Bassett Healthcare Network
Community Health Navigation

Policy Title: **Standards and Requirements for Referrals, Eligibility Verification, Outreach and Enrollment into Health Home Care Management Services**	**DOH Policy Name:** ➢ **Health Homes, Health Home Care Management Agencies, and Medicaid Managed Care Plans** ➢ **Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings** ➢ **Eligibility Requirements: Identifying Potential Members for Health Home Services** ➢ **Guidance to Managed Care Organizations, Health Homes, Care Management Agencies, and Providers: Sharing Protected Health Information for Outreach to support Enrollment of Individuals in Health Homes** **DOH Reference Number: HH0011/HH0016** **Effective Date:** ➢ **07/01/2020** ➢ **02/21/2020** ➢ **03/2022**
Policy Number: BCHN002	**QMP Review Date: 5/15/2024**
Original Date: 10/17/2022 **Revision Date: 7/24/2023, 11/17/2023, 5/14/2023** **Date of Issue: 08/21/2023, 11/20/2023, 5/17/2024**	**Created by: Kali Angell** **Approved by: Miranda Blakeslee**

POLICY STATEMENT

Bassett Community Health Navigation Health Home (BCHNHH) as the lead Health Home will provide policy to ensure timely access to quality Care Management Services for eligible individuals within the HHs service area in compliance with NYS DOH Medicaid Health Home Statewide Policy Guidance. BCHNHH will serve as the single point of contact for managing referrals and assignment to qualified Care Management Agency (CMA) providers to continue Outreach and Engagement, Assessment, and Enrollment of persons eligible for care management services.

SCOPE

Individuals may be referred to Health Homes (HH) from providers or other entities, including Medicaid Managed Care Organizations (MCO), physicians and other healthcare and behavior health providers, emergency departments, schools, community-based providers, criminal justice, supportive housing providers, shelters, family members, self-referrals, and so forth. These referrals are known as community referrals. Regardless of referral source, the eligibility of the individual and their interest in HH enrollment must be verified.

CMAs, HHs must routinely conduct a review of their enrolled Health Home members to determine whether the need and eligibility criteria exists for continued Health Home Program level of care management. Members who are no longer eligible or appropriate for Health Home services must be stepped down to a lower intensity care coordination service, such as their MCO, a Managed Long-term Care (MLTC) Plan, Patient-Centered Medical Home (PCMH), or family/natural supports.

When the HH receives a referral of an individual for HH Care Management services the HH will utilize resources and the referral source to assist in confirming eligibility for service provision prior to assignment to a CMA. When a CMA/CM receives a referral of an individual the CM must initiate appropriate outreach activities to engage the member in services. In cases where a member is referred from an excluded setting it is imperative that the CMA/CM follow specific activities of collaboration and engagement to enroll the member. Prior to enrollment the CM must further verify eligibility, complete necessary outreach, required documentation, assessment, and planning for enrollment.

OBJECTIVES

This policy outlines the steps that must be taken to ensure every individual meets the required eligibility criteria needed to support HH enrollment and continued enrollment in the HH program.

This policy outlines the process when an individual in an excluded setting is newly referred to the HH program for enrollment, it is important for the assigned CMA/CM to appropriately enroll the member into care management services, connect with the discharge planning staff to discuss the needs of the individual, discharge date, and HH and HCBS eligibility.

HH's, MCO's, and network care management partners should have policies and procedures that document the responsibilities for establishing and verifying diagnostic eligibility and need criteria, but the Medicaid biller remains ultimately responsible. As described in the New York State Plan Amendment (SPA) recent claims and/or encounter data or other clinical data should be used to verify medical and psychiatric diagnoses. It is expected that documentation of Medicaid eligibility, diagnostic eligibility, and risk assessment be maintained as defined by agreements between the Managed Care Organization, the Health Home, and the network care management agency.

DEFINITIONS

Excluded settings
For the purpose of this policy, excluded settings are those not compatible with Health Home or HCBS enrollment. Examples of excluded settings include but not limited to: nursing homes, inpatient settings such as psychiatric centers; institutions, residential facilities (RTC, RTF). Please refer to the Guide to Restriction Exception (RE) Codes and Health Home Services for a description. For HCBS there are specific allowable settings for the services to be provided which can be found in the HCBS Settings Rule.

Individual or Member
For the purpose of this policy, when individual or member is used, it includes the individual (adult, child/youth), parent(s), guardian, or legally authorized representative as applicable to the situation.

ROLES AND RESPONSIBILITIES

Health Home Administration
It is the HH Administrations responsibility to ensure guidance and resources are provided to allow partnering CMA's to appropriately and accurately enroll members eligible for the HH Program. Once enrolled it is the Lead HH responsibility to complete quality reviews to ensure the appropriateness of enrolled members and submit billing for partners.

CMA Supervisor
It is the role of the Supervisor to ensure the HH is aware of the CMA's monthly availability, and member assignment is appropriate. Provide staff with guidance on outreach procedures and ensure that outreach and potential enrollments are being properly completed.

Care Manager
It is the responsibility of the Care Manager to review and follow the provided policy and procedure. It is the responsibility of the CM to ensure that the appropriate documents are uploaded. The CM is essential in the process of outreach to enrollment of members into the Health Home Care Management program as they complete the tasks to complete the process of helping members enroll in the program.

PROCEDURES

Determining Assignment Availability

Each month downstream partners will indicate the number of referrals they are able to receive prior to the 15th business day of the month.

1. Partners will email the lead HH of availability by the 25th business day of the current month to indicate their availability for the following month. Partners will remain in direct contact with the lead HH throughout the month.

Referrals that require immediate assignment after the 15th business day of the month will require the lead HH to reach out to the CMA Supervisor prior to assigning the referral to ensure bandwidth for completion of outreach and assignment.

1. An assignment made on/after the 16th of the month requires outreach to begin immediately. If outreach cannot be initiated until the following month assignment will be held until the following month to provide an entire month of outreach. Outreach must begin no later than the 5th business day of the following month.
2. Documentation from CMAs regarding failure to commence outreach activities within these timeframes, is required. Such documentation shall state the reasons for not meeting such timeframes and shall propose a corrective action plan.

The lead HH will assign members within 30 days of receiving the referral.

1. HH+ eligible members will be assigned to a CMA within 72 hours of retrieval by the HH.

If bandwidth is not available the lead HH will determine a resolution.

Referral Sources

The lead HH receives referrals from many sources, including but not limited to:

1. Hospitals/Medical Facilities
   a) In alignment with the Executive Order DHDTC DAL 17-04 distributed on February 15, 2017, the Health Home State Plan Amendment (SPA) SPA #NY-15-0020 and the Centers for Medicare and Medicaid Services (CMS) state “that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Home providers.”
   b) The Lead HH works with the Bassett Medical Center to review the Emergency Department (ED) Admissions and Discharge Dashboards. The lead HH utilizes the ED dashboards to refer eligible individuals for HH Care Management services.
   c) CMAs may contact providers who currently or previously (in the past 12 months) served individuals to ask for assistance with outreach, excluding OASAS-certified provider information which is protected from being shared under 42 CFR Part 2, and prevents acknowledgement by providers of an individual’s participation in the program. CMAs and providers may wish to share contact information and/or prior service use information they have available as part of their joint effort to engage the potential enrollee. CMAs may request that the provider explain the Health Home service to the potential enrollee and either ask the enrollee to contact the CMA staff or help arrange a meeting between the individual and the CMA staff.
2. Partnering CMAs
   a) The Lead HH contracts Care Management Agencies to conduct its outreach activities, and to provide care management services to enrollees. The CMA should require the same information for outreach that is required by the Health Homes. PHI relating to identification of an individual participating in an OASAS-certified treatment program must not be disclosed in any form relating to previous Medicaid service use, unless patient consent is received.

3. Community Based Organizations (CBO)
4. Managed Care Organizations (MCO)
    a) MCOs are responsible for assigning individuals to specific HHs and often have information on recent service use that can guide HH Outreach. MCOs may have additional information in their administrative records that can assist Health Home outreach and enrollment. Information that can be shared with the lead Health Home agency includes:
        i) Contact information including address and phone numbers
    b) Prior Medicaid service use data including names and contact information for providers who previously treated the individual and who the MCO believes may be able to assist Health Home outreach. This may include Primary Care Providers, mental health providers, and hospital inpatient and/or emergency department providers. However, under 42 CFR Part 2, OASAS-certified providers may not acknowledge an individual's participation in an alcoholism or substance abuse program, so access to this information is not allowable.
    c) DOH has BAA and or DEAA with MCOs and HHS. These agreements permit DOH to share information with the MCOs and HHs. In order for the MCO to share information with the HH, the MCO must have similar agreement(s) with the Health Home.
5. Other Health Homes
    a) State and County governmental services
    b) Single Point of Access (SPOA) Liaison
    c) Correctional Facilities
    d) Probation/Parole
    e) Mental Health
    f) Addiction Recovery
    g) Department of Social Services
6. Excluded Settings
    a) A referral from an excluded setting can be received at any time prior to the individuals anticipated discharge date.
        i) Billing for CM activities related to discharge planning is restricted to the thirty-day period prior to the individual's discharge.
            (1) CM activities related to discharge planning and transition must not duplicate usual discharge planning activities performed by the excluded setting.
            (2) Acceptable CM activities include: meeting face to face with the individual; working directly with staff of excluded settings for the purpose of discharge planning (e.g., confirm discharge date; attend discharge planning meetings; discuss discharge plan to establish post discharge needs; etc.), confirming the individual meets all eligibility requirements for HH enrollment or HCBS eligibility with documented evidence; obtaining Health Home consent to complete the enrollment process; and so forth.
            (3) One billing instance is allowed for CM activities performed during the time the individual is in the excluded setting awaiting discharge.
            (4) The CMA/CM must maintain documented evidence of all activities conducted to support billing. Such documentation must include proof of eligibility to support HH or HCBS enrollment, and a completed and signed Health Home consent.
7. Referrals may be handled differently based on the referral source and the member risk level.
8. All referrals are sent to the lead HH for tracking and processing.
    a) CMAs are not to begin the outreach/enrollment process until a member is assigned by the lead HH.

Referral Submission

The Health Home has multiple methods for referral submission. Submission may occur as follows:

1. Online referral via the Health Home website.
2. Paper referral via fax, mail or email.
3. Direct Referral via the Medicaid Analytics Performance Portal (MAPP)
    a) Managed Care Organizations (MCO)
    b) Care Management Agencies (CMA)

c) Single Point of Access (SPOA)
d) Any other **State** agency with access to the MAPP system.

Referrals may also be submitted directly to Care Management Agencies, who will submit referrals directly through MAPP.

Direct MAPP Referrals Process

Referrals submitted through the MAPP system are the preferred method. Managed Care Plans, Care Management Agencies, and other providers with MAPP access can submit a referral through MAPP. Once a referral is submitted through MAPP, with a selected Health Home, the individual will show in the Health Home referrals. The Health Home will:

1. Review the members demographic information in MAPP.
2. Accept the Assignment.
3. Create a segment and assign a CMA.
4. Health Home then completed a "My Member" Upload in Netsmart.
   a) This automatically creates an episode for the member in Netsmart updates information according to MAPP.
   b) CMA is auto-assigned.

Care Management Agencies Supervisor must:

1. Check Netsmart for assignments, daily.
2. Assign member to a care manager.

Online Referral Electronic Referral Process

Referrals submitted online through the Health Home website will be processed, as follows:

1. Upon retrieval of a referral the Health Home will review the referral.
2. Based on information provided in the referral the Health Home will utilize the report assignment availability to reach out to a Care Management Agency partner to assure availability.
3. Health Home will securely send referral to the Care Management Agency.
4. Care Management Agency will submit referral via MAPP.
5. Referral will be processed as stated in **Direct MAPP Referrals Process** section.

Paper Referral

Referrals sent to the Health Home or CMA via email, fax or mail will be submitted as a **Direct MAPP Referral.**

If a CMA received a paper referral and cannot accept the referral, they must securely send the referral to the Health Home. Health Home will then enter the referral as a **Direct MAPP Referral** and assign to an appropriate CMA, in accordance with **Assignment Availability** and resource availability.

Health Home and/or Care Management Agency Referral Review Process

Upon retrieval of a referral the lead HH/CMA will:

1. Verify Medicaid eligibility/activity in the MAPP system.
   a) Review for restriction codes that may hinder a person's ability to enroll in services.
      i) In the event a restriction code is present the lead HH will contact the referral source and discuss the barrier and ways to solve the barrier, if possible.
         (1) Refer to the DOH *Guide to Coverage Codes and Health Home Services.*
   b) Verify member is not enrolled with another HH or CMA through the MAPP HHTS system and/or EPACES.

2. Verify member's chronic condition eligibility, via the referral source documentation.
   a) If this section is not complete on referral form, lead HH/CMA will reach out to the referral source for information.
      i) To be eligible for Health Home Services, an individual must have either two chronic conditions or one single qualifying condition, as follows:
         (1) HIV/AIDS, or

(2) Serious Mental Illness (SMI), or
(3) Sickle Cell Disease, or
(4) Two Chronic Conditions

ii) If additional documentation was not provided to support chronic condition eligibility, the lead HH/CMA will contact the referral source and request supporting documentation be sent prior to enrollment.
(1) If the referral source is an individual's physician, Mental Health Provider, Therapist, or other professional who through their work has access to an individual's medical/behavioral health history, the health home may accept the information provided on the referral or through verbal communication from those professionals.
(2) Any supporting chronic condition information should be uploaded with the member's referral to the Care Management Record Documents.

Once preliminary eligibility is verified, lead HH/CMA will enter the referral via the **Direct MAPP Referral.**

If referral is submitted via **Direct MAPP Referral** a CMA assignment determination will be made based on:
1. Members with specific chronic conditions where a partnering agency may specialize.
2. Members risk level being determined as Health Home Plus, needing to be assigned to specifically designation CMA's.
   a) Specialized CMA partners can take Serious Mental Illness (SMI), HIV/AIDS, and Assertive Outpatient Treatment (AOT).

For assignment timeframes, refer to section: **Determining Assignment Availability**

Assignment to a Care Management Agency

Utilizing the **Direct MAPP Referral Process** allows for a more efficient workflow when assigning to a CMA and Care Manager in the Netsmart CareManager system.

The lead HH will complete a My Members CareManager Import from MAPP to Netsmart CareManager daily. *Process Outline in the My Members CareManager Import.*

CMA will assign member to an appropriately skill Care Manager by following the *CMA Assignment Workflow.*

1. CMA Supervisors must assign care managers to enrollees based upon care manager experience and defined member characteristics including, but not limited to, acuity, presence of co-occurring or co-morbid Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED), Substance Use Disorder (SUD) or co-occurring medical co-morbid conditions, and patterns of acute service use.
2. CMAs that provide direct services must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.
3. Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.
4. Members shall be provided with a choice of providers from among all the MCO's network providers of a particular service. Health Homes shall document the member's selection in the plan of care.

The CMA will ensure the individuals demographic section is complete with the following:
1. Name
2. Sex Assigned at Birth
3. Date of Birth
4. CIN
5. Address
6. County
7. Phone Number (as reported on the referral document)

The CMA will ensure the individuals referral documentation is uploaded to documents.

Care Management Agency Outreach to Enrollment

Complete the Initial Appropriateness Review is a two-part process:

1. Confirming Initial Appropriateness must include:
   a) Findings of significant behavioral, medical, physical, or social risk factors that require the Care Management services provided through the HH.
   b) 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.
2. Requirement for Reporting Initial Appropriateness
   a) This is completed post enrollment within 30 days of a signed consent.

CM will outreach an individual for Care Management services for two consecutive months.

1. Month 1:
   a) When a member is assigned to a CMA/CM, the CM must outreach the member within 48 hours of assignment.
      i) Upon initial outreach a CM will enter a note into the member Care Management Record to change their status from assigned to client search.
   b) If initial contact is unsuccessful in scheduling an intake, CM will attempt to contact the member two additional times, utilizing two different methods of contact within Month 1.
      i) Methods of contact may include:
         (1) Phone Calls
         (2) Face to Face visits
         (3) Mailed Letter
            (a) If this method is used, letter must be uploaded to the documents section, with an associated note in the members care management record.
         (4) Email if provided.
   c) Contact referral source to confirm retrieval of referral.

2. Month 2:
   a) If CM is unsuccessful in reaching an individual in outreach in Month 1, CM will continue outreach to Month 2.
      i) In Month 2 CM will make, at minimum, three contacts, and;
      ii) Will utilize, at minimum, two different methods of contact.
   b) In addition, in both Month's 1 and 2 CM will contact the referral source to inform of progress with outreach and possible enrollment.
   c) Contact referral source to confirm retrieval of referral.

3. Upon successful contact of an individual, CM will:
   a) Discuss HH Care Management Services with the member and see if member is interested in receiving services.
      i) If the individual is not interested in services CM must complete a note stating the reason for the individuals disinterest and opt them out of services.
      ii) If the individual is interested in services CM will schedule an intake meeting with the member to enroll in services and appropriately document in the members care management record.

Completing Member Enrollment and Eligibility Verification

Prior to CM meeting with the individual to enroll, CM will:

1. Verify members Medicaid is active with no restriction codes in EPACES, prior to outreach beginning.
   a) CM must document in *Bassett Medicaid Check* in the Care Management Record.
      i) Members Medicaid coverage can change frequently and must be monitored, at minimum, once monthly throughout outreach and for the duration of enrollment.

CM will meet with the member to complete an intake to enroll in services.

1. It is required that CMA's maintain policy and procedure to ensure safety of their CM's and the environmental

requirements they feel appropriate to conduct meetings.

2. Intake completion must include, but is not limited to:
   a) DOH-5055 Patient Information Sharing Consent
      i) Refer to: BCHN009: *Use of Health Home Consents and the Provision of Access and Sharing of Member's Personal Health Information (PHI) Policy* for proper completion of the DOH-5055.
   b) RHIO Consents (if additional RHIO's are used beyond those stated on the DOH-5055)
   c) Rights and Responsibilities

At intake, it is best practice to, begin work on the Comprehensive Assessment, in which a face to face contact is required during completion of the members first assessment. Refer to: BCHN013: *Standards of the Comprehensive Assessment and Practice of Person-Centered Care.*

Following the intake;

1. CM will verify members eligibility for HH services, which includes:
   a) Active Medicaid Coverage, and
   b) Single Qualifying Condition, or
   c) Two Chronic Conditions
      i) Substance use disorders (SUDS) are considered chronic conditions, but do not by themselves qualify an individual for Health Home services. Individuals with SUDS must have another chronic condition (as described below) to qualify.
      ii) CM must confirm and maintain documentation of individual's chronic condition(s) and other qualifying factors in the members Care Management Record.
         (1) Information may be accepted from any one of these sources:
         (2) Plan referrals,
         (3) medical records or assessments,
         (4) written verification by the individual's physician or treating healthcare provider,
         (5) Regional Health Information Organization (RHIO), or
         (6) Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES).
         (7) MCOs and medical providers may provide the Care Management Agency (CMA) or Health Home with a Clinical Discretion of Diagnostic Requirements, to allow the CMA/HH to service the member without documentation and verification of qualifying conditions.
      iii) An individual can have two chronic conditions and be managing their own care effectively. An individual must be assessed and found to have significant behavioral, medical, or social risk factors that require the intensive level of Care Management services provided by the Health Home Program. Determinants of medical, behavioral, and/or social risk can include:
         (1) Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement);
         (2) Lack of or inadequate social/family/housing support, or serious disruptions in family relationships;
         (3) Lack of or inadequate connectivity with healthcare system;
         (4) Non-adherence to treatments or medication(s) or difficulty managing medications;
         (5) Recent release from incarceration, detention, psychiatric hospitalization or placement;
         (6) Deficits in activities of daily living, learning or cognition issues; or
         (7) Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.
      iv) CM must refer to the DOH *Health Home Program Chronic Condition Update with Developmental Disability Conditions* Document to ensure chronic condition eligibility of each member. This Document is made available to CMA's and CM's as a resource.
         (1) If a CM determines a member has a Serious Mental Illness (SMI) as a qualifying condition the CM must ensure the member has an active, associated DSM5 diagnosis:
            (a) Psychotic Disorders: F21, F22, F23, F20.81, F20.9, F25.0, F25.1, F06.2, F06.0, F06.1, F28, F29
            (b) 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
            (c) Obsessive-Compulsive Disorders: F42
            (d) 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

(e) Anxiety Disorders: F41.9, F41.0, F41.1, F44.81, F40.0, F43.10
(f) Personality Disorders: F60.0, F60.1, F60.3, F60.04, F60.5, F60.6, F60.9, F60.81, F21

(2) In addition, to having a qualifying diagnosis a member must meet one or more of the following criteria to be considered a member with an SMI qualifier:
(a) Marked difficulties in self-care such as personal hygiene, diet, clothing, avoiding injuries, securing health care, or complying with medical advice; or
(b) 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
(c) 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
(d) Frequent deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner in work, home, or school setting. 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.

2. Initial Appropriateness
   a) 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.
      i) Effective December 1, 2023, Health Homes must ensure that within **thirty days of signed consent**, 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.
      ii) This process requires the selection of one of the Significant Risk Factors in the Initial Appropriateness Criteria chart that reflects the significant risk that makes the individual eligible for HH enrollment.
         (1) 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.
      iii) 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 CM will work on that is also important to the member.
         (1) 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.
3. Update member's demographics, programs, consents, care team, etc. in the care management record.
4. Notify the referral source of a successful enrollment
   a) Referral source should be listed on the DOH-5055

The CM will determine the individual's eligibility and appropriateness for HH services.

1. Appropriateness for Health Home services must be determined for MAPP HHTS Referral Portal referrals, as well as community or bottom up referrals. An assessment must be performed for all individuals to evaluate whether the person has significant risk factors.
2. The use of the Comprehensive Assessment and Person-Centered Care planning will assist in determining an individual's appropriateness for the HH Care Management program. Refer to BCHN009: *Standards of the Comprehensive Assessment and Practice of Person-Centered Care*

COMMUNICATION/TRAINING/IMPLEMENTATION

The HH will be responsible for providing necessary training needed to follow procedures as outlined in this policy. Training and resources will be provided and distributed with the policy and procedures. The HH will provide, at minimum, bi-annual trainings available to all staff, to ensure up-to-date understanding of policies and procedures are maintained.

HH and 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:

1. Referral and Assignement

2. Initial eligibility requirements and continued eligibility, staff are responsible for appropriateness assessments
3. Appropriateness criteria - selection and timeline requirements
4. Reporting Initial Appropriateness and uploading into MAPP HHTS
5. Documentation requirements
6. Completing Initial Appropriateness, CES Tool, staff responsible, and timeline requirements
7. Reporting CES Tool outcomes

The policy will be distributed to CMAs for review and attestation from all HH employees upon implementation, attestations will be returned and kept on file with the Health Home.

QUALITY MANAGEMENT & PERFORMANCE IMPROVEMENT

The HH will ensure quality through regular reviews related to managing referrals of HH-eligible individuals newly referred to the program, including from excluded settings. The HHs standards for quality management are outlined in the BCHN011: *Health Home Quality Assurance & Performance Program.*

Through its Quality Management Program (QMP), 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. HHs must work with their network CMAs to assure a method is in place for reviewing activities surrounding enrollment, continued enrollment and disenrollment of members no longer eligible for HH services.

RELATED FORMS

- CMA Bandwidth spreadsheet
- Health Home Program Chronic Condition Update with Developmental Disability Conditions
- Intake Checklist
- *Process Outline in the My Members CareManager Import*
- *CMA Assignment Workflow*
- DOH *Guide To Coverage Codes and Health Home Services*
- *Appropriateness Criteria Reference Guide*