Broome County

Mental Health Department

GUIDELINES

Adult Non-Medicaid Care Management

***PROPOSED* Effective: 01/01/2025**

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1. INTRODUCTION

In 2014, the NYS Office of Mental Health (OMH) *Adult Targeted Case Management* (TCM) program transitioned to the NYS Department of Health (DOH) Health Home (HH) Care Management and making 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. Further, only those SMHCMAs that applied to OMH, and were approved, were able to accept, serve, and bill Medicaid for Health Home Plus (HH+) Care Management services for individuals under an Assisted Outpatient Treatment (AOT) order. 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 *GUIDELINES*[3] 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 January 1, 2025.

2. FUNDING

a. NYS OMH State Aid funding is provided to serve eligible individuals, with specific service needs, that cannot be enrolled in a Health Home because they are without proper Medicaid coverage. BCMHD directly contracts with, and governs the oversight of, local not-for-profit service providers for the provision of the services.

b. All providers that receive funding to operate Adult Non-Medicaid Care Management programs must:

   1) Operate an established NYS Department of Health (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 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.

   4) Assist individuals – who may be eligible - to activate / apply for Medicaid and/or Managed Care services packages (e.g., New York State of Health) whenever possible, to establish these benefits and transition the individual to Medicaid-supported Health Home Care Management.

[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.

3. PROVIDER REQUIREMENTS

a. Program requirements are to be carried out consistent with the New York State (NYS) Department of Health (DOH) Medicaid Health Homes Policy and Guidance[4] AND OMH guidance[5].

b. The Non-Medicaid Care Management program provides services in alignment with the New York State (NYS) Department of Health (DOH) Medicaid Health Home (HH) program as specified in NYS DOH Medicaid HH Policy and Guidance[6] and NYS Office of Mental Health Guidance[7] for individuals ages 18 and older with Mental Illness (SMI) who meet eligibility requirements to receive NYS Medicaid Health Home services, with the exception of active Medicaid eligibility.

c. All providers that receive funding to operate Adult Non-Medicaid Care Management programs must:

1) Operate an established NYS Department of Health (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 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.

4) Wherever possible, assist individuals – who may be eligible - to activate / apply for Medicaid and/or Managed Care services *(e.g., New York State of Health)*, to establish these benefits and transition the individual to Medicaid-supported Health Home Care Management.

4. POLICIES AND PROCEDURES

a. Specialty Mental Health Care Management Agencies (SMHCMAs) must have planning, policies, and procedures in place to ensure care managers create, document, execute and update an individualized, person-centered *Plan of Care* for everyone. As detailed in the New York State (NYS) Department of Health (DOH) Medicaid Health Homes Policy and Guidance.[8] These services include, but are not limited to:

1) Comprehensive Care Management

2) Care Management and Health Promotion

3) Comprehensive Transitional Care

4) Enrollee and Family Support

5) Referral to Community and Social Supports, *and*

6) Use of Health Information Technology (HIT) to access data through the Regional Health

[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/
[6] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm
[7] https://omh.ny.gov/omhweb/adults/health_homes/
[8] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

Information Organization (RHIO)/qualified entities for the implementation of Health Homes.

5. EXPECTED OUTCOMES

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

e. Reduce in incidences of homelessness, justice-involved recidivism, Comprehensive Psychiatric Emergency Program (CPEP) utilization, and number of psychiatric hospitalizations as evidenced in Healthcare Effectiveness Data and Information Set (HEDIS) measures and/or Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) indicators.

f. The program will deliver services in a culturally competent, strength-based / trauma informed manner, and will work to reduce racial/ethnic disparity that may exist for individuals with Serious Mental Illness (SMI) in Broome County.

6. SCOPE OF WORK

a. Non-Medicaid Care Management program requirements include:

1) Referral & Prioritization
2) Case Assignment & Engagement
3) Caseload & Service Provision Contact Requirements
4) Cultural Literacy & Language Access
5) Documentation & Utilization Review
6) Transition & Discharge
7) Personnel / Staffing & Funding
8) Data Collection & LGU Oversight

b. Providers are expected to:

1) Provide 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* noted above.

2) Participate in at least 80% of scheduled A-SPOA Committee meetings annually. A-SPOA meetings are held on the second and fourth Wednesday of each month.

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

4) Assist individuals to obtain Medicaid coverage including application, documentation, and communication with providers and community partners.

5) Transition individuals to/from Non-Medicaid Care Management slots to Medicaid-reimbursable Health Home services without disruption of Care Management services once Medicaid eligibility is established.

7. PERSONNEL

a. Due to anticipated future Medicaid eligibility, and a sincere desire for continuity of services with the least disruption to the recipient, personnel who will provide the Non-Medicaid Care Management services must meet NYS DOH[9] & OMH guidance[10] 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. 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/.[11]

8. CULTURAL COMPETENCY & LANGUAGE ACCESS

a. 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.[12][13]

b. 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.[14]

c. 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 training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees."[15][16]

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

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

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

[12] 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.

[13] 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.

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

[15] 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)

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

d. NYS Department of Health, Office of Mental Health, Office of Addiction Services and Supports, and Office of Children and Family Services cite the following:[17]

> *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 families and children they serve and use that knowledge to implement policies and inform practices that support quality interventions and good health outcomes for children. Given changing demographics, this process is ongoing.*
>
> *Medicaid-enrolled children may live in families where English is not spoken at home. State Medicaid agencies and Medicaid managed care plans, as recipients of federal funds, also have responsibilities to assure that covered services are delivered to children 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.[18] 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.[19][20]*
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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.*

e. 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*;[21] *A Physician's Practical Guide to Culturally Competent Care*;[22] *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* [23](the National CLAS Standards); and *The National CLAS Standards implementation guide, A Blueprint for Advancing and Sustaining CLAS Policy and Practice*.[24]

9. CASELOAD REQUIREMENTS

a. To promote continuity of service for individuals, Adult Non-Medicaid Care Management services mirror those of NYS DOH HH including eligibility, documentation, services, and staff requirements. Accordingly, caseload sizes will allow for adequate time to provide Care Management based on individual need.

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

[18] 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

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

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

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

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

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

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

b. The intensity of service, including the number of contacts per month, is driven by the needs of the individual being served, and will be justified and documented in the individual's case record accordingly.

c. For care managers serving individuals receiving AOT (Kendra's Law), NYS DOH and OMH requirements must be followed, accordingly. Full details of requirements located in the Health Home Plus (HH+) Program Guidance for Assisted Outpatient Treatment (AOT), Re-Issued September 2021[25].

10. 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 active Medicaid and meet Health Home[26] eligibility criteria - which must include a mental health diagnosis(es) and a goal in the Plan of Care related to mental health diagnosis(es).

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 SMHCMA provider.

d. Priority Status is assigned to individuals on Assisted Outpatient Treatment (AOT), high-need SMI populations, and those returning to the community from institutional settings.

11. INITIAL AUTHORIZATION

a. Initial authorization is approved for twelve (12) months of Non-Medicaid Care Management at the time of initial assignment at the A-SPOA meeting.

b. Requests for continued Length of Stay (LOS) via Utilization Review process are covered later in this document.

12. CASE ASSIGNMENT & ENGAGEMENT

a. Case Assignment is made by the Broome County Adult SPOA Team and take a number of factors into account including, but not limited to:

   1) Recipient choice.

   2) Previous Care Management Agency relationship

b. Providers should begin OUTREACH/ENGAGEMENT to the identified recipient within 48 business hours after receipt of the referral from Adult SPOA.

c. Providers should advise A-SPOA Team of any communication/location barriers and/or inability to contact assigned recipient within 30 days of assignment as defined in NYS DOH HH Diligent Search Efforts.[27]

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

[27] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0006_continuity_of_care_policy.pdf

13. CASELOAD & SERVICE PROVISION CONTACT REQUIREMENTS

a. Caseload per qualified Care Manager should follow NYS DOH & OMH guidelines.

b. Contact requirements are to occur in alignment with the NYS DOH Medicaid Health Homes Policy and Guidance[28], or in accordance with any subsequent update that may be released by NYS DOH or NYS OMH.

c. Recipient will receive, at minimum, at least:

1) One (1) face-to-face contact of 15 minutes or more, quarterly.

AND

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

AND

3) Providers must contact recipients within 48 business hours of admission to/discharge from an inpatient unit or hospital once notified. This is to facilitate the care transition and engage in the discharge planning process.

d. Collateral Contacts – including phone calls between the provider and recipient's care team - are acceptable, but do not replace the efforts necessary by the provider 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 recipient are not possible, the attempt(s) to contact must be documented to evidence work completed to try and engage the individual 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 are continuing to be provided to the recipient, and justification documented in the individual's record.

h. If the individual is being served as an *AOT*, Health Home Plus (HH+) Program Guidance for Assisted Outpatient Treatment (AOT)[29] outlines that at least four (4) face-to-face contacts be made within the month.

14. MONTHLY ROSTER AND MEDICAID VERIFICATION

a. Providers will submit monthly rosters - via method identified by A-SPOA - to document changes in 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 the month. Meeting schedule is available from: AdultSPOA@broomecountyny.gov.

b. At the beginning of each month, providers 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.

c. If an individual has compatible Medicaid code upon a monthly check, please see *Transfer of Programs* section of this document.

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

15. CASE RECORD

A care management record must be maintained for all individuals enrolled in the Non-Medicaid Care Management program. The record will contain, at minimum:

a. Comprehensive Assessment / Needs Assessment

1) Assessments should be completed in accordance with the following Time Frames:

a) Initial: Providers are required to complete the Assessment no later than 60 days from the Date of Admission. [NOTE: *Date of Admission* - the date the individual signs consent for the provision of care.]

b) Annual Reassessment: Reassessments are to be conducted annually in preparation for a request for Length of Stay (LOS) via the Utilization Review process.

c) As Needed: Reassessments can be conducted at any time, based on care manager discretion.

2) Assessment for 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.

3) Assessments should evaluate the following:

a) Individual's eligibility and appropriateness for Non-Medicaid Care Management services.

b) Recipient's strengths, interests, resources, and support systems.

c) Individual's behavioral/medical health conditions and Care Management needs.

d) Social Determinant factors and related service needs.

e) High-risk behavior that may impact the individual's overall health and recovery.

4) For individuals under the provision of AOT, Health Home Care Managers and 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).[30]

b. Plan of Care (POC)

1) For individuals assigned to Non-Medicaid Care Management through A-SPOA, a Plan of Care (POC) must be developed no later than 60 days from the Date of Admission (as defined in section [15(a)(1)(a)(1)] above) – consistent with NYS DOH Guidance.[31]

2) 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.

3) The plan of care must include the following specific elements:

a) The individual's stated, person-centered Goal(s) related to treatment, wellness, and recovery.

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

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.

g) Documentation of participation Any involved behavioral/medical/community providers and supports.

4) 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.

5) 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.

c. Documentation of Contacts

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

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

16. UTILIZATION REVIEW

a. As indicated this document, 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 needs of recipients and determine continued eligibility and transparency with the A-SPOA Committee.

b. If the Specialty Mental Health Care Management Agency (SMHCMA) documentation substantiates – and the recipient is agreeable to continued service provision – the Care Manager must submit a completed *Utilization Review (UR) for extension of Length of Stay (LOS)* form to AdultSPOA@BroomeCountyNY.gov at nine (9) months of enrollment to allow time for a transitional discharge plan if an individual is not approved for a continuation of services by the A-SPOA Committee.

c. Each UR is presented to the A-SPOA Committee for a determination of continued eligibility. The UR requires, at a minimum:

1) Mental health diagnosis(es).

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

3) Progress made on the 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.

d. A *Disposition Letter*, documenting the determination of the A-SPOA Committee, will be distributed to SMHCMA personnel who submitted the request and includes dates for service provision discussed at the A-SPOA Committee meeting.

17. TRANSFER OF PROGRAMS

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

1) As noted above, SMHCMAs must check a recipient's Medicaid eligibility monthly. If a recipient is noted to have active Medicaid, without a disqualifying Restriction Code, the SMHCMA should work to transfer the individual to the SMHCMAS's Medicaid-reimbursed Health Home program.

2) With consideration of the needs of the recipient, and the relative strengths of the current Case Manager and other Health Home personnel, care should be taken to exercise the least disruption to the recipient.

3) The SMHCMA must notify the recipient of the anticipated program status change – from Non-Medicaid Care Management to Medicaid Health Home - and ensure a smooth transition between programs will be made. The individual should then be noted as a "Transfer" on the program's monthly roster with A-SPOA.

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

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 may be considered to continue to support the individual in managing their needs.

2) Referral and Prioritization processes noted above are applicable including an A-SPOA Application and valid *Universal Consent for Release of Information*. Care Management Agencies should verify necessary documents are on file with A-SPOA for any planned transfers. The individual can be viewed with a Priority Status, bypass the waitlist, assigned to a SMHCMA, and presented to the Adult SPOA Committee for assignment to the Non-Medicaid Care Management Roster.

c. Transition BETWEEN Care Management Agencies

1) The A-SPOA Team is to be notified of any potential transfers and reassignment via this process.

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

3) If an individual continues to express interest in transferring, open communication and planning between all parties involved is expected to ensure a smooth, successful transition. A Transitional Plan will be constructed, and a warm hand-off will be utilized whenever possible to reduce gaps in services. Whenever possible and appropriate, the current Care Manager will continue to work with the individual using the active and update-to-date Plan of Care (POC) while transitional activities are occurring to ensure the least amount of disruption to the individual.

18. DILIGENT SEARCH EFFORTS

a. As outlined in NYS DOH Policy Number HH0006, Continuity of Care and Re-engagement for Enrolled Health Home Members[32], in the event individuals disengage 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. In accordance with the guidance, Diligent Search Efforts and Excluded Setting status allows flexibility regarding the expected timelines and are considered on a case-by-case basis.

19. DISCHARGE

a. Individuals are discharged from Non-Medicaid Care Management services in accordance with their needs, recovery goals and eligibility criteria. The individual, 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. As outlined in NYS DOH Policy Number HH0006, Continuity of Care and Re-engagement for Enrolled Health Home Members[33], in the event individuals disengage 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. In accordance with the guidance, Diligent Search Efforts and Excluded Setting status allows flexibility regarding the expected timelines and are considered on a case-by-case basis.

c. Reasons for discharge may include, but are 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.
   4) The individual is lost to contact/engagement.
   5) The individual has obtained Medicaid and is HH eligible.
   6) The individual has been placed in an "Excluded Setting" for an extended period of time.
   7) The individual has since deceased.

d. Notification to the A-SPOA team for individuals discharged from the Non-Medicaid Care Management program via email, phone call, or as reported in the A-SPOA Committee meeting by the care manager or SMHCMA.

e. If a discharge plan has previously been discussed with the Adult SPOA team and/or Committee, and the plan changes, updates to the Comprehensive Assessment must be completed to reflect changes and communicated to A-SPOA Team.

f. For AOT-involved individuals, providers should follow discharge procedures in accordance with AOT HH+ Guidance.[34]

[32] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/ces_tool_faqs.htm
[33] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/ces_tool_faqs.htm
[34] https://omh.ny.gov/omhweb/adults/health_homes/hhp-final.pdf

g. Discharges occurring within the *Initial Authorization* period of twelve (12) months, or within the extension period as approved by the A-SPOA Committee, do not require a Utilization Review.

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

20. DATA COLLECTION & LGU OVERSIGHT

a. Under Mental Hygiene Law, the Local Government Unit (LGU), all population groups 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.[35]

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

a) 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.

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

2) Data Collection & Analysis

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

c. 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) Contract Analysis

Minimally, contracts are reviewed annually upon renewal.

21. PARTICIPATION IN SPOA COMMITTEE MEETINGS

a. Agencies operating Non-Medicaid Care Management programs are expected to attend 80% of the scheduled A-SPOA meetings to receive referrals and provide updates on previously assigned cases.

b. A-SPOA Committee meetings are conducted virtually and scheduled to meet twice monthly, presently the 2nd and 4th Wednesday of the month at 10:30AM. 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 (1) Primary Contact and (2) Secondary Contact for A-SPOA business.

[35] 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

22. QUESTIONS – CLARIFICATIONS

Questions and/or Clarifications regarding these *GUIDELINES* are directed to:

a. For case-specific information, Adult SPOA

- AdultSPOA@broomecountyny.gov
- P: (607) 778-1119/(607) 778-1120

b. For contract processes and data, Performance & Contract Management team

- MHContracts@broomecountyny.gov
- P: (607) 778-1118

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