Broome County

Mental Health Department

GUIDELINES

Adult Non-Medicaid Care Management

Effective: 10/01/2025

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Broome County Mental Health Department
GUIDANCE - Adult Non-Medicaid Care Management (NMCM)

1. INTRODUCTION

In 2014, the New York State (NYS) Office of Mental Health (OMH) *Adult Targeted Case Management* program transitioned to the NYS Department of Health (DOH) Health Home (HH) Care Management and made the service eligible for Medicaid billing. Beginning March 8, 2021, only NYS DOH Care Management Agencies (CMAs) that were designated as a Specialty Mental Health Care Management Agency[1] (SMHCMA) by DOH/OMH were eligible to enroll new individuals meeting the Health Home Plus (HH+) Serious Mental Illness (SMI) criteria. Recognizing that not all individuals with Serious Mental Illness are recipients of Medicaid, OMH has published Guidance[2] for *Non-Medicaid Care Management* services.

In an effort to align with both DOH and OMH guidance, the Broome County Mental Health Department (BCMHD) constructed local program *Guidlines*[3] henceforth for Adult Non-Medicaid Care Management programs contracted with the County. For the purpose of this guidance, Adult Non-Medicaid Care Management includes the following program codes:

a. 2620: Health Home Non-Medicaid Care Management
b. 2720: Non-Medicaid Care Management

These GUIDELINES are an update to the previously released edition of January 2020, and are effective as of October 1, 2025.

2. FUNDING

a. NYS OMH State Aid funding is provided to serve individuals, who meet programmatic eligibility, with specific mental health service needs, that cannot be enrolled in a Health Home because they are without Medicaid coverage. BCMHD directly contracts with, and governs the oversight of, local service providers for the provision of the services.

3. SCOPE OF WORK

a. The Non-Medicaid Care Management program provides services in alignment with the NYS Department of Health (DOH) Medicaid Health Home (HH) program as specified in NYS DOH Medicaid HH Policy and Guidance[4] and NYS Office of Mental Health Guidance[5] for individuals ages 18 and older with mental health service needs who would likely meet eligibility requirements to receive NYS Medicaid Health Home services, with the exception of active Medicaid eligibility.

b. To promote continuity of service for individuals, Adult Non-Medicaid Care Management services are inclusive of those of NYS DOH HH including documentation, service provision, cultural competency and staff requirements.

4. CARE MANAGEMENT AGENCY PROVIDER REQUIREMENTS

a. All providers that receive funding to operate Adult Non-Medicaid Care Management programs in Broome County must:

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[1] https://omh.ny.gov/omhweb/adults/health_homes/

[2] https://omh.ny.gov/omhweb/adults/health_homes/health_home_non-medicaid_care_management.pdf

[3] Initial Guidance was released, effective 01/01/2020.

[4] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm

[5] https://omh.ny.gov/omhweb/adults/health_homes/

1) Operate an established NYS DOH Care Management Agency (CMA), with designation as a Specialty Mental Health Care Management Agency (SMHCMA). The CMA must be in good standing with Lead Health Home(s) and actively providing services to a caseload of adults with Serious Mental Illness (SMI) in Broome County.

2) Have an established working relationship with Broome County Adult Single Point of Access (A-SPOA) as demonstrated by consistent A-SPOA meeting attendance, responsivity to referrals, and consistent communication and correspondence with the A-SPOA Team.

3) Maintain adequate staffing capacity for current and expanding service provision and the supervision thereof as outlined by NYS Department of Health (DOH) Health Home (HH) Guidance. If unable to maintain adequate staffing, notification will be made to the Broome County Mental Health Department via the Adult Single Point of Access (A-SPOA) team for coordination of referrals and care.

b. Providers are expected to:

1) Deliver care management services to eligible individuals in accordance with the current and future versions of the NYS Department of Health (DOH) Health Home (HH) policies and guidance, along with Broome County Mental Health Department, developed *Adult Non-Medicaid Care Management Guidelines* listed henceforth.

2) Commit to agency representation at A-SPOA Committee meetings. See **Section 5, PARTICIPATION/COORDINATION WITH SPOA**, below for more information.

3) Delegate representation and participation in local services planning within the Community Services Board and/or one of its Subcommittees.

4) Assist individuals in obtaining Medicaid and/or Managed Care services *(e.g., New York State of Health)* if eligible, through application completion, documentation, and communication with providers and community partners.

5) Transition individuals from Non-Medicaid Care Management slots to Medicaid-reimbursable Health Home services without disruption of Care Management services. See **Section 16, TRANSFER OF PROGRAMS** for more information.

5. PARTICIPATION/COORDINATION WITH SPOA

a. Agencies operating Non-Medicaid Care Management (NMCM) programs are expected to attend at least 80% of scheduled A-SPOA meetings annually to provide updates on previously assigned cases.

b. A-SPOA Committee meetings occur twice monthly, presently the 2nd and 4th Wednesday of the month at 10:30AM. Meetings are held virtually apart from two in-person only meetings occurring the beginning of the 2nd and 4th quarter. Providers receive agendas with anticipated case discussion ahead of the meeting and are expected to be participatory and responsive to A-SPOA Committee questions about the program or the individual recipient being discussed. NMCM programs are expected to identify a primary and secondary contact for A-SPOA business. Meeting schedule is available from: AdultSPOA@broomecountyny.gov.

c. Providers will submit monthly rosters - via method identified by A-SPOA - to document changes in case status *(e.g., outreach, enrollment, disenrollment)*. Rosters are to be submitted no later than end of business the Friday prior to the first A-SPOA meeting of each month.

6. PERSONNEL

a. Personnel who provide Non-Medicaid Care Management services must meet NYS DOH[6] & OMH guidance[7] for Specialty Health Home Care Management Agency, Health Home Plus (SMHCMS-HH+) minimum staff criteria. Supervisors of personnel for this project must meet the minimum staff criteria for Supervisor of personnel working with individuals with a HH+ caseload.

b. Due to anticipated future Medicaid eligibility, it is recommended that Non-Medicaid Care Management personnel have ample caseload and capabilities to work with those receiving Health Home Care Management services under the NYS DOH to allow for the continuity of services with the least disruption to the individual recipient.

c. All program staff who have the potential for, or may be permitted, regular and substantial unsupervised or unrestricted video, phone, and/or physical contact with clients, must complete the Pre-Employment Background Check steps outlined by the NYS Office of Mental Health, Pre-Employment Background Check guidance located here: https://omh.ny.gov/omhweb/dqm/pec/.[8]

7. CULTURAL COMPETENCY & LANGUAGE ACCESS

a. In alignment with the NYS Department of Health, Office of Mental Health, Office of Addiction Services and Supports, Office of Persons with Developmental Disabilities, and Office of Children and Family Services, The Broome County Mental Health Department defines Cultural Competency as follows:

1) Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.[9,10]

2) A culturally competent health care system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care.[11]

b. In addition, in New York State, the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model contract section 15.10(c,) states that a plan must "ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including

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[6] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0010_background_checks_policy.pdf

[7] https://omh.ny.gov/omhweb/adults/health_homes/

[8] https://omh.ny.gov/omhweb/dqm/pec/

[9] Cultural Competence In Health And Human Services | National Prevention Information Network (cdc.gov). US Department of Health and Human Services, Health Resources and Service Administration, Bureau of Primary Health Care.

[10] Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

[11] Becoming a Culturally Competent Health Care Organization | AHA

training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees."[12,13]

c. The NYS Department of Health, Office of Mental Health, Office of Addiction Services and Supports, and Office of Children and Family Services, also cite the following:[14]

> *All Medicaid-participating health care providers should be culturally competent. This means they need to recognize and understand the cultural beliefs and health practices of the [individuals] … they serve and use that knowledge to implement policies and inform practices that support quality interventions and good health outcomes… Given changing demographics, this process is ongoing.*
>
> *State Medicaid agencies and Medicaid managed care plans, as recipients of federal funds, have responsibilities to assure that covered services are delivered… without a language barrier. They are required take "reasonable steps" to assure that individuals who are limited English proficient have meaningful access to Medicaid services.*
>
> *Though interpreter services are not classified as mandatory 1905(a) services, all providers who receive federal funds from HHS for the provision of Medicaid services are obligated, under Title VI of the Civil Rights Act, to make language services available to those with limited English proficiency.[15] The US Departments of Health and Human Services, Office for Civil Rights and the Department of Justice, Civil Rights Division have provided guidance for recipients of federal funds on expectations of how to provide language services.[16,17]*
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> *Providers of New York State Plan Amendment Services are expected to deliver effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.*

d. This is also an expectation of SMHCMA's who will be providing Non-Medicaid Care Management services. For further guidance on providing culturally and linguistically appropriate services, The DHHS Office of Minority Health offers numerous resources, including: *Center for Linguistic and Cultural Competence in Health Care; Think Cultural Health*;[18] *A Physician's Practical Guide to Culturally Competent Care*;[19] *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* [20](the National CLAS Standards); and *The National CLAS Standards implementation guide, A Blueprint for Advancing and Sustaining CLAS Policy and Practice*.[21]

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[12] https://health.ny.gov/health_care/managed_care/plans/cultural_competence_completion.htm#:~:text=The%20Medicaid%20Managed%20Care%2FFamily%20Health%20Plus%2FHIV%20Special%20Needs,who%20have%20regular%20and%20substantial%20contact%20with%20Enrollees.%E2%80%9D Cultural Competency Completion (ny.gov)

[13] Cultural Competence Training for Participating Providers (ny.gov)

[14] https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf

[15] https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html#:~:text=All%20providers%20who%20receive%20federal,Match%20For%20Translation/Interpreter%20Services

[16] https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html

[17] https://www.justice.gov/crt/executive-order-13166

[18] https://minorityhealth.hhs.gov/think-cultural-health

[19] https://cccm.thinkculturalhealth.hhs.gov/

[20] https://thinkculturalhealth.hhs.gov/clas/standards

[21] https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

8. REFERRAL & PRIORITIZATION

a. The Local Government Unit (LGU), via Broome County Mental Health Department (BCMHD) Adult Single Point of Access (A-SPOA), works collaboratively to coordinate care management services for individuals who do not have proper Medicaid coverage, with specific mental health service needs. BCMHD directly contracts with, and governs the oversight of, local not-for-profit service providers for the provision of the services.

b. Every individual seeking Non-Medicaid Care Management services must have an active A-SPOA application – inclusive of signed/valid A-SPOA *Universal Consent for Release of Information* - to be both considered for eligibility and to remain on the provider's monthly recipient roster.

c. Referrals to A-SPOA are received from multiple sources including community providers, schools, Assertive Community Treatment (ACT) teams, forensic / justice-involved settings, hospitals, etc. The A-SPOA team reviews all referrals for completeness and eligibility, discusses appropriateness, and facilitates distribution to an appropriate NMCM provider.

d. Priority Status is assigned to individuals on Assisted Outpatient Treatment (AOT), transfers from existing care management services and those returning to the community from institutional settings.

9. CASE ASSIGNMENT & ENGAGEMENT/OUTREACH

a. Case assignment is made by the Broome County A-SPOA Team to the receiving Non-Medicaid Care Management Agency. A number of factors are taken into account in this process, including but not limited to:

   1) Recipient choice
   2) Previous Care Management Agency relationship
   3) Care Management Agency (CMA) Slot Capacity

   In the case that an applicant makes no selection of provider, has no pre-existing relationship with a Care Management Agency, and multiple Agencies have availability, the A-SPOA team will monitor and refer based on a rotational process to ensure equitable referrals across available providers.

b. Providers should begin Outreach to the identified recipient within two (2) business days after receipt of the referral from Adult SPOA, unless otherwise communicated. Providers will explain the NMCM program, including the individual recipient's right to decline enrollment.

c. Providers should contact Adult SPOA Application referral source, identified on the application, within two (2) business days after receipt of the referral from Adult SPOA, unless otherwise communicated. Providers will confirm receipt of the application and discuss the individual recipient's needs to inform how Non-Medicaid Care Management Program can best serve such needs.

d. Upon case assignment, if an individual is viewed to be inappropriate for Non-Medicaid Care Management services by the receiving Non-Medicaid Care Management Provider, this is to be communicated to the A-SPOA Team directly and to the A-SPOA Committee, to provide transparency and to allow for additional information to be shared that may impact the eligibility determination. The original referral source is to be notified of a recipient's cause for lack of eligibility, or denial for services, to the Non-Medicaid Care Management Program by the CMA making the determination.

e. While the NYS Department of Health's (DOH) Health Home (HH) Care Management Program only allows for two (2) months of Outreach, the Non-Medicaid Care Management Program can have flexibility surrounding an individual recipient's Outreach time-frame, given there appears to be an enrollment pending soon.

f. Providers should advise A-SPOA Team of any communication barriers and/or inability to contact assigned recipient within 30 days of assignment.

10. APPROVAL FOR SERVICES

a. Individuals are approved for twelve (12) months of NMCM services from the date of their initial enrollment.

b. If additional services are recommended beyond the initially approved twelve (12) months, an extension must be requested by submitting a Utilization Review Request. Please refer to Section 14, ***UTILIZATION REVIEW***, for detailed instructions on completing and submitting the request.

11. EXPECTED PROGRAM OUTCOMES

Care Management Agency Providers are expected to:

a. Aide individuals in achieving goals identified within their person-centered *Plan of Care* as evidenced by goal progress, completion, or program discharge.

b. Improve transitions between levels of care, such as discharges from emergent or inpatient care as evidenced by reduced lapse in services, benefits, medication and/or housing.

c. Provide linkages to appropriate services as evidenced by participant connection to needed care.

d. Assist individuals in applying for Medicaid as evidenced by individuals successfully transitioning to NYS DOH HH services if eligible.

e. Increase communication among providers of an individual's care as evidenced by documentation within case record.

f. Reduce incidences of homelessness, justice-involved recidivism, Comprehensive Psychiatric Emergency Program (CPEP) utilization, and number of psychiatric hospitalizations.

g. Deliver services in a culturally competent, strength-based / trauma informed manner, and work to reduce racial/ethnic disparity that may exist for individuals with mental illness in Broome County.

12. CASELOAD & SERVICE PROVISION CONTACT REQUIREMENTS

a. Personnel caseload should follow NYS DOH & OMH guidelines. As staff are likely serving both Medicaid (under Health Home) and Non-Medicaid individuals, caseload sizes will allow for adequate time to provide care management services based on individual recipient's need. The intensity of service, including the number of contacts per month above the minimum required, is driven by the needs of the individual recipient being served, and will be justified and documented in the individual's case record accordingly.

b. Minimum contact requirements are to occur in alignment with the NYS DOH Medicaid Health Homes Policy and Guidance[22], or in accordance with any subsequent update that may be released by NYS DOH or NYS OMH.

c. Recipient will receive, at minimum:

   1) One (1) face-to-face contact once every three (3) months ***AND***

   2) One (1) face-to-face, or phone, or email, or text message, monthly ***AND***

   3) Providers will contact recipients within two (2) business days of enrollment to/discharge from an inpatient unit or hospital once they are notified. This is to encourage the transition of care from hospitalization back into the community. If possible, care managers should be involved in the discharge planning process prior to the individual recipient's discharge.

d. Collateral Contacts – including phone calls between the care manager and the individual recipient's care team - are acceptable, but do not replace the efforts necessary by the care manager to attempt the required contact minimum with the recipient.

e. Attempts to contact the recipient must be made each month regardless of collateral contact frequency.

f. If, for any reason, required contacts with the individual recipient are not possible, the attempt(s) to contact must be documented to evidence work completed to try and engage the recipient in services.

g. Provider discretion may be utilized when working with individuals who do not wish to meet face to face, provided care management services continue to be provided to the recipient, and justification is documented in the individual's record.

h. For care managers serving individuals receiving Assisted Outpatient Treatment (AOT), NYS DOH and OMH requirements must be followed, accordingly. At least four (4) face-to-face contacts are required to be made each month. Full details of requirements located in the Health Home Plus (HH+) Program Guidance for Assisted Outpatient Treatment (AOT), Re-Issued September 2021[23].

13. CASE RECORD

a. A complete care management record must be maintained for all individuals enrolled in the Non-Medicaid Care Management program. The record will contain at minimum: contact notes, needs assessment, the plan of care, and copies of any releases of information signed by the individual.

   1) Documentation of Contacts

      i. Contacts - and contact attempts - with the recipient are to be noted in the care management record.

      ii. Collateral contacts with service providers and other supports are to be maintained in the care management record.

   2) Comprehensive Assessment / Needs Assessment

[22] https://omh.ny.gov/omhweb/adults/health_homes/hh-plus-high-need-smi-guidance.pdf

[23] https://omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf

i. Providers serving the non-Medicaid population will be required to complete a needs assessment no later than 60 days from the Date of Enrollment.

ii. The needs assessment should evaluate the following:

a. The individual's eligibility and appropriateness for Non-Medicaid Care Management services

b. The individual's strengths, interests, resources and support systems

c. The individual's behavioral and medical health conditions

d. Current behavioral/medical/community network providers and care coordination needs

e. Social determinant factors and related service needs

f. High-risk behaviors that may impact the individual's overall health and recovery

g. Reassessments are to be conducted at a minimum annually. Reassessments in addition to annual completion can be conducted at any time, based on care manager discretion.

h. For individuals under the provision of AOT, Health Home Care Managers to submit all AOT reporting requirements to the NYS Office of Mental Health (OMH) as required to AOT legislation and as currently reported in the OMH Child and Adult Integrated Reporting System (CAIRS).[24]

3) Plan of Care (POC)

i. Providers serving the non-Medicaid population will be required to complete and develop a POC no later than 60 days from the Date of Enrollment.

ii. The POC should include, at minimum, the following elements:

a. The individual's stated, Person-Centered Goal(s) related to mental health wellness, and recovery.

b. The individual's Preferences and Strengths related to treatment, wellness, and recovery goals.

c. Functional Needs related to treatment, wellness, and recovery goals.

d. Key Community Networks and Supports both formal and informal that address identified needs.

e. Description of planned Care Management Interventions.

f. The individual's signature documenting agreement with the plan of care.

iii. The POC is to be updated at least annually, or more often - as new needs are identified, and/or the individual's goal(s) change over time – constructed with the individual with the same collaborative efforts as the initial POC.

[24] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

iv. The individual should play a central and active role in the development - and consent for the execution of their POC. The individual should agree with the goals, interventions and time frames contained in the plan.

v. The POC is intended to be shared with the individual's active provider system of support, or treatment team – initially and at least annually - when updated/reviewed with the individual. This can be shared via Secure Email, Fax, or the US Postal Service.

vi. The POC should follow the guidelines set forth by the DOH as of the date of this edition and adjust/align with all subsequent guidance released henceforth.

4) Universal Consent

i. All Non-Medicaid Care Management recipients are to have an active Adult SPOA Universal Consent on file.

ii. The Universal Consent is to be checked for validity at least annually, during the Utilization Review process. See **Section 14, UTILIZATION REVIEW** for more information regarding this process.

iii. If an individual's consent is seen to be expired or to expire within the next three (3) months, care managers are to work with the recipient to have a new consent signed as soon as possible.

iv. If the recipient refuses to sign the Universal Consent, they are to be discharged from the Non-Medicaid Care Management Program. See **Section 18, DISCHARGE** for more information.

14. UTILIZATION REVIEW

a. As previously noted, individuals are initially approved for twelve (12) months of Non-Medicaid Care Management starting at time of enrollment. To assure continued eligibility and appropriateness of resource allocation, the A-SPOA Team follows a Utilization Review (UR) process to examine the ongoing strengths and needs of recipients.

b. In preparation of the annual authorization, if the provider agency and the individual recipient are agreeable to continued service provision – the Care Manager must submit a completed *Utilization Review (UR) for extension of Length of Stay (LOS)* form and a copy of the recipient's current POC to AdultSPOA@BroomeCountyNY.gov at nine (9) months of enrollment. This allows three (3) months for the provider to coordinate a transitional discharge plan if an individual is not approved for a continuation of services.

c. While Utilization Reviews are typically approved for a 12-month extension of Length of Stay, it is not a guaranteed approval timeline. Recipients may be approved for shorter or longer extension timeframes based upon individual case needs.

d. Each UR is reviewed by the A-SPOA Team and reviewed for completeness and eligibility criteria. The UR requires, at a minimum:

1) Mental health diagnosis(es).

2) Goal in the Plan of Care related to mental wellness and recovery.

3) Progress/Barriers to goals outlined in the Plan of Care.

4) Outstanding needs that require ongoing Care Management services.

5) Updates on any circumstances or adverse events that necessitate continued support.

e. The recipient's UR is then presented at the A-SPOA Committee Meeting, to assure committee transparency and to allow for additional information to be shared that may impact the recipient's eligibility determination.

f. A *Disposition Letter*, documenting the recipient's eligibility determination, will be distributed to provider personnel who submitted the request and include dates for service provision discussed at the A-SPOA Committee meeting.

g. A UR is not required if a recipient of services will be discharged within either the initial twelve (12) months of enrollment or discharge will occur within the approved period for extension of services.

15. MEDICAID VERIFICATION

a. At the beginning of each month, Non-Medicaid Care Management Program Agency staff are to access *ePACES*, or other applicable platform, to verify a recipient's Medicaid status to ensure continued eligibility for Non-Medicaid Care Management services.

b. If an individual has a compatible Medicaid Coverage Code with Health Home Services upon a monthly check, and no current incompatible Restriction Exception (RE) Codes, please see **See Section 16, TRANSFER OF PROGRAMS** section of this document for more information on initiating a transfer of programs.

16. TRANSFER OF PROGRAMS

a. Transition FROM Non-Medicaid Care Management TO Medicaid Health Home:

1) As noted in Section 15 (a), Non-Medicaid Care Management (NMCM) Providers must check a recipient's Medicaid eligibility monthly. If a recipient is noted to have active, compatible Medicaid, without a disqualifying Restriction Code, the provider should work to transfer the individual to the agency's Medicaid-reimbursed Health Home program.

2) With consideration of the needs of the recipient, care should be taken to exercise the least disruption to the recipient.

3) The NMCM Provider must notify the recipient of the anticipated program status change – from Non-Medicaid Care Management to Medicaid Health Home - and ensure a seamless transition between programs. The transfer should then be noted on the program's monthly roster with A-SPOA.

b. Transition FROM Medicaid Health Home TO Non-Medicaid Care Management:

1) If an individual currently enrolled in the Medicaid Health Home Program is noted to lose their Medicaid compatibility, a referral to A-SPOA for Non-Medicaid Care Management services may be recommended to continue to support the recipient in managing their needs.

2) Referral and Prioritization processes, noted in Section 8, are applicable including an A-SPOA Application and valid *Universal Consent for Release of Information*. The individual will be given a Priority Status and be assigned to a NMCM Provider.

c. Transition BETWEEN one NMCM Provider to another NMCM Provider:

1) If a recipient expresses an interest to transfer their Non-Medicaid Care Management services between qualified Non-Medicaid Care Management Agencies under contract with the Department for this service, efforts will first be placed in exploring the recipient's wish to transfer and encouraging feedback and transparency to support continued services with the same agency, if possible.

2) If a recipient continues to express interest in transferring agencies, open communication and planning between all parties involved is expected. A warm hand-off will be utilized whenever possible. If appropriate, the current care manager will continue to work with the recipient using the current Plan of Care (POC) while transitional activities are occurring to ensure the least amount of disruption to the recipient.

3) The A-SPOA Team is to be notified of and will be involved in any potential transfers and reassignment via this process. Recipients seeking transfer to a differing NMCM Provider will require a Situational Update Form be completed and will be presented at the A-SPOA Committee Meeting to assure committee transparency and to allow for additional information to be shared.

4) A brief summary of the recipient's strengths and needs, as well as a copy of the recipient's Plan of Care and Comprehensive Assessment will also be submitted to A-SPOA to forward to the future NMCM Provider.

17. DILIGENT SEARCH EFFORTS

a. As outlined in NYS DOH Policy Number HH0006, Continuity of Care and Re-engagement for Enrolled Health Home Members[25], in the event a recipient disengages in services, providers shall make efforts to re-engage the individual. Efforts to re-engage may include letters, phone calls, face-to-face visits, and outreach to known providers or supports. This is expected of Non-Medicaid Care Management (NMCM) Providers as well.

b. As the NMCM Program is separate from the NYS DOH, Diligent Search Efforts and Excluded Setting status can be handled with flexibility regarding the expected timelines and can be discussed further on a case-by-case basis if and when necessary.

18. DISCHARGE

a. Individuals are discharged from Non-Medicaid Care Management services in accordance with their needs, recovery goals and eligibility criteria. The recipient, along with the providers and other supports, should be involved in the development of a discharge plan whenever possible. All discharge plans will document and include any linkages and/or information to support the individual's health, service needs, and safety post discharge.

b. Reasons for discharge may include, but not limited to:

1) The individual, care manager, and providers/natural supports agree that the individual has met the goals of their Plan of Care and no longer requires the services of a care manager.

2) The individual no longer wants to receive care management services.

3) The individual has relocated outside of Broome County.

[25] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/ces_tool_faqs.htm

4) The individual is eligible for Medicaid services yet declines application for such services.

5) The individual is lost to contact/engagement.

6) The individual is not making forward progress towards goals in the care plan, and no alternative goals can be established to address.

7) The individual refuses to sign the Adult SPOA Universal Consent.

8) The individual has obtained Medicaid and is HH eligible.

9) The individual has been placed in an "Excluded Setting" for an extended period of time.

10) The individual has since deceased.

c. Non-Medicaid Care Management (NMCM) Providers are to notify the A-SPOA team regarding an individual's planned discharge from the NMCM program via email, with planned discharge date and reason for discharge.

d. If a discharge plan has previously been discussed with the Adult SPOA team and the plan changes, this must be communicated to the A-SPOA Team.

e. For AOT-involved individuals, providers should also follow discharge procedures in accordance with AOT HH+ Guidance.[26]

f. Discharges must occur by the last day of the month in which the *Initial/Extended Authorization* period ends.

19. DATA COLLECTION & LGU OVERSIGHT

a. Under Mental Hygiene Law, the Local Government Unit (LGU) works to ensure that individuals with mental illness, substance use disorders, and/or intellectual/developmental disabilities are adequately covered, sufficient services are available for all the mentally disabled within its purview, that there is coordination and cooperation among local providers of services, that the local program is integrated and coordinated with the provision of community support services, that the local program is also integrated and coordinated with the programs of the department, and that there is continuity of care among all providers of services. [27]

b. Adult Single Point of Access (A-SPOA) is one program that fulfills this LGU role. A-SPOA facilitates the monitoring and oversight of referrals, enrollments, transfers, and discharges of SPOA-covered services, which includes Non-Medicaid Care Management (NMCM) services. This includes, but is not limited to:

1) Rosters

i. In a template format prescribed by A-SPOA, NMCM Providers will submit a roster monthly, in accordance with the schedule of due dates outlined on an annual basis.

ii. Roster submissions are reviewed by the A-SPOA team for accuracy and for data collection.

2) Data Collection & Analysis

[26] https://omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf

[27] NYS Mental Hygiene Law: Article 41.13(4): https://casetext.com/statute/consolidated-laws-of-new-york/chapter-mental-hygiene/title-e-general-provisions/article-41-local-services/section-4113-powers-and-duties-of-local-governmental-units

c. Contracted program staff will enter data monthly, on pre-determined metrics, into a designated portal utilized by Broome County Mental Health Department.

d. The BCMHD Performance and Contract Management (PCM) Team oversees the development and execution of contracts, inclusive of performance metric data collection, and contract analysis. Performance Review(s) programming can occur in one, or more, of the follow ways:

1) Site Visit

2) Contracts: Contracts are reviewed annually upon renewal and the Department reserves the right to conduct a contract analysis to include program review, fiscal review, and ensure program alignment with community need(s).

20. CONTACT INFORMATION

a. Any questions and/or clarifications regarding the *Adult Non-Medicaid Care Management (NMCM) Guidelines* and case-specific information may be directed to:

1) AdultSPOA@broomecountyny.gov
2) Phone: (607) 778-1119
3) Fax: (607) 778-6189

b. For contract processes and data, contact the Performance & Contract Management team at:

1) MHContracts@broomecountyny.gov
2) Phone: (607) 778-1118

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