Broome County

Mental Health Department

Adult & Child Non-Medicaid Care Coordination

Guidelines

Adult & Child Non-Medicaid Care Coordination Guidelines

1. Introduction

In an effort to streamline waitlists and clarify expectations, Broome County Mental Health Department (BCMHD) has developed guidelines for Adult and Child Non-Medicaid Care Coordination programs regardless of Consolidated Fiscal Report (CFR) Program Code. Non-Medicaid Care Coordiation includes the following program codes, operationalized as Care Coordination:

- 2620 Health Home Non-Medicaid Care Management,
- 2720 Non-Medicaid Care Coordination, and
- 5990 MICA Network.

These guidelines are effective beginning 01/01/2020.

2. Funding

Funding, by OMH via State Aid letter to Broome County as a Local Government Unit (LGU), is provided to serve individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED), who are without Medicaid. BCMHD directly contracts with and governs the oversight of local not-for-profit service providers for the provision of certain services.

OMH State Aid funding is used to serve individuals in need of care managment services that cannot be enrolled in a *Health Home* because they are without Medicaid. For individuals who are without Medicaid, but may be eligible for Medicaid and/or Managed Care services packages, the Care Manager should work with the individual, whenever possible, to establish these benefits and transition the individual to Health Home Care Management.

Beginning September 2020, providers receiving funding to operate Adult & Child Non-Medicaid Care Coordination programs are expected to be a contracted downstream Care Management Agency (CMA) with a corresponding Medicaid Health Home, in good standing, with an active case load. Providers who do not meet this expectation will be reviewed for appropriateness for 2021 Non-Medicaid Care Coordination programming.

3. Eligible Population

Individuals in need of care managment services who cannot be enrolled in a Health Home because they are without Medicaid.

a. Adult

Eligible population is individuals 18 years of age or older with Serious Mental Illness (SMI). This would include special populations such as those receiving *Assisted Outpatient Treatment (AOT)* and other high-need SMI populations.

b. Child
Eligible population is individuals up to 21 years of age with Serious Emotional Disturbance (SED) diagnosis or Complex Trauma involvement.

4. Referral Process and Case Assignment

It is expected *Adult* and *Children's Single Point of Access (A-SPOA & C-SPOA)* and providers work collaboratively to manage individuals without Medicaid. As provided under Article 41 of Mental Hygiene Law, LGU/SPOA has oversight responsibilities for high-need populations and facilitates access to behavioral health serivces. Referrals to SPOA come from multiple sources including community providers, schools, Assertive Community Treatment (ACT) teams, forensics, hospitals, etc. Documentation is needed to support that the referred individual has a SMI or SED diagnosis.

Upon receipt, SPOA reviews the referral for eligibilty, discuss appropriateness, and facilitate distribution to an appropriate provider at the SPOA Committee meeting. Individuals are approved for twelve (12) months of Non-Medicaid Care Coordination at the time of initial assignment at the SPOA meeting.

Priority Status is assigned to individuals on *Assisted Outpatient Treatment (AOT)*, high-need SMI/SED populations, and those returning to the community from institutional settings. SPOA works directly with providers to facilitate rapid access in warranted cases.

5. Caseload and Contact Requirements

To promote clarity and continuity of service for individuals, *Non-Medicaid Care Coordination* expectations mirror those of Health Homes including eligibility, documentation, services, and staff requirements. Accordingly, caseload sizes should ensure the following:

- Caseload size should allow for adequate time providing care coordination based on individual need.
- For care managers serving individuals receiving *AOT* (Kendra's Law), NYS Department of Health and Office of Mental Health requirements must be followed accordingly.

The intensity of service, including the number of contacts per month, is driven by the needs of the individual being served.

- At minimum, the individual receives at least one (1) face-to-face contact of 15 minutes or more and one (1) additional contact either face-to-face or via phone, email, or text message within the month.
- If the individual is *AOT*, at least four (4) face-to-face contacts must be made within the month; refer to AOT HH+ Guidance.

Documentation of contact with the individual, providers, and other supports should be maintained in the care management record.

6. Staffing Requirements

Education, experience and training requirements for staff and supervisors are consistent with Medicaid Health Home guidelines:

- Children Care Manager Qualifications Waiver Request Guidance for "high" acuity: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/guidance/hhcm_staff_qualification_waiver_guidance.htm

- Adult Care Manager Qualifications to conduct the NYS Community Mental Health Assessment: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_bh/index.htm#ref1

Background checks should be performed consistent with the NYS DOH Medicaid Health Home policy: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0010_background_checks_policy.pdf

7. Care Management Record

A care management record must be maintained for all individuals enrolled in the *Non-Medicaid Care Coordination* program. The record contains at minimum: the plan of care, needs assessment, progress notes, and copies of any releases of information signed by the individual or their caregiver.

a. Needs Assessment

Providers serving the Non-Medicaid population are required to complete an approved Needs Assessment no later than 60 days from the date of admission, which is the date of consent to the program. Reassessment may be conducted as needed including if there is an adverse event, and in preparation for Utilization Review. The needs assessment should evaluate the following:

- The individual's strengths, interests, resources and support systems
- The individual's behavioral/medical health conditions and care coordination needs.
- Current behavioral/medical/community network providers
- Social determinant factors and related services needs
- High-risk behavior that may impact the individual's overall health and recovery

Child

The *Child and Adolescent Needs and Strengths – New York (CANS-NY)* assessment should be used by Care Managers serving the child population and entered into the NYS OMH *Child and Adult Integrated Reporting System (CAIRS)* database.

Adult

The *Comprehensive Assessment* should be used by Care Managers serving the adult population. https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

b. Plan of Care (POC)

For individuals assigned to Non-Medicaid Care Coordination through SPOA, a POC must be developed no later than 60 days from the date of admission. The POC should include, at minimum, the following elements:

- The individual's person-centered goals,
- Description of planned care management interventions,
- The individual's preference and strengths, and
- Any involved behavioral/medical/community providers and supports.

The POC is updated at least annually, or more often as needed when new needs are identified, and/or the individual's goal(s) change over time. Updates should be made when warranted by a significant life event or change in the individual's medical and/or behavioral health condition.

8. Program Requirements

Program requirements are to be carried out consistent with the *Health Home Standards and Requirements for Health Homes, Care Management Providers, and Managed Care Organizations guidance* document distributed by the NYS Department of Health. Namely, the service should provide the six Health Home Core Services:

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Enrollee and Family Support
5. Referral to Community and Social Supports
6. Use of Health Information Technology (HIT) to Link Services

9. Utilization Review

While individuals are approved for twelve (12) months of *Non-Medicaid Care Coordination* at initial assignment at the SPOA meeting, a Utilization Review (UR) process examines the ongoing needs of individuals at nine (9) months of enrollment. The UR is presented to the SPOA Committee and discussed for continuation. The UR requires, at a minimum, progress that has been made on the goals outlined in the plan of care, outstanding needs that require ongoing care coordination, and updates on any adverse events that occurred.

10. Transition/Discharge from *Non-Medicaid Care Coordination*

Individuals are discharged in accordance with their needs, recovery goals and preferences. The individual, along with their providers and natural supports, should be involved in the development of a discharge plan. The plan should include any linkages and/or information to support the individual's health, service needs, and safety post discharge.

Reasons for disenrollment may include, but are not limited to:

- The individual, care manager, and providers/natural supports agree that the individual has met the goals of his/her Plan of Care and no longer requires the services of a care manager.
- The individual no longer wants to receive care coordination.
- The individual has relocated outside of Broome County.
- The individual is lost to contact.
- The individual has obtained Medicaid and is *Health Home* eligible.

For individuals disengaged in services, consistent with NYS guidance, the provider 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. For AOT individuals, providers should follow discharge procedures in accordance with AOT HH+ Guidance.

11. LGU Oversight

LGU/SPOA has oversight of *Non-Medicaid Care Coordination* slots funded by OMH State Aid. SPOA facilitates a current roster of individuals enrolled with each program. Providers are expected to work cooperatively with SPOA, providing notification of status changes promptly. SPOA maintains a single Adult, and a single Child, waitlist for access to *Non-Medicaid Care Coordination* programs. Eligibility and priority are determined in concert during SPOA Committee meetings.

a. Performance and Contract Management

BCMHD *Performance and Contract Management* staff conduct a site visit and on-site audit of records consisting of 10% of individuals served by each program on an annual basis, but not less than five (5) records. Advanced notification of at least one week is provided prior to the record review. Record review looks for the required elements of the Care Management record including, but not limited to: a Plan of Care, progress notes, and number and type of contacts.

b. Quality Measures

BCMHD monitors the *Length of Stay (LOS)*, percent of referred individuals enrolled (% enrolled), and number of days spent on the waitlist for individuals referred to each program.

c. Participation in SPOA Committee Meetings

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

- A-SPOA Committee meeting is scheduled to meet on the 2nd and 4th Wednesday of the month at 10:30AM.
- C-SPOA Committee meeting is scheduled to meet every Tuesday of the month at 9:00AM.

Questions

Any questions may be directed to: *MHContracts@co.broome.ny.us*.