HEALTH HOME PLUS: MCO CLINICAL DISCRETION

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CLINICAL DISCRETION FOR HH+ PLUS

- Individuals who do not fall within at least one of the high need categories for Health Home Plus (HH+) eligibility could still be eligible for HH+ services based on clinical discretion, with documentation being shared with lead Health Homes (HHs) and Care Management Agencies (CMAs) to support provision and billing for HH+.

HH+ Program Guidance for High-Need Individuals with SMI (2024)

- The local Single Point of Access (SPOA) or the Managed Care Organization (MCO) may establish a member's HH+ SMI eligibility based on the consideration of social determinants of health or other factors.

HH+ Program Guidance for Individuals with HIV (2026)

- Medical Providers and Managed Care Organizations (MCOs) have clinical discretion to refer members for HH+ level of service.
- Clinical discretion requests must include:
  - Status of members' viral load (VL), AND
  - Factors that indicate the need for referral into Health Home Plus (HH+) or a continuation of services such as newly diagnosed HIV status, unstable viral load suppression, housing instabilities, poor adherence to treatment plan, etc.

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CLINICAL DISCRETION FOR HH+ PLUS

- MCOs - including mainstream plans, HIV-SNPs and HARPs - have responsibility in ensuring high-need members have positive health outcomes and receive needed services.
- MCOs are the only entity able to support clinical discretion for BOTH HH+ SMI and HH+ HIV populations
- When HHs/CMAs report these members, MCOs must be part of deciding the best care to meet their needs

Benefits of HH+ Clinical Discretion:

- Benefit for members: Access to intensive level of support and HH+ CM to all who need (not just those meeting a State definition)
- Supports CMA in providing the *sustained* engagement with the member needed to address a significant need (eg., member was previously homeless but now housed but needs support managing new tenant responsibilities, neighborhood resources, household tasks)
- Benefits to MCO: a tool to utilize in response to members showing quality indicators (eg, readmission) and improve member outcomes

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Clarifications:

- The sole purpose of clinical discretion is to provide high need individuals access to HH+
- Clinical discretion for HH+ is **NOT utilization management (UM)** of HH+ SMI and HH+ HIV services; UM protocols such as appeals, fair hearing, and grievances do not apply to HH+ services.

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H.R.1 UPDATES

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CHANGES TO MEDICAID COVERAGE

H.R.1 (House Resolution 1), referred to as the One Big Beautiful Bill Act (P.L. 119-121), is a 2025 federal law that changes some rules for Medicaid. Under H.R.1, some Adults (ages 19 through 64) who have Medicaid coverage, will need to show they are working, going to school, helping out in the community or participating in job training, in order to keep their Medicaid coverage.

MEDICAID COVERAGE REQUIREMENTS

To meet the Medicaid coverage work requirements, individuals must demonstrate:

A) monthly income of at least $580

B) at least 80 hours per month of any of the following activities (or combination of activities);

- work in a job
- go to school at least half time (higher education, career and technical education program, high school, or high school equivalency program)
- join a job training or work program
- volunteer or help out in their community

C) earn some income and complete some hours of approved activities (B above) each month

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INDIVIDUALS NOT INCLUDED IN THE WORK REQUIREMENTS

- 18 years old or younger
- 65 years old or older
- Pregnant, or were pregnant in the last 12 months
- Enrolled in Medicaid with a disability
- Diagnosed with a physical or mental health condition that makes it hard to work
- Entitled to, or enrolled in Medicare Part A or enrolled in Part B
- American Indian or Alaska Native
- A parent, guardian, caretaker relative, or family caregiver to a disabled individual
- A parent, guardian, caretaker relative, or family caregiver to a child under 14
- In a SNAP household, and subject to SNAP work requirements
- Enrolled in TANF and meeting TANF work requirements
- In a program to help with drug or alcohol use
- Currently in jail or prison, or released in the last 3 months
- Currently in foster care
- Under 26 and aged out of foster care
- A veteran with a total disability

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TEMPORARY EXCEPTIONS TO THIS RULE

Some individuals may not have to follow this rule if:

A) they were in the hospital or a nursing facility

B) they or a dependent had to travel for serious medical care not offered in their community

C) they live in an area where the federal government declared an emergency or disaster

D) they live in an area with very high unemployment

For A) and B) temporary exceptions, individuals need to provide information on their Medicaid application. For C) and D) temporary exceptions, New York State will let individuals know if those apply to them.

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TIMELINE

By September 30, 2026:

- If work requirements apply, NY State of Health will send the individual a notice by mail (or email if preferred) about upcoming Medicaid changes. This notice explains what to expect and what may be needed in the future, including how to meet the requirements. **Nothing is changing with coverage at this time.**

Starting on October 1, 2026:

- Some adults may no longer qualify for Medicaid due to changes in eligibility rules based on immigration status. NY State of Health is notifying such impacted adults their status has changed. The state will work to determine what coverage the individual may be eligible for.

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TIMELINE

Starting on January 1, 2027:

- Some adults ages 19–64 (in expansion population and not exempt) will have new work requirements for Medicaid coverage which will be reviewed when applying for/renewing their coverage on/after this date. Proof of working, in school, in job training, or volunteering may be needed.

Starting on January 1, 2027:

- Some adults ages 19–64 will need to renew their Medicaid **every 6 months** instead of once a year.
  - Individuals who apply for Medicaid before January 1, 2027, or renew **before** March 1, 2027, will get 12 months of coverage if eligible. After that, renewal will be every 6 months.
  - Applying for Medicaid coverage after January 1, 2027 or renewing after March 1, 2027 requires renewal every 6 months, if the individual still qualifies.

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