

Eligibility Requirements: Identifying Potential Members for Health Home Services Appropriateness Criteria

This document provides clarification and defines key components of the *Appropriateness Criteria*, the final step in the process to establish and maintain Health Home eligibility. This document is specific to the enrollment of adults and serves as a supplement to Health Home policy, [Eligibility Requirements: Identifying Potential Members for Health Home Services](#).

Appropriateness Criteria

The final step in determining whether to enroll a member in a Health Home is to determine appropriateness for Health Home services. Simply meeting Medicaid eligibility and qualifying conditions is not sufficient to confirm appropriateness for Health Home enrollment. For example, an individual can have two chronic conditions and be managing their own care effectively thereby not requiring health home care management assistance. To qualify for enrollment and ongoing care management services under health home, 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*. Examples of Determinates of Risk are provided below. While this is not an exhaustive list of possible risk factors, additional risk factors not listed here must be well documented in the clinical record and must be related to a requirement for intensive care management in order for the member to be effectively served. It should be noted that even if existing enrolled HH members are triggering some of these historical risk factors, if they are currently managing their condition well with existing services and natural supports they can and should be transitioned to lower levels of care management.

Reference Guide - Examples of Determinants of Risk	
Determinants of medical, behavioral, and/or social risk can include:	Documentation Guidance and Examples:
<p>Probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)</p>	<ul style="list-style-type: none"> • Use various Quality flags in PSYCKES, such as “Preventable admissions for asthma” “Preventable admissions for Diabetes”, etc. • Anyone with a HH+ flag in PSYCKES at the time of enrollment • Anyone with a POP flag in PSYCKES at the time of enrollment • Anyone with an H-code in EMEDNY at the time of enrollment (eligible or enrolled) • Direct referral from an inpatient medical, psych, or detox admission • Direct referral from ER also possible if member is a frequent flyer (this could be captured as a PSYCKES category) • Direct referral from APS, CPS, or preventive program • Direct referral from MCO or medical provider

<p>Lack of or inadequate social/family/housing support, or serious disruptions in family relationships; needs benefits; nutritional insufficiency</p>	<ul style="list-style-type: none"> • Meeting one of the HUD definitions for homelessness (HUD 1, 2 and 4 housing) • Lack of social supports as evidenced by fewer than 2 people identified as a support by the member, change in guardianship • The institutionalization or nursing home placement of primary support member • Needs assistance applying for/accessing benefits such as SNAP, SSI, etc. • Unable to access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc. • Intimate Partner Violence
<p>Lack of or inadequate connectivity with healthcare system</p>	<ul style="list-style-type: none"> • Individual does not have healthcare connectivity or utilization e.g., does not have a PCP or specialist to treat a chronic condition, or has not seen their provider in the last year. • Individual is unable to appropriately navigate the health care system for the treatment or care of the diagnosed or undiagnosed physical or behavioral health condition. • Potentially preventable utilization based on identified flags in the RHIO, from the Plan, or in PSYCKES (such as 2 or 3+ ED visits in the past year, 1 BH or substance use inpatient visit in the past year, etc.)
<p>Non-adherence to treatments or medication(s) or difficulty managing medications (define source e.g. self-reported or other source with knowledge)</p>	<ul style="list-style-type: none"> • Identify WHICH medication(s) and/or treatment(s) are involved per individual or referral source. • Per PSYCKES flag (e.g., Adherence to Mood Stabilizers, Antipsychotics, and Antidepressants; No Diabetes Monitoring)
<p>Deficits in activities of daily living, learning or cognition issue (define source e.g., self-reported, reported by other, observed by HHCM, etc.)</p> <p><i>(This should not be the only risk factor)</i></p>	<ul style="list-style-type: none"> • Instrumental Activities of Daily Living (IADLs) include transportation, shopping, managing finances, meal preparation, housecleaning, home maintenance, communications, and managing medications¹ • Deficits can be caused by medication side effects, social isolation, home environment, cognitive or mental decline (e.g. dementia), aging, Musculoskeletal, neurological, circulatory, sensory conditions, lack of Durable Medical Equipment (DME), hospitalization, or acute illnesses.
<p>Recent release from incarceration, detention, psychiatric hospitalization or placement; other justice referrals for those not incarcerated</p>	<ul style="list-style-type: none"> • Released within the last 90 days • Identify name of institution, approximate date of release, or name of “other justice referral for those not incarcerated”

¹Instrumental Activity of Daily Living (IADL); Guo HJ, Sapra A. Instrumental Activity of Daily Living (IADL) [Updated 2019 Dec 18]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK553126/> Last Update: December 18, 2019.