect current system functionality and applicable requirements without requiring revision of this policy.

Determining Assignment Availability

Each month, the CMA will provide the Lead Health Home with its available assignment capacity, for the following month, **by the 25th day of the current month**. The CMA will indicate the number of referrals/members it has the capacity to accept for assignment during the following month.

Referrals received **after the 15th day of the month** that require assignment during the remainder of the current month will be coordinated with the CMA, to determine whether the CMA has sufficient capacity, and time to initiate and complete the required outreach activities within the applicable outreach timeframe.

The Lead Health Home will discuss the referral with the CMA Supervisor, or designated CMA contact to confirm whether the CMA can accept the referral for assignment during the current month. **The CMA will consider current caseload, staffing, planned leave, and other operational factors when determining whether they can complete the required outreach within the applicable timeframe.**

If the CMA confirms that they can complete the required outreach within the applicable timeframe, the referral may be assigned during the current month.

If the CMA determines that sufficient time is not available to appropriately initiate and complete the required outreach during the remainder of the current month, the HH may ask another CMA if they are able to accept assignment, or the assignment may be held until the following month. When assignment is held, the referral must be assigned and outreached no later than the 5th business day of that month. Any reason for holding the assignment or delaying outreach must be documented in accordance with the escalation, and documentation requirements.

Referral Review and Assignment

Upon receipt of a referral, BCHNHH will review available information to determine whether the individual may meet Health Home eligibility requirements, and whether assignment to a Care Management Agency (CMA) is appropriate.

The Lead Health Home will consider, as applicable:

- Medicaid status and compatibility.
- Restriction/Exception (R/E) codes.
- Potential qualifying condition(s).
- Existing Health Home enrollment.
- Known level of need or acuity.
- Health Home Plus (HH+) eligibility, when applicable.
- Specific qualifying conditions, service needs, or member characteristics that may require assignment to a specialized CMA.
- CMA capacity and staff qualifications.
- Specialized CMA capabilities.

- Other information necessary to support appropriate assignment.

When information necessary to support preliminary eligibility or appropriate assignment is not available, BCHNHH may request additional information or supporting documentation from the referral source, as appropriate, prior to assignment. Information received to support eligibility or assignment must be maintained in the member's care management record. The previous BCHN002 specifically allowed information from physicians, mental health providers, therapists, or other professionals with access to the individual's clinical history to be used to support preliminary eligibility, with supporting information retained in the record.

The Lead Health Home will assign eligible referrals to an appropriate CMA within **thirty (30) days of receipt of the referral**. **HH+ eligible members will be assigned to an appropriate CMA within seventy-two (72) hours of receipt by the Health Home.** Assignment will consider the individual's needs, referral characteristics, eligibility or risk level, specialized service needs, CMA capacity, and staff qualifications.

Once assigned to a CMA, the CMA will assign the individual to an appropriately qualified Care Manager based on the individual's needs, acuity, Care Manager experience, and relevant member characteristics. Assignment considerations may include, but are not limited to, the presence of co-occurring or co-morbid Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED), Substance Use Disorder (SUD), co-occurring medical conditions, patterns of acute service use, and other factors that may affect the individual's care management needs.

When a CMA provides both care management and direct services, the CMA must ensure that the individual providing Health Home care management is not the same individual providing the member's direct care services, and that the individuals are subject to different supervisory structures.

Health Home Care Managers must not assess or provide Health Home care management to an individual when the Care Manager has a financial interest or other existing relationship that presents a conflict of interest or could impair the Care Manager's ability to provide services objectively.

Members must be provided a choice of available providers consistent with applicable Health Home and managed care requirements. The member's provider selection must be documented in the member's care plan or other required record.

When an assignment or required activity cannot be completed within an established timeframe, the reason for the delay must be documented and the applicable escalation and corrective-action process followed.

Excluded Setting Referrals

A referral from an excluded setting must be managed in accordance with applicable NYS DOH excluded-setting requirements. A referral may be received **prior to the individual's anticipated discharge date**.

For a **newly referred individual who is in an excluded setting**, the Care Manager will, as applicable:

- Coordinate with discharge-planning staff.
- Confirm or establish the anticipated discharge date.
- Participate in discharge-planning activities appropriate to the Health Home role.
- Discuss post-discharge needs and transition requirements.
- Verify Health Home eligibility and document supporting evidence.
- Verify HCBS eligibility, when applicable, and document supporting evidence.
- Obtain the required Health Home consent.
- Coordinate a transition/warm handoff into community-based Health Home care management.

Health Home care management activities related to discharge planning **must not duplicate the excluded setting's usual discharge-planning activities**.

NYS DOH limits reimbursement for qualifying care management activities related to discharge planning to the **thirty (30) days immediately preceding discharge**, when applicable, and permits **one billing instance** for qualifying activities performed while the individual remains in the excluded setting awaiting discharge.

Allowable care management activities may include face-to-face contact with the individual; coordination directly with staff of the excluded setting; confirmation of the anticipated discharge date; participation in discharge-planning meetings; discussion of post-discharge needs; verification of Health Home or HCBS eligibility; obtaining required Health Home consent; and other activities permitted under applicable excluded-setting requirements.

The CMA/Care Manager must maintain documentation sufficient to support all activities performed and any associated billing. Documentation must include, as applicable, evidence of the individual's Health Home or HCBS eligibility, the activities performed, the anticipated or actual discharge information, and the required completed and signed Health Home consent.

If the individual's **discharge is delayed or circumstances change**, staff must follow current NYS DOH excluded-setting guidance to determine the appropriate timing and requirements for continued care management activities, billing, and enrollment. Staff must not assume that the original discharge date or applicable timeframe remains unchanged.

An individual who is **already enrolled in Health Home Care Management and subsequently enters an excluded setting** must be managed under the applicable continuity-of-care and re-engagement requirements and is not considered a newly referred individual under this pathway.

Eligibility Verification

Eligibility verification is a three-step process. Each required element must be verified and documented in the member's record before enrollment.

Step One – Medicaid Eligibility

The Care Manager must verify that the individual has active Medicaid coverage that is compatible with Health Home services, and does not contain a disqualifying Restriction/Exception (R/E) code.

Medicaid eligibility must be verified at the time of enrollment and monitored thereafter as Medicaid eligibility may change. Verification must occur prior to service provision in accordance with current NYS DOH requirements.

The Care Manager must document Medicaid eligibility verification in the designated BCHN/CMA record and address identified coverage barriers before enrollment or billing, as applicable.

Step Two – Qualifying Condition(s)

The individual must have either two qualifying chronic conditions or one applicable single qualifying condition. For Health Homes Serving Adults, applicable single qualifying conditions include; HIV/AIDS, Serious Mental Illness (SMI), and Sickle Cell Disease.

Qualifying condition(s) must be supported by documentation maintained in the member's record. Acceptable sources may include MCO information, referral information, medical records, medical assessments, written verification from a treating healthcare provider, RHIO, or PSYCKES, as applicable.

The Care Manager must use the current NYS DOH Health Home Program chronic condition guidance and other applicable state resources when determining whether a condition meets Health Home qualifying criteria.

Refer to Attachment A – SMI Qualifying Diagnosis, for more information on F-codes that qualify under SMI.

Step Three – Initial Appropriateness

The Care Manager must determine whether the individual has significant behavioral, medical, physical, or social risk factors that require the comprehensive care management services provided through the Health Home Program.

The selected Initial Appropriateness risk factor must be supported by documentation in the member's record, and must demonstrate the need for Health Home care management.

If an individual meets multiple appropriateness criteria, the criterion selected for reporting must reflect the significant risk that supports the care management activities to be addressed, and is important to the member.

Refer to Attachment B – Initial Appropriateness Assessment Tool

Initial Appropriateness Reporting

The Care Manager must complete the Initial Appropriateness determination and select the significant risk factor that most appropriately supports the individual's need for Health Home care management. The selected risk factor must be supported by documentation in the member's record. When multiple criteria apply, the criterion selected for reporting should reflect the significant risk that supports the individual's enrollment and the care management needs to be addressed with the member.

For all enrolled individuals, Initial Appropriateness must be documented in the individuals record **within twenty-eight (28) days of signed consent**. The Health Home will upload to the MAPP HHTS through the required process and monitor failure to complete the required reporting within the applicable timeframe may result in MAPP HHTS preventing billing for the member. Staff must monitor the reporting timeframe and promptly address rejected or incomplete submissions.

The Initial Appropriateness questions and criteria are provided in Attachment B – Initial Appropriateness Questions and Criteria. Care Managers must use the attachment as a reference when completing the Initial Appropriateness determination and must maintain supporting documentation in the member's care management record.

The Comprehensive Assessment and person-centered care planning process may be used to support the determination of appropriateness in accordance with **BCHN013: Standards of the Comprehensive Assessment and Practice of Person-Centered Care**.

Outreach and Engagement

Once a referral has been assigned to a CMA, the assigned Care Manager will initiate and document outreach in accordance with BCHN operational outreach standards.

Outreach will continue for two consecutive months unless the individual is successfully engaged, declines services, is determined to be ineligible, or another appropriate referral disposition is reached.

Month 1 – Initial Outreach

1. The Care Manager must initiate the first outreach attempt **within forty-eight (48) hours of assignment**.
2. The Care Manager must document each outreach attempt in the member's care management record, including:
   a. Date of contact;
   b. Method of contact;
   c. Outcome;
   d. Barriers to engagement; and
   e. Applicable referral/client-search status update, when required.
3. If the initial outreach attempt does not result in successful contact, or scheduling of an intake, the Care Manager must make, **two additional outreach attempts during Month 1 using at least two different methods of contact**.
4. Outreach methods may include; telephone calls, face-to-face visits, mailed correspondence, and email when an email address is available.
5. When a mailed letter is used, the letter must be uploaded to the applicable document section, and an associated note entered in the member's care management record.
6. During Month 1, the Care Manager will communicate with the referral source, when appropriate and consistent with applicable privacy and information-

sharing requirements, to confirm receipt of the referral and provide an update regarding outreach progress and potential enrollment.

Month 2 – Continued Outreach

If the individual has not been successfully reached or engaged during Month 1, the Care Manager will continue outreach during Month 2.

During Month 2, the Care Manager must:

1. Make **at least three (3) outreach contacts**; and
2. Use **at least two (2) different methods of contact**.

All Month 2 outreach attempts, outcomes, barriers, and responses must be documented in the member's care management record.

The Care Manager will communicate with the referral source, when appropriate, and consistent with applicable privacy and information-sharing requirements, regarding outreach progress and potential enrollment.

Successful Contact and Engagement

When the Care Manager successfully contacts the individual, the Care Manager will:

1. Explain Health Home Care Management Services;
2. Answer questions and provide information necessary for the individual to make an informed decision regarding participation;
3. Determine whether the individual is interested in receiving Health Home Care Management Services; and
4. Document the individual's response in the member's care management record.

If the individual declines services, the Care Manager will document the individual's decision and the reason for declining, when provided, and complete the applicable referral disposition.

If the individual agrees to participate, the Care Manager will schedule an intake meeting, document the scheduled intake, and proceed to the **Intake, Enrollment, and Eligibility Verification** process.

Completion of Outreach

Outreach is considered complete when:

- The individual is successfully engaged and proceeds to intake/enrollment;
- The individual declines Health Home Care Management Services;
- The individual is determined to be ineligible for Health Home services;
- The individual cannot be engaged after completion of the required BCHN outreach process; or
- Another appropriate referral disposition is identified and documented.

The Care Manager must document the final referral disposition, and the activities supporting that disposition in the member's care management record.

BCHN outreach timeframes, and contact-attempt requirements are operational standards, and are not NYS DOH reimbursement requirements. Outreach and engagement activities performed prior to enrollment are not reimbursable Health Home services.

PHI and Information Sharing During Outreach

BCHNHH and CMA staff must comply with applicable Federal and New York State confidentiality, privacy, and information-sharing requirements during referral, outreach, engagement, and enrollment activities.

Information shared during outreach and engagement must be limited to information permitted for the applicable purpose and must comply with current NYS DOH requirements regarding Health Home outreach, consent, and Protected Health Information (PHI).

Information protected under **42 CFR Part 2** must not be disclosed except as permitted by applicable law and authorization. Staff must not acknowledge an individual's participation in an OASAS-certified substance use disorder treatment program when such disclosure is prohibited.

Once an individual is enrolled, information sharing must be consistent with the member's current Health Home consent and applicable privacy requirements.

Staff must refer to **BCHN009: Use of Health Home Consents and the Provision of Access and Sharing of Member's Personal Health Information (PHI)** and current NYS DOH consent and PHI guidance for detailed requirements.

Enrollment Requirements

The Care Manager will complete the intake and enrollment process in accordance with BCHN requirements for eligibility verification, consent, assessment, person-centered care planning, and documentation.

Verify Medicaid Eligibility

Prior to enrollment, the Care Manager must verify that the individual's Medicaid coverage is active and compatible with Health Home services and that there are no applicable Restriction/Exception (R/E) codes that would prevent enrollment.

The Care Manager must document Medicaid eligibility verification in the **Bassett Medicaid Check** within the Care Management Record.

Because Medicaid eligibility may change, the Care Manager must monitor the individual's Medicaid status at least monthly throughout outreach, and for the duration of enrollment, and document the required verification in accordance with BCHN procedures.

Complete the Intake

The Care Manager will meet with the individual to complete the intake for Health Home Care Management Services.

CMA's must maintain policies and procedures addressing Care Manager safety and the environmental requirements applicable to conducting member meetings.

Intake must include, but is not limited to:

- **DOH-5055 Patient Information Sharing Consent.** Staff must follow BCHN009, *Use of Health Home Consents and the Provision of Access to and Sharing of Member's Personal Health Information (PHI) Policy*, for completion and use of the DOH-5055.
- **RHIO consents**, when additional RHIOs are utilized beyond those identified on the DOH-5055.
- **Rights and Responsibilities.**
- Required demographic and identifying information.
- Other enrollment documentation required by BCHN and NYS DOH.

At intake, the Care Manager should begin the **Comprehensive Assessment**, when appropriate. A face-to-face contact is required during completion of the member's first assessment. Staff must follow BCHN013, *Standards of the Comprehensive Assessment and Practice of Person-Centered Care*, for assessment and person-centered care planning requirements.

Verify Health Home Eligibility

Following the intake, the Care Manager must verify and document the individual's eligibility for Health Home Care Management Services, including:

- Active Medicaid coverage compatible with Health Home services; and
- One applicable **single qualifying condition**, when applicable; or
- **Two qualifying chronic conditions**.

Substance Use Disorders (SUDs) are considered chronic conditions but do not, by themselves, qualify an individual for Health Home services. An individual with SUD must have another qualifying chronic condition or applicable single qualifying condition to meet Health Home eligibility requirements.

The Care Manager must maintain documentation supporting the individual's qualifying condition(s) and other applicable eligibility factors in the Care Management Record.

Information supporting a qualifying condition may be obtained from appropriate sources, including:

- Health Home or MCO referrals;
- Medical records or assessments;
- Written verification from the individual's physician or treating healthcare provider;
- Regional Health Information Organization (RHIO);
- Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES); or
- Other sources permitted by current NYS DOH requirements.

For SMI eligibility, the Care Manager must use **Attachment A – SMI Qualifying Diagnoses and Criteria** and applicable current NYS DOH guidance to verify the qualifying diagnosis and associated requirements.

Determine Initial Appropriateness

The Care Manager must determine and document the individual's **Initial Appropriateness** for Health Home services using the criteria in **Attachment B – Initial Appropriateness Questions and Criteria**.

Initial Appropriateness must be determined for individuals referred through the MAPP HHTS Referral Portal as well as individuals referred through community or other referral pathways.

The selected Initial Appropriateness criterion must be supported by documentation in the member's record and demonstrate the individual's need for comprehensive Health Home care management.

Initial Appropriateness reporting must be completed in accordance with the requirements described in the **Initial Appropriateness Reporting** section of this policy.

Complete Enrollment Documentation and MAPP HHTS Activities

The Care Manager must ensure that required eligibility, consent, assessment, and enrollment documentation is complete and maintained in the Care Management Record before the individual is enrolled and submitted for Health Home billing, except where a specific NYS DOH requirement or exception applies.

The Care Manager must update the member's demographics, programs, consents, care team, and other required information in the designated Care Management Record.

The Lead Health Home will complete applicable MAPP HHTS enrollment and reporting activities within the required timeframes.

When required, the appropriate **Notice of Determination** and related enrollment notification must be completed in accordance with current NYS DOH requirements.

Referral Source Notification

The referral source must be identified on the DOH-5055 when applicable.

Following successful enrollment, the referral source will be notified in accordance with BCHN procedures and applicable information-sharing requirements.

Court-Ordered Assisted Outpatient Treatment (AOT)

For individuals subject to a court-ordered Assisted Outpatient Treatment (AOT) order, Health Home enrollment may proceed pursuant to the applicable court order and NYS AOT requirements. The absence of voluntary consent or refusal to participate does not, by itself, prevent enrollment when the individual has been appropriately referred and meets applicable Health Home eligibility requirements.

The Care Manager must document the AOT order, applicable referral and enrollment requirements, eligibility determination, and any required authorizations or consents in the member's Care Management Record. Staff

must follow current NYS DOH and AOT requirements regarding information sharing, enrollment, engagement, and service delivery.

Documentation Requirements

The Care Manager and CMA must maintain a complete and accessible record of the referral, outreach, eligibility verification, intake, and enrollment activities performed for each individual. **Required documentation must be entered into the member's Care Management Record, and/or uploaded to the designated document section of the record, as applicable, so that the documentation is available for review, monitoring, quality assurance, and audit.**

Documentation must be completed contemporaneously with the activity whenever practicable and must accurately reflect the activity performed, information obtained, determination made, and outcome.

The member's Care Management Record must contain, as applicable:

- **Referral documentation**, including the referral source, date received, referral information, and supporting documentation received with or obtained in connection with the referral.
- **Assignment documentation**, including the CMA assignment and applicable Care Manager assignment.
- **Medicaid eligibility verification**, including documentation of the required Medicaid check and any identified Restriction/Exception (R/E) codes or other eligibility barriers.
- **Qualifying condition documentation**, including documentation supporting the individual's qualifying chronic condition(s) or applicable single qualifying condition. Supporting documentation obtained from a referral source, provider, MCO, medical record, RHIO, PSYCKES, or other permitted source must be maintained in the member's record.
- **Initial Appropriateness documentation**, including the assessment of significant risk factors, the criterion selected, supporting documentation, and required MAPP HHTS reporting.
- **Outreach documentation**, including each required outreach attempt, date, method, outcome, barriers to engagement, and other information necessary to demonstrate compliance with BCHN outreach standards. Mailed correspondence or other supporting outreach documentation must be uploaded to the member's record when applicable.
- **Documentation of successful engagement**, including the information provided to the individual regarding Health Home Care Management Services and the individual's interest in or decision regarding participation.
- **Documentation of declination**, when applicable, including the individual's decision not to participate and the reason when provided.
- **Intake and enrollment documentation**, including the completed **DOH-5055 Patient Information Sharing Consent**, applicable RHIO consents, Rights and Responsibilities, required demographic information, and other required enrollment documentation.
- **Eligibility verification documentation**, sufficient to demonstrate that all applicable Health Home enrollment requirements were verified before enrollment and billing.
- **Assessment and person-centered care planning documentation**, in accordance with BCHN013 and other applicable BCHN requirements.

- **MAPP HHTS enrollment and reporting documentation**, as applicable, including documentation necessary to support the member's enrollment status and required reporting.
- **Excluded-setting documentation**, when applicable, including documentation supporting discharge planning activities, eligibility, consent, anticipated discharge, and transition activities.
- **Referral disposition**, documenting the final outcome of the referral, including enrollment, declination, inability to engage after completion of required outreach, ineligibility, referral to another resource, or other applicable disposition.

Documentation must be sufficient for BCHNHH, the CMA, and authorized reviewers to **reconstruct the referral-to-enrollment process and verify that required activities occurred within the applicable timeframes**.

Where a required document is maintained outside the Care Management Record, the member's record must contain the applicable documentation, reference, or other evidence necessary to demonstrate that the requirement was completed and to allow the documentation to be located and accessed in accordance with BCHN procedures.

Training

BCHNHH will ensure that Health Home and CMA staff whose responsibilities include referral review, assignment, outreach, eligibility verification, engagement, intake, or enrollment receive training necessary to perform the requirements of this policy.

Training will address the processes and requirements applicable to the staff member's role, including, as applicable:

- **Referral and Assignment:** Referral sources, referral submission and receipt, referral review, assignment requirements, CMA availability, and applicable assignment timeframes.
- **Medicaid Eligibility:** Medicaid eligibility and compatibility requirements, Restriction/Exception (R/E) codes, required verification processes, and documentation requirements.
- **Qualifying Conditions:** Health Home qualifying condition requirements, acceptable sources of verification, and use of current NYS DOH qualifying-condition guidance.
- **Initial Appropriateness:** Initial Appropriateness criteria, use of **Attachment B – Initial Appropriateness Assessment Tool**, required supporting documentation, selection of the appropriate risk factor, and applicable reporting requirements.
- **Outreach and Engagement:** BCHN outreach standards, required outreach timeframes and attempts, communication methods, documentation of outreach activity and outcomes, member engagement, and referral disposition.
- **Excluded-Setting Referrals:** Requirements for newly referred individuals from excluded settings, including coordination with discharge-planning staff, eligibility verification, consent, documentation, and transition activities.
- **Enrollment and Intake:** Required intake activities, Health Home consent, Rights and Responsibilities, demographic information, assessment requirements, eligibility verification, and enrollment documentation.
- **PHI and Information Sharing:** Requirements for the use, disclosure, and protection of member information during referral, outreach, engagement, intake, and enrollment, including requirements addressed in BCHN009.

- **MAPP HHTS:** Applicable MAPP HHTS referral, assignment, enrollment, Initial Appropriateness reporting, status, segment, and upload requirements.
- **Documentation:** Requirements for maintaining complete, accurate, contemporaneous, and accessible documentation in the member's Care Management Record, including documentation necessary to demonstrate compliance with this policy.

Training will be provided **prior to or upon implementation of this policy for applicable staff** and thereafter when necessary to address changes in NYS DOH requirements, BCHN policy or procedures, MAPP HHTS functionality, identified quality or compliance issues, or other operational changes.

BCHNHH may provide periodic refresher training when needed to maintain staff competency and consistent application of the requirements established in this policy.

At implementation, BCHNHH will distribute this policy to applicable CMA staff for review and acknowledgement/attestation in accordance with BCHN requirements. Documentation of required training and attestations will be maintained in accordance with BCHN's applicable training and personnel documentation requirements.

Quality Monitoring

BCHNHH will monitor the effectiveness and compliance of the referral, eligibility verification, outreach, and enrollment processes through the BCHN Quality Management Program and in accordance with **BCHN011: Health Home Quality Assurance & Performance Program**.

Quality monitoring will include review of a representative sample of referrals and/or other monitoring activities to identify whether established processes are being followed and whether required activities are occurring within applicable timeframes.

Monitoring activities may evaluate:

- **Timeliness of the referral-to-enrollment process**, including identification of delays or barriers that may affect timely assignment, outreach, eligibility verification, or enrollment.
- **Referral and enrollment outcomes**, including patterns in successful enrollment, declination, inability to engage, ineligibility, and other referral dispositions.
- **Eligibility and appropriateness determinations**, including whether determinations are supported by appropriate documentation.
- **Outreach and engagement practices**, including patterns indicating missed outreach requirements or barriers to successful engagement.
- **Documentation practices**, including whether required information is present, complete, accurate, and accessible in the member's Care Management Record.
- **MAPP HHTS activity**, when applicable, to identify patterns of inaccurate, incomplete, rejected, or untimely reporting.
- **Excluded-setting referrals**, including whether referrals from excluded settings are being managed in accordance with the requirements established in this policy.
- **Recurring or systemic issues** affecting referral processing, outreach, eligibility verification, enrollment, or documentation.

BCHNHH will evaluate identified findings and trends to determine whether **corrective action, targeted education, workflow modification, additional monitoring, or other quality improvement activities** are necessary.

Quality monitoring findings and corrective actions will be managed in accordance with **BCHN011 and the BCHN Quality Management Program**.

Supporting Policies and Resources

The following policies, procedures, guidance documents, forms, tools, and resources support implementation of this policy. Staff must refer to the current controlled version of applicable documents when completing referral, eligibility, outreach, intake, and enrollment activities.

NYS Department of Health (NYS DOH) Policies and Resources

- **NYS DOH HH0016 – Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program.**
- **NYS DOH HH0011 – Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings.**
- **NYS DOH HH0009 – Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents.**
- **NYS DOH HH0002 – Health Home Comprehensive Assessment Requirements.**
- **NYS DOH Guide to Coverage Codes and Health Home Services.**
- **NYS DOH Guide to Restriction/Exception (R/E) Codes and Health Home Services.**
- **NYS DOH Health Home Program Chronic Condition Update with Developmental Disabilities Conditions.**
- **NYS DOH Appropriateness Criteria and Codes and applicable current appropriateness criteria resources.**
- **NYS DOH MAPP HHTS resources and current system guidance.**
- **NYS DOH Health Home Plus (HH+) Program Guidance**, when applicable.

BCHN Policies and Procedures

- **BCHN009 – Use of Health Home Consents and the Provision of Access and Sharing of Member's Personal Health Information (PHI).**
- **BCHN011 – Health Home Quality Assurance & Performance Program.**
- **BCHN013 – Standards of the Comprehensive Assessment and Practice of Person-Centered Care.**
- **BCHN Intake Checklist.**
- **BCHN CMA Assignment Workflow.**
- **BCHN CMA Bandwidth/Assignment Capacity Process.**

BCHN Attachments and Operational Tools

- **Attachment A – SMI Qualifying Diagnosis Reference.**
- **Attachment B – Initial Appropriateness Assessment Tool.**