CCMP

Adult Policy and Procedure Manual

A New York State Health Home Program

CCMP Health Home
31-21 31st Street
5th Floor
Long Island City, NY 11106

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ii.INTRODUCTION

A. Background & Mission

CCMP is a New York State Department of Health (NYSDOH) approved Health Home comprised of partners with a long history of service to those experiencing chronic mental and physical health challenges.

CCMP helps chronically ill New Yorkers navigate and access healthcare and social services to improve their health and wellbeing. Through our comprehensive community-based network, we offer person-centered, high-quality, and cost-effective care coordination services that promote stability, autonomy, and dignity.

The goal of CCMP is to improve the health of our members by providing quality care management. We pledge to promote the quality standards and best practices set forth by the NYSDOH with regard to health home implementation. Section 1945(h)(4) of the Social Security Act defines health home services as "comprehensive and timely high-quality services" and promulgates the following health home services be provided by designated care management agencies:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support, which includes authorized representatives
- Referral to community and social support services, if relevant
- The use of health information technology (HIT) to link services, as feasible and appropriate

Our Care Management Agencies are the central points for coordinating and directing patient-centered care and are accountable for reducing avoidable health care costs, preventing unnecessary hospital and emergency room visits; providing timely post discharge follow-up, wellness and preventative care; improving member outcomes by addressing primary medical, specialist and behavioral health care; assisting the member in connecting with appropriate service providers, and promoting comprehensive and integrated support.

While the guidelines in this manual adhere to best practices and regulatory standards of care management, we expect that many of our network members and care management providers already meet or exceed the standards herein. Therefore, this program manual presents the minimal standards and procedures that will be reflected in our partners, providers, and network members.

This manual and supporting forms are available to all FCM users at this link: CCMP Support Page-FCM

B. CCMP Partners & Network

MAILING ADDRESS: 31-21 31st Street, 5th Floor, Long Island City, NY 11106.

The CCMP governing partners are:

- Argus Community, Inc., 760 East 160th Street, Bronx, NY 10456
- Sun River Health, 71 West 23rd Street New York, NY 10010
- Community Healthcare Network, 60 Madison Avenue, 5th Floor, New York, NY 10010
- iHealth, c/o AIDS Service Center NYC, 41 East 11th Street, 5th Floor, New York, NY, 10003
- The Institute for Family Health, 16 East 16th Street, 4th Floor, New York, NY 10003
- The Mount Sinai Medical Center, One Gustave L. Levy Place, New York, NY 10029
- Urban Health Plan, Inc., 1065 Southern Boulevard, Bronx, NY 10459
- VNS Health, 220 E 42nd St, New York, NY 10017

The CCMP Health Home entity is overseen by a full-time Chief Executive Officer who reports directly to the CCMP Board of Directors.

The CCMP Health Home effort is supported by a large city-wide interdisciplinary network of Care Management Agencies (CMAs) for whom this manual has been developed.

<u>CCMP Health Home Contact Information</u>
Nathan Ito-Prine, Chief Executive Officer
31-21 31st Street, 5th Floor, Long Island City, NY 11106
Phone: 917-566-9314
Email: Nathan.Ito-Prine@ccmphealthhome.org

C. Care Management Overview

Care management is a multi-step process which ensures coordination of and expedient access to a range of appropriate medical and social services for the member and family. The goal is to promote and support the independent functioning of the member and their family unit. Care management staff work with the member to assess strengths and identify needed services, assist the member in developing a Health Home Plan of Care to meet those needs, help to arrange access to appropriate services, act as a member and systems advocate, monitor progress in obtaining these services, and make necessary adjustments to the Health Home Plan of Care as resources and needs change over time.

Care coordination and integration of health care and social services are provided to all health home members by an interdisciplinary team of providers, where each member's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the member's Health Home Plan of Care.

All Care Management Models described in this Policy Manual apply to CMAs serving Adults (HHSA).

The Health Home Serving Children (HHSC) Model is not covered in the Policy Manual. Please see the CCMP Children's Policy and Procedure Manual.

Prior to 10/31/19, the Children's Manual was supplemental to the Adult Manual and Children's CMAs were instructed to follow both Manuals.

Effective 10/31/19, Children's CMAs should follow only the Children's Manual as it is now a standalone document.

D. Notes on Language

Members:

CCMP strives to use Person-Centered language in its documents whenever possible. Previous versions of our policy manual described the recipients of our Health Home Care Management services as “clients”. This appears to be the most common term in use within our CMAs, though the terms “consumers”, “service recipients”, and “members” are also used.

In the 2019 version of this manual, we have adjusted our language to match that used in DOH Policies, and by the Medicaid MCOs, which is most commonly “members”. Our Electronic Health Record (FCM) uses the term “patients”. Some supporting documents related to use of FCM may also use the term “patients” to match verbiage within FCM.

Managed Care Organizations:

In this manual, the abbreviation “MCO” is used to refer to any Medicaid Managed Care Organization that is contracted with CCMP (including MLTCs), and any subcontractors such as Behavioral Health Organization (BHO) or clearinghouses.

iii.ADMINISTRATIVE REQUIREMENTS

A. Contracting Policy

First issued: 12/17/12
Reviewed by Quality Committee:
Revised Effective: 5/2/24

Purpose:
To ensure CMAs understand when and how they may subcontract with other providers.

Policy:
CMAs may not subcontract Health Home services without CCMP approval. CMAs that engage in this practice hold full responsibility for the actions of their subcontractor, inclusive of requirements under OMIG, NYS Social Services Law (SOS) § 363-d, Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) SubPart 521-1, HIPAA, and HITECH. CMAs are required to honor their contracts with CCMP, an notify CCMP of key changes.

Procedure:
1. CMA must notify CCMP of their intention to engage a subcontractor for billable Health Home services, and request approval prior to entering into a subcontracting relationship.
   1.1. If approval is not granted, the issue will be presented to the board of directors for review.

2. The board of directors must come to a decision within ten business days. If no decision is reached within the ten days, then the subcontractor is considered approved.

3. CMAs must notify CCMP of any changes to the CMA's National Provider Identification (NPI) number, Medicaid Management Information System (MMIS) provider ID, Corporate Name, or Category of Service (COS) 0265.

4. CCMP uses the Notification of Change Form to update DOH of changes as they occur.

5. A CMA interested in expanding their program to provide care to an additional population served by CCMP should reach out to Nathan Ito-Prine, Chief Executive Officer, at nathan.ito-prine@ccmphealthhome.org.

B. Minimum Billing Standards Policy

First Issued: 8/4/15

Reviewed by Quality Committee: 10/13/20

Revised Effective: 6/14/24

PURPOSE: To outline the requirements to bill for Health Home Care Management Services within an Enrolled Segment. Effective 7/1/20, CCMP continues to use the Outreach Segment to track referrals and pre-enrollment work, but there are no billable services associated with the Outreach Segment.

POLICY:

To bill for a Health Home Care Management Rate Code, eligibility, core service, and plan of care requirements must be met and documented on a billing support questionnaire.

Procedure:

1. Member is eligible for the Health Homes Program, including eligibility requirements for Health Home Plus (if applicable).
   1.1. All eligibility requirements must be verified/documented in the record per the Eligibility Requirements Policy and Continued Eligibility for Services Policy.
   1.2. Health Home Consent, Initial Appropriateness, Qualifying Diagnoses, and Continued Eligibility for Services Tools must be synced to MAPP within specified timeframes.

2. The required minimum number, and type of Core Services were provided to the member within the month, per the program model (Standard or Health Home Plus).
   2.1. A note describing the provision of the Core Service(s) is documented in the record.

3. A Billing Support Questionnaire synced to MAPP, documenting the provision of the Core Service(s), the Functional Clinical Indicators of the member, and whether or not the member is eligible for and met requirements for Health Home Plus (if applicable).
   3.1. Verification of Functional Clinical Indicators must be present in the case record per the Billing and Documentation Guidance for Health home Adult Rates with Clinical and Functional Adjustments.

4. A Plan of Care must be updated, signed, and synced to MAPP See the Plan of Care Policy for details.

5. FCM and MAPP have “hard-stops” to prevent claims from being processed for members who do not meet the billing requirements.

6. CMAs are expected to provide supervisory and quality oversight over the claims submission and reconciliation process to ensure that all requirements for billing are supported in the chart, and that bills are submitted at the correct rate code.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits, billing audits, FCM validation controls, and monthly metrics, per the Quality Management Program Policy.

Sources:

Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016
Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009
Billing and Documentation Standards for Health Home: High, Medium, and Low (HML) Rates with Clinical and Functional Adjustments
DOH Guidance: Elimination of Health Home Billing for Outreach

C. Quality Management Program Policy

First Issued: 12/7/12
Reviewed by Quality Committee: 7/9/19
Revised Effective: 6/14/24

Purpose:
CCMP is responsible for supporting high quality outcomes for all Health Home members attributed to NYS Medicaid and contracted MCOs. The purpose of this policy is to ensure that CCMP can effectively assure and improve quality within our network, through a Quality Management Program (QMP).

Policy:
CCMP helps chronically ill New Yorkers navigate and access healthcare and social services to improve their health and wellbeing. Through our comprehensive community-based network, we offer person-centered, high-quality, and cost-effective care coordination services that promote stability, autonomy, and dignity. CCMP's QMP is an integral part of carrying out our mission. The Chief Policy and Compliance Officer has overall responsibility for the daily operation of the QMP and serves as both the QMP Committee Chair and QMP Coordinator.

Procedure:
1. The Chief Policy and Compliance Officer reports to the Chief Executive Officer and has their support for all QMP activities.

2. The Chief Policy and Compliance Officer reports to the CCMP Board of Directors about QMP activities at least quarterly. These reports are documented in the Governance Committee meeting minutes.

3. The Chief Policy and Compliance Officer chairs a monthly Quality Committee.

Membership consists of:

CCMP: Chief Executive Officer, Operations Manager, Quality Improvement Specialists, and other CCMP staff as needed.

CMAs: At least one representative from all CCMP Network CMAs. Representatives have a significant role in quality oversight for their CMA, and may be in a Supervisor, Director, or Quality Assurance role. Participation of Care Managers or Executive level staff may be allowed on a case-by-case basis.

4. Responsibilities of the Quality Committee are described in the CCMP Quality Committee Charter as:
   - Advising the CCMP Health Home regarding the development and implementation of policies and best practices that guide the provision of service by CCMP Care Management Agencies (CMA).

- Recommending policies and best practices that establish the required and expected standards for care management intervention built upon the regulatory frameworks established and enforced by the CCMP Health Home Governance Committee, the New York State Department of Health, and the Managed Care Organizations which reimburse for Care Management services.
- The guiding principles driving the committee's recommendations are person-centered care, mitigation of barriers to wellbeing related to the social determinants of health, and increased adherence to recommendations for primary, behavioral, and pharmacy health services.

5. Standing Agenda items for the Quality Committee are:
    - Review of new/revised DOH Policies
    - Development, review, and approval or new/revised CCMP Policies
    - Review of CMA Network Metrics
    - Review of CMA Network Chart Audits
    - Guest or CMA presentations/trainings on innovative programs and best practices

6. The Quality Committee reviews trends in other areas on an as needed or annual basis, including oversight of member/family satisfaction surveys and complaints.

7. All data shared with the Quality Committee is de-identified; no Protected Health Information is shared.

8. Quality Committee minutes, slide decks, and other materials are saved in the CCMP files.

9. The Quality Committee is attended by Children's and Adult CMAs. Children's CMAs also attend a bi-monthly Children's Committee to address quality and operational issues that only apply to the HHSC program.

10. The Quality Management Program is reviewed annually for successes, areas for improvement, and new goals.

11. The CCMP Quality Management Program consists of five main areas:
    - Policies
    - Metrics
    - Audits
    - Performance Improvement
    - Training

1. Policies

1. The CCMP Policy and Procedure Manual is distributed to all CMAs upon joining the network. An updated version is distributed annually, with earlier updates made if needed. There is a separate version of the Manual for Adult CMAs and Children's CMAs.

2. New and revised policies are reviewed by the Quality Committee prior to issuance, whenever possible.
   2.1. Policies that apply only to Children's CMAs, or where the Children's version of the policy is significantly different from the Adult version, may be reviewed in the Children's Committee instead of the Quality Committee.

3. Policies are dated as follows:

   First Issued: The date any version of the policy was first released to the CMA Network
   Reviewed by Quality Committee: The most recent date that the current version was reviewed and approved by the Quality Committee (if it was reviewed by the Children's Committee, it will say "Children's Committee" instead)
   Revisions Effective: If the current version is a revision, the effective date of that revision.

4. All prior versions of policies (including revision dates) are saved in the CCMP files.

5. When new or revised DOH Policies are issued, CCMP shares them with the CCMP CMA Network immediately. This allows them to begin learning and understanding the new policy, and they may initiate changes to their internal procedures accordingly.

6. CCMP endeavors to issue new policies and policy revisions in response to DOH policy changes as soon as possible, but no more than 60 days after the DOH policy was issued.

7. CMAs are held accountable during audit for the most recent CCMP Policy Revision in effect at the time of the document or service being audited.

8. CCMP CMAs are expected to follow all CCMP Policies and Procedures; they complete an annual attestation of such at the time of the annual Policy and Procedure Manual distribution.

9. CCMP Policies are written to follow all DOH policies governing Health Homes.

2. Metrics

1. CCMP conducts large-scale quality reviews (Metrics) using Health Information Technology (HIT) tools monthly and shares the results with the network.

2. Metrics are identified, developed, reviewed, and revised by the Quality Committee.

3. For each Metric, the Quality Committee identifies at least one specific benchmark that can be measured out of the FCM Electronic Health Record.

For example:
Metric*- Assessments*
Benchmark*: At any given time, at least 95% of Enrolled (not Pended) members will have a completed Comprehensive Assessment in FCM within the last 12 months.*

4. As benchmarks are met by the network, they are replaced with new and "deeper" benchmarks.

For example:
Metric*- Assessments*
Benchmark*: At any given time, at least 95% of Enrolled (not Pended) members will have a completed Comprehensive Assessment in FCM within the last 12 months that was done on time.*

5. Data on CMA Metric Performance is shared with CMAs monthly via email. De-identified data on CMA Metric Performance, and Network Average Performance, is discussed as an agenda item at Quality Committee at least quarterly.

6. Whenever possible, Benchmarks that the Quality Committee has vetted to be well designed and useful are built into the FCM platform, and performance on these benchmarks are filtered down to the Care Manager level.

7. CMAs' Metrics Performance over time is shared and discussed at the time of the annual site visit.

8. CMAs who do not show progress towards meeting Benchmarks are engaged in a Performance Improvement process, documented with a Performance Improvement Plan.

9. In consultation with the Operations Committee and the Quality Committee, CCMP may impose general restrictions on CMAs who do not meet certain Benchmarks. Possible restrictions are:
    - Not allowed to enroll Bottom-Up Referrals into CCMP
    - Not allowed to receive Lead Health Home Referrals from CCMP
    - Not allowed to participate in Pilot projects or MCO Incentive projects.

3. Audits

All CMAs within the CCMP network participate in three types of audits:

- CMA-Self Audits
- Lead Health Home Quality Chart Audits
- Billing Audits

CMA Self-Audits:

1. CMAs complete self-audits each quarter to send to CCMP Quality Improvement Specialist (QIS) for review

1.1. Sample size is 5% (minimum 4: maximum 20) of enrolled (not pended) members.
1.2. QIS determines the type of charts selected each quarter
- Enrolled, Discharged, or a combination
- Special Populations (Substance Abuse, HIV, SMI)
- Length of enrollment

2. CMAs use the CCMP Chart Audit Tool.

3. CCMP QIS reviews a sample of the audits and documents agreement or disagreement with the audit; feedback is given to CMAs to share with their auditors.

4. CMAs who are not able to effectively audit their own charts are engaged in a Performance Improvement process, documented with a Performance Improvement Plan.

5. Trends in Self-Audit results, including participation, timeliness, quality of audit, and audit results, are reviewed with CMAs at their annual site visits.

Lead Health Home Quality Chart Audits:

1. QIS completes Quality Chart Audits 5-10 charts, using the CCMP Chart Audit Tool prior to each CMAs annual site visit.

2. Results are shared with the CMA at the time of the site visit, and de-identified CMA results and network averages are shared with the Quality Committee.

3. CMAs that do not meet acceptable scores on the audit are engaged in a Performance Improvement process, documented with a Performance Improvement Plan.

Billing Audits:

1. Billing Audits are done using the CCMP Billing Audit Tool, by CCMP and/or the CMA, when Metrics, Self-Audits, and/or Lead Health Home Quality Audits indicate the possibility of billing concerns.

2. Billing concerns are triggered by poor performance in the following areas:
   - Eligibility
   - Health Home Plan of Care
   - Core Service Provision
   - Billing Support Questionnaire submission and/or back up documentation

3. Billing Audits may also be done in response to any allegations of suspicious claims or fraudulent activity.

4. All non-billable claims identified through Billing Audits are voided or otherwise re-paid to the payor and disclosed to OMIG.

5. Results of Billing Audits are shared with the CMA. Any indication of fraudulent billing or a pattern of non-billable claims is reported to the Governance Committee. We report issues to the requisite government agencies and payors, per the Reporting and Self Disclosure Policy.

4. Performance Improvement

1. In response to audit results, Metrics Performance, or other circumstances, CMAs may be required to engage in a Performance Improvement process, documented with a Performance Improvement Plan (PIP). The process is designed to address quality monitoring and the ability to meet Health Home quality standards.

2. he CCMP PIP Template supports the CMA in understanding the area(s) of poor performance and policy non-compliance, root cause analysis, goals for improvement, timeline for improvement, assignment of tasks to appropriate staff, need for additional training, expectations for reviewing barriers, and consequences if improvements are not met.

3. While a CMA is engaged in a Performance Improvement process, their ability to receive Lead Health Home Referrals, enroll Bottom-Up Referrals, and participate in special initiatives may be suspended.
   - 3.1. If the PIP is related to billing practices, their ability submit claims may be suspended, or claims may go through a CCMP review process prior to submission.
   - 3.2. If there is evidence that the CMA is not able to serve their current members, CCMP may require member transfers as part of the PIP.

4. Modifications to a CMA's PIP may be made by CCMP at any time, in response to progress or lack thereof.

5. CCMP will review CMA progress on the PIP at designated intervals, but no longer than six months from the start of the PIP.

6. CCMP, with express permission from Governance, will have the authority to temporarily suspend or terminate any CMA that fails to comply with their PIP and will provide the CMA with the required 30 day advance written notice.

5. Training

1. General training requirements for CMAs are described in the Staff Training Policy. In addition to the general required trainings, the Quality Management Program uses information gleaned from audit results, Metric Reports, and Quality Committee discussions to identify new training needs, and CMAs in need of more focused training and technical assistance.

2. The CCMP Quality Team has developed the following trainings for the CCMP Network:

- Intro to Health Homes, CCMP, FCM, and TalentLMS Training
- CCMP Eligibility Training
- CCMP Enrollment Training
- CCMP Health Home Plan of Care Training
- CCMP Care Conferencing Training
- CCMP Comprehensive Assessments Training
- CCMP Core Service Definitions Training
- CCMP Continuity of Care Training
- CCMP Disenrollment Training
- CCMP Intro to HARP Training
- CCMP Referral to HCBS Training
- CCMP Referral to CORE Training
- CCMP Screening for Special Populations Training
- CCMP Billing Support Questionnaire Training
- CCMP Chart Audit Tool Training
- CCMP DOH CES Tool Training
- CCMP Incident Reporting Training
- CCMP Gaps in Care Training

2.1. The training content is accessed via TalentLMS, and can be taken via live Zoom sessions, watching recordings of prior trainings, or by reviewing training content slides.

Sources:
Health Home Quality Management Program #HH0003

D. Documentation Requirements

First issued: 8/4/15
Reviewed by Quality Committee:
Revised Effective: 5/2/24

To maintain an accurate and timely record of all Health Home services provided and all changes to member status, CCMP's CMAs are required to use the Foothold Care Management's electronic health record (FCM) and Health Commerce System (HCS) to document all provided services. FCM will transmit data to BTQ, CMART and MAPP to meet billing and tracking requirements.

The following data elements must be entered into FCM within one business day of completion:

- Consents
- DOH-5055
- Notices of Determination
- DOH-5234
- DOH-5235
- DOH-5236
- Letters
- Disenrollment Letter
- Enrollment Letter
- Assessments & Screenings
- Comprehensive Assessment
- Billing Support Questionnaire and supporting documentation
- HCBS Eligibility Assessment
- DOH Continued Eligibility for Services Tool
- Health Home Plus Screening
- Care Plans
- Health Home Plan of Care
- Encounters
- All services attempted or provided to members or potential members
- All associated detail in the form of encounter notes
- Supervisory or care manager notes relevant to health home members

For additional guidance on entering data into FCM please attend one of the FCM trainings provided by FCM or contact the FCM help desk at (212) 220-3807/ *fcm-support@footholdtechnology.com*

E. Personal Representative Policy[1]

First issued: 6/14/24

Reviewed by Quality Committee: 6/11/24

PURPOSE:

To help Care Managers understand the role of personal representatives in Health Home Care Management.

POLICY:

Some prospective or enrolled Health Home members are supported by personal representatives. For the purpose of the HIPAA Privacy rule, a Personal Representative is a person authorized (under State or other applicable law, e.g., tribal or military law) to act on behalf of the individual in making health care related decisions. There are different types of personal representatives, with differences in who chooses the representative, when the representative can act on behalf of a member, and what types of decisions the representative can make for the member.

Health Home Care Management is a voluntary program that requires active participation from the member. Care Managers must understand when there is a personal representative supporting the member, document it appropriately, and know what responsibilities the representative does and does not have for the member.

It is unusual to enroll a member into Health Home Care Management who has a Personal Representative with the power to make broad healthcare decisions for the member, outside of Guardianship of a Child. This is primarily because if a member is incapacitated they are unlikely to be able to actively participate in the program. It is also because in cases where a Personal Representative has broad healthcare decision making powers, they would generally be doing the job functions of a Care Managers (identifying needs, making referrals, obtaining services, removing barriers to care) for the member. If such a member is enrolled, it may be a relatively short enrollment, helping the Personal Representative put needed services in place, and then the Personal Representative would do the ongoing management of the services.

Types of Personal Representatives in New York State:

Guardianship of a Child: Naturally designated as the child's parent(s) but can be assigned by the courts when there is a determination that one or both parents are unable to care for the child. The guardian has the same decision-making powers as a parent regarding decision making for personal needs (including healthcare), property, or both. Guardianship lasts until the child turns either 18 or 21.

[1] Nothing in this policy should be taken as legal advice or opinion, there are more specific nuances to various representative types that are not covered. This is general guidance as applicable to Health Home Care Management.

Guardianship of an Incapacitated Person (Article 81 Guardianship): A person authorized and chosen by a judge to help a person manage their personal needs (including healthcare), property, or both after a judge has determined that they are incapacitated. Once Guardianship has been granted the determination of incapacity has already been made; and is expected to be ongoing, but to last only as long as is necessary.

Guardianship of an Adult who is Intellectually or Developmentally Disabled (Article 71A Guardianship): A person authorized and chosen by a judge to help protect the interests of an intellectually or developmentally disabled adult and make decisions for them, when they are unable to do so for themselves, after a judge has determined that they are incapacitated. Once Guardianship has been granted the determination of incapacity has already been made; and is expected to be ongoing. Article 17-A guardianship is the most restrictive type of guardianship in the State of New York, and is almost always permanent. It covers most decisions typically made by a parent for a child.

Health Care Proxy: Someone authorized and chosen by the member to make certain healthcare decisions for them, in the event that they are determined by a doctor to be unable to make their own healthcare decisions due to incapacity. When a Proxy is established the member has not yet been determined to be incapacitated, and the Proxy is only triggered when the member becomes incapacitated. The member is planning that if there is such a time when they are incapacitated (short or long term), the Proxy can make certain healthcare decisions for them. In other states, this may be called a “Medical Power of Attorney” or “Durable Power of Attorney” and may or may not be triggered by incapacitation.

Power of Attorney (POA): A person authorized and chosen by the member to make certain financial decisions for them. When the Power of Attorney is established, the member is not incapacitated, and the Power of Attorney’s ability to act on behalf of the member is not contingent upon the member’s incapacitation. The member can revoke the Power of Attorney status at any time if they are “of sound mind”. In New York State the POA cannot make healthcare decisions for the member.

PROCEDURE:

1. When a Health Home Care Manager becomes aware that a member or prospective member has a Personal Representative supporting them, who may be able to make decisions for them, they must:
   - Request a copy of the paperwork authorizing the personal representative to make certain decisions for the member.
   - Document clearly in the chart the type of Personal Representative (Health Care Proxy, Guardian, or Power of Attorney), the full name and contact information for the Personal Representative, what decisions they can or cannot make for the member, and in what context.
   - Determine whether the member will be able to actively participate in the Health Home Care Management program and wants to receive Health Home Care Management services.

2. If the Personal Representative is an **Article 81 or 71A Guardian**, a determination of incapacity has already been made by the court system.

2.1. The CMA needs to review the paperwork to see exactly what decisions the Guardian can make for the member.

3. If the Personal Representative is a **Health Care Proxy**, the Proxy can only make decisions for the member if the member is incapacitated.
   3.1. The CMA needs to review the paperwork to see exactly what decisions the Proxy can make for the member, when the member is incapacitated. Often these are limited to decisions around emergency surgeries, life sustaining measures, etc.
   3.2. If the Proxy has broad decision-making powers, such that they could enroll the member into Health Home Care Management, the CMA needs to ascertain whether the member is currently incapacitated, triggering the Proxy's decision-making powers. This determination is made by a doctor and should specify when the member will no longer be incapacitated.

4. If the Personal Representative is a **Power of Attorney**, the POA can only make financial decisions for the member.
   4.1. The CMA needs to review the paperwork to see exactly what types of financial decisions the POA can make for the member.

5. If the Personal Representative is a **Guardian of a Child**, the Guardian can make all decisions for the child that a parent would.
   5.1. This is most commonly seen with foster care cases.

6. If the CMA determines that the Personal Representative has the power to make healthcare decisions for the member that would include enrolling into Health Home Care Management, the following rules apply:
   6.1. The Personal Representative must sign the Health Home Consent form or Plan of Care. If the document allows for both the Personal Representative and member signatures, then both can sign.
   6.2. The member should still be included in decision making around enrollment, care plans, etc. to the greatest extent possible.
   6.3. Even though technically the Personal Representative can sign documents on their own, Health Home Care Management is a voluntary program, and decisions should not be made without the member's participation.

7. If the Personal Representative will be signing forms for the member, the form itself may use a different term, such as "Legal Representative" or "Legally Authorized Representative".

	Health Care Proxy	Guardian of a Child	Article 81 Guardian	Article 71a Guardian	Power of Attorney
Member has to have capacity at outset	Yes	No	No	No	Yes
Member has to be incapacitated at outset	No	No	Yes	Yes	No
Decision Making Powers Active…	If/when member becomes incapacitated	Always	Always	Always	Always
Representative status continues…	Until revoked	Until member is 18/21	Until revoked	Until revoked	Until Revoked
Incapacity is determined by…	Medical doctor	N/A	Judge	Judge	N/A
Length of Incapacity	Short or Long Term	N/A	Ongoing, only as long as necessary	Ongoing, almost always permanent	N/A
Types of Decisions	Only Healthcare	Personal (including Healthcare), Property (including Financial), or both	Personal (including Healthcare), Property (including Financial), or both	Personal (including Healthcare), Property (including Financial), or both	Can not include Healthcare
Broad vs. Specific Decisions/Limitations	Either – MUST CHECK THE DOCUMENT	Broad	Either – MUST CHECK THE DOCUMENT	Broad	Either – MUST CHECK THE DOCUMENT
Member must want to be in the program and be able to actively participate	Yes	Yes	Yes	Yes	Yes
Can sign the Health Home Consent/Plan of Care, Enroll/Disenroll member from the program	It Depends	Yes	It Depends	It Depends	It Depends

F. Language Accessibility Policy

First issued: 5/14/19
Reviewed by Quality Committee:
Revised Effective: 6/14/24

PURPOSE:
To ensure that Care Managers can effectively communicate with all members receiving services.

POLICY:
Health Home Care Management services must be accessible to all eligible members, regardless of verbal/written language needs.

Procedure:

1. CCMP maintains a varied network of CMAs which should collectively be able to provide services in any language.

2. The CMA must document in FCM the member's primary language (verbal and writing), and any specific language barriers.
   2.1. The member's identified language needs are documented in the Comprehensive Assessment, and the plan to meet that need should be on the member's Plan of Care.

3. In limited cases, CMAs may need to use a translation phone service to communicate with members, while they work to hire someone who has specific language skills.

4. Each CMA is required to maintain a translation line so that they can communicate with any member or Care Team Member.
   4.1. Each CMA must contract with a language translation agency that at a minimum provides phone-based translation/interpretation in real time between the member or Care Team Member and the Care Manager.
   4.2. The phone line must be accessible to the care managers without restrictions.
   4.3. The phone line must cover every language that can be reasonably accommodated.

5. If a CMA is unable to hire someone to meet the member's language needs, they should offer the member a choice of continuing to use the translation line, or to be transferred to another CMA that has staff with those specific language skills.
   5.1. Under no circumstances should a member be unable to communicate with their Care Manager due to language barriers, or to be left "pending CM assignment" while the CMA is recruiting for a CM with specific language skills.
   5.2. CMAs may contact CCMP at any time to find out if there are other CMAs in the network with capacity in the member's language.

5.3. If the CCMP network does not have the capacity in that language, CCMP will contact other Health Homes to try to find another CMA.

6. A member must not be required to use a family member, friend, or home attendant to translate, solely because the CMA does not have language capacity.
    6.1. If the member wants the family member, friend, or home attendant involved in their care, and prefers to use them for translation rather than language line or a new Care Manager, that should be clearly documented.

7. Written materials, such as consents, Plans of Care, and referrals, must be provided to the member in their primary language.
    7.1. Online translation services[2] may be used when materials are not produced in multiple languages.

[2] https://www.onlinedoctranslator.com/ works well for PDFs, such as Plans of Care.

G. Member Rights and Complaint Management Policy

First Issued: 12/7/12
Reviewed by Quality Committee:
Revised Effective: 6/14/24

Policy:
A complaint can be any experience of dissatisfaction expressed verbally or in writing by a member or their representative related to Health Home services or an urgent issue, event, or action including actions taken by or against a member that could result in physical and/or psychological harm.

Members have the right to the following:
1. Receipt of information, if requested, from any Health Home organization about ownership and control.
2. Receipt of information, if requested, from any Health Home organization, about the organization's grievance procedures which include contact names, phone numbers, hours of operation and how to communicate problems.
3. Information about services/products and equipment available directly or by contract.
4. Information about names and responsibilities of the staff that will provide care and the proposed frequency of visits/service.
5. Participate in the plan for care and/or any change in the plan before it is made.
6. Receive information about the scope of services that will be provided and specific limitations on those services.
7. Receive services without regard to race, creed, gender, age, handicap, national origin, sexual orientation, veteran status, or lifestyle.
8. Refuse care or treatment and explore alternative health care options after learning the potential results and/or risks.
9. Be free from mistreatment, neglect or verbal, mental, sexual, and physical abuse, including injuries of unknown source.
10. Be free from misappropriation of property.
11. Be treated with consideration, respect and full recognition of individuality and dignity.
12. Receive service without regard to whether any advance directive has been executed.
13. Make independent informed decisions about care and treatment plans and to receive information in a way that is understandable.
14. Be notified in advance of treatment options, transfers of care to other programs, when and why care would be discontinued.
15. Receive adequate, appropriate, and timely services.
16. Education, instruction, and recommendations for continuing care if the services of the Health Home program are discontinued.
17. Participate in the selection of options for alternative levels of care or referral to other organizations, as indicated by the need for continuing care.

18. Receive disclosure information regarding any beneficial relationships the organization has that may result in profit for the referring organization.
19. Be referred to another agency if the CMA is unable to meet member needs or if there is dissatisfaction with the care received.
20. Be advised of the availability, purpose and appropriate use of State and Medicaid hotline numbers.
21. Express complaints free from interference, coercion, discrimination or reprisal to staff at any organization within the Health Home network, the New York State Department of Health, or any outside representative of the member's choice.
22. Receive a written response from the agency regarding investigation and resolution of a complaint about the care and services provided including notification that if not satisfied by the response, a complaint to the Department of Health's Office of Health Systems Management may be made.
23. Appeal a grievance. A grievance appeal is a continuation of the complaint process that offers a second level of recourse to the member. It begins when a member expresses dissatisfaction with the disposition of a complaint or if the complaint is not resolved within the specified period.
24. Not to participate in or receive any experimental research or treatment without specific agreement and full understanding.
25. Have a confidential clinical record.
26. Information regarding the organization's liability insurance upon request.

Procedures:

1. If a complaint is filed with the CMA or Health Home for a potential member who is not yet enrolled, the complaint should be responded to in the same manner as if it had happened during an enrolled segment, even though potential members have not yet been formally informed of the complaint rights and process.

2. At the time of enrollment, CMAs must provide members with clearly written instructions on how to file a complaint and their rights in the program. This information is contained in a Member Rights and Responsibilities document which the CMA reviews with the member at the time of enrollment.
   2.1. This information must be written at a reading level no higher than 7th grade.
   2.2. An agency Member Rights Document can be used if the above Member Rights are included.
   2.3. This should be provided to the member both verbally and in writing and should be reflected in the case notes or as a document upload.
   2.4. The CCMP Member Rights and Responsibilities Form may be used and customized by the CMA.

3. At the time of enrollment, the potential member must be provided with a Welcome/Enrollment Letter, along with a DOH-5234 Notice of Determination of Enrollment, that includes contact information for the Health Home and CMA if the potential member needs to file a complaint.

4. Any care management staff who receives a Complaint from a member, a member's consented family member, or another consented provider must attempt to resolve the concern directly with the person filing the complaint within 48 hours. If the complaint is from a family member or provider for whom the member has not provided consent, the CMA may follow up with the member directly to attempt to get consent and/or address the complaint.

5. Members may communicate their complaints verbally or writing and cannot be required to use official complaint or grievance forms. CMAs must document receipt of and response to complaints in the case record.

6. CCMP recommends that CMA supervisors provide oversight of the complaint management and response process.

7. CMAs should escalate any complaints that they do not feel capable of resolving to CCMP for additional assistance.

8. Complaints that are made directly to CCMP, or that are escalated to CCMP after they could not be resolved at the level of the CMA, will be documented on the CCMP Grievance Form.
   8.1. The CCMP Grievance Form may be completed by the member, CCMP staff, or someone assisting the member, and includes an opportunity for CCMP to document their proposed resolution to the grievance, and the members agreement or disagreement with the resolution.
   8.2. Regardless of how the member communicated the grievance to CCMP, CCMP will document it using the CCMP Grievance Form, and offer to share a copy of the completed form with the member for their records.

9. Members or other concerned parties may report complaints and grievances about CCMP services anonymously to CCMP, using the Lighthouse/Syntrio service. This service allows for anonymous reporting along with ongoing communication with the reporter. Information on how to report is available on the CCMP website.

H. Confidentiality Policy

First issued: 12/7/12
Reviewed by Quality Committee:
Revised Effective: 12/17/20

PURPOSE:
To ensure that all staff working in any organization in the Health Home network understand and agree to comply with rules and regulations governing the protection of member information and guidelines for disclosure of member health information. To comply with all State and Federal laws and regulatory requirements, including the laws specific to care of the members with HIV/AIDS, care of minors, substance and alcohol abuse, Civil Practice, Health Insurance Portability and Accountability Act of 1996 (HIPAA).

POLICY:

1. All member information, including Protected Health Information (PHI) and Personal Identifying Information (PII) is considered confidential and will be held in strict confidence by agency personnel.

2. No information about the member/family/caregiver which might identify the member will be released by a member of the agency without the informed consent of that member or his/her representative, unless otherwise required to provide care to the member or required by court order, federal, state or monitoring agencies or other use or disclosure identified in the Health Home Consent.
   2.1. CMAs must have policies in place outlining the process and timeframes for members to request copies of their records, and to request that their records be shared with entities not identified on their Health Home Consent. CMAs must comply with member requests regarding the sharing of PHI.

3. Members will be required to sign a Health Home Consent (DOH-5055) at time of enrollment into the Health Home that authorizes disclosure of information to specific entities, for defined purposes as permitted by law and agreed upon as regulation. Members can update their Health Home Consent at any time to add new entities or revoke consent. The Health Home Consent serves as the member's Notice of Privacy Practices.

4. Only personnel with the need to access, use or disclose PHI/PII as part of their job responsibilities or who are involved in the care or supervision of care of specific members will have access to member information.

5. PHI/PII will be kept secure and will only be discussed in the clinical setting or in locations where confidentiality can be maintained.

6. It is standard, acceptable and necessary practice to share information with other members of the member care team for the purposes of providing care and treatment, obtaining payment for services provided or carrying out health care operations.

7. Members have the right to confidentiality, privacy and security of their health information and medical record.

8. All staff of Health Home organizations will be informed and educated about member confidentiality, safeguarding of PHI/PII, and appropriate disclosure procedure.

9. Failure by any CMA to comply with the confidentiality policy or department-specific procedures issued and pursuant to this policy, may result in disciplinary action. CCMP may order the temporary or permanent suspension of member referrals and will provide the care management agency with 30-day advance written notice of the sanction.

10. The care management agency must offer the member a copy of the signed Health Home member information sharing consent form, the federally required NPP (if not already provided by the respective agency members for other services), and any signed addendums at the request of the member.

11. The CMA must report all breaches of PHI/PII to the Health Home per the Incident Management and Reporting Policy, and to the Office of Civil Rights, per regulations.

12. The exchange of information is critical to the ability of Health Homes, MCOs, and CMAs to integrate and coordinate services. The sharing of PHI/PII in all cases must be restricted to the minimum amount of information necessary to accomplish the purpose. Additionally, the parties sharing PHI/PII must attain legal assurance to ensure confidentiality of the information and prevention of re-disclosure to other parties.

13. When PHI shared is consistent with legal authorities, it does not lose its confidential status. The recipient of the information is bound by these same requirements and may only re-disclose the information consistent with the same legal authorities.

14. In order to ensure that the recipient of the PHI understands the confidential nature of the information, and agrees to avoid wrongful re-disclosure, it is therefore necessary that there be adequate legal assurance, in the form of such agreements as a Business Associates Agreement (BAA), a Confidentiality and Non-Disclosure Agreement (CNDA), or a Data Exchange Application Agreement (DEAA), whereby the recipient agrees to abide by these confidentiality provisions, and, in the event it does re-disclose any such information, that it will enter into a similar agreement with the sub-recipient of the information.

15. After a member has been consented and enrolled into a Health Home, PHI may be shared with the various entities that are included on the consent form. For example, for a Health Home to share additional PHI with a Managed Care Plan and Care Management Agency, the Health Home would want to

include both the Managed Care Plan and the Care Management Agency on its consent for release of information.

16. MCOs need to share relevant information with CCMP to improve enrollment. Information that can be shared with CCMP includes:
    - Contact information including address and phone numbers.
    - Prior Medicaid service use data including names and contact information for providers who previously treated the individual and who the MCO believes may be able to assist with Health Home enrollment. This may include primary care providers, mental health providers and hospital inpatient and/or emergency department providers. However, under 42 CFR Part 2, OASAS-certified providers may not acknowledge a member's participation in an alcoholism or substance abuse program, so access to this information is not allowable.

17. CCMP shares information with CMAs to facilitate enrollment and provide care management services to members. The CMA requires the same information for enrollment that is required by CCMP. If CCMP has received information from the MCO relating to contact information and/or prior Medicaid service use, then that information would also be necessary for the CMA to perform the same function.

18. CMAs may contact providers who currently or previously (in the past 12 months) served individuals to ask for assistance with enrollment, excluding OASAS-certified provider information.

19. All PHI being sent from one agency to another via email must be encrypted and this encryption must meet HIPAA standards.

I. CMA Conflict of Interest Guidance

First Issued: 11/8/19
Reviewed by Quality Committee: 11/12/19

While CCMP supports the integration of Health Home Care Management into established healthcare and social service settings, Health Home Care Management is a separate program from other agency offerings. Health Home Care Management has its own eligibility requirements, disenrollment policies, etc. Compliance with Federal Conflict Free Case Management practices is required for members being referred to or receiving HCBS services, and strongly recommended for general Care Management practice.

Any CMA that is unsure of whether their agency practices might constitute a conflict of interest should consult with their agency's Compliance Officer and CCMP.

The following practices are to be avoided, as they may present conflicts of interest, represent policy violations, and/or result in billing complications. This is not an exhaustive list; it is representative of the types of potential conflicts that can arise.

1. Requiring people receiving other services from an agency to automatically enroll in Health Home Care Management.

Ex. All people on Medicaid with HIV who attend the HIV support group are given a Health Home consent to complete on the first day of the group.

2. Enrolling people into Health Home Care Management so that they will qualify for a different agency service.

Ex. All Medicaid enrollees with health conditions at the agency shelter are enrolled into Health Home so that they qualify for the same agency's MRT Housing Program.

3. Using Health Home Care Managers to do the work of other agency departments.

Ex. The member attends the agency's mental health clinic. The member is instructed to call the Health Home Care Manager to schedule all their clinic appointments, and the Health Home Care Manager conducts all clinic appointment reminder calls.

4. Automatically transferring members' other services to the agency when they enroll into Health Home.

Ex. The member has medical and psychiatric providers at enrollment, but at the first visit the Care Manager schedules them to see the agency medical and psychiatric providers.

5. Only serving members who use other agency services.

Ex. A Health Home member who goes to the agency's medical clinic, where the Care Manager is co-located, decides to change to a different medical clinic. The Care Manager disenrolls the member since they will no longer be coming onsite to see her.

6. Only referring members to other agency services.

Ex. A Health Home member who wants outpatient mental health treatment, or CORE/HCBS services, is only referred to the internal agency mental health program and CORE/HCBS program.

J. Incident Management and Reporting Policy

First Issued: 12/7/12
Reviewed by Quality Committee: 6/8/21
Revised Effective: 5/2/24

PURPOSE:
To establish an incident management program to protect the health and safety of members, enhance the quality of care delivered to members, and by reviewing and investigating incidents that occur during care coordination. The result of the investigation should ease the impact of the situation for the member and prevent recurrence of similar or future incidents whenever possible.

DEFINITIONS: An incident is any event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member.

Reportable incidents include:

Abuse: Any of the following acts by an individual service provider:

Physical Abuse: any non-accidental physical contact with a member which causes or has the potential to cause physical harm. Examples include, but are not limited to, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment.

Psychological Abuse: includes any verbal or nonverbal conduct that is intended to cause a member emotional distress. Examples include, but are not limited to, teasing, taunting, name calling, threats, display of a weapon or other object that could reasonably be perceived by the patient as a means of infliction of pain or injury, insulting or coarse language or gestures directed toward a patient which subjects the patient to humiliation or degradation, violation of patient rights or misuse of authority.

Sexual Abuse/Sexual Contact: includes any sexual contact involving a service provider (e.g., HH staff, CMA staff, or other provider) and a member. Examples include, but are not limited to, rape, sexual assault, inappropriate touching and fondling, indecent exposure, penetration (or attempted penetration) of vagina, anus or mouth by penis, fingers, or other objects. For purposes of this Part, sexual abuse shall also include sexual activity involving a member and a service provider; or any sexual activity involving a member that is encouraged by a service provider, including but not limited to, sending sexually explicit materials through electronic means (including mobile phones, electronic mail, etc.), voyeurism, or sexual exploitation.

Neglect: any action, inaction or lack of attention that breaches a service provider's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a member.

Misappropriation of Member Funds: use, appropriation, or misappropriation by a service provider of a member's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a member's belongings or money.

Crime Level 1: An arrest of a member for a crime committed against persons (i.e. murder, rape, assault) or crimes against property (i.e. arson, robbery, burglary) AND is perceived to be a significant danger to the community or poses a significant concern to the community.

Death: The death of a member resulting from an apparent homicide, suicide, or unexplained or accidental cause; the death of a member which is unrelated to the natural course of illness or disease.

Missing Person: When a member 18 or older is considered missing AND the disappearance is possibly not voluntary, or a Law Enforcement Agency has issued a Missing Person Entry, OR when a child's (under the age of 18) whereabouts are unknown to the child's parent, guardian or legally authorized representative.

Suicide Attempt: An act committed by a member in an effort to cause his or her own death.

Violation of Protected Health Information: Any violation of a member's rights to confidentiality pursuant to State and Federal laws including, but not limited to, 42 CFR Part 2 or the Health Insurance Portability and Accountability Act (HIPAA), and Article 27F. The CMA has a responsibility to review to determine whether the incident is a breach of security vs. a breach of privacy.

Procedures:

1. If a reportable incident occurs for an individual was not yet enrolled, a determination must be made regarding the nature of the allegation and the extent to which the allegation needs to be investigated by the CMA within 24 hours. CCMP only requires incident reporting to the Health Home for enrolled members.

2. For members who are enrolled, CMA must submit the incident as an Issue in the NYS Incident Reporting and Management System (IRAMS), which is housed within HCS.
   - 2.1. Incidents must be submitted within 24 hours of learning that a reportable Incident occurred (or the next business day).
   - 2.2. Submission in IRAMS triggers an auto-email to CCMP, CMAs do not have do directly notify CCMP.
   - 2.3. CMAs must ensure that all notes relevant to the incident are available in FCM for CCMP to review.
   - 2.4. CCMP may contact the CMA to clarify information about the incident or incident response and may make recommendations regarding appropriate preventative/corrective actions.
   - 2.5. CCMP will ensure that all follow-up actions are taken to address the incident. If the CMA does additional actions after their initial submission, they must update the issue in IRAMS.

3. CCMP will notify their DOH Health Home Liaison of incidents that contain any form of media coverage referencing the NYS Department of Health or the NYS Health Home Program via HCS.

4. Incidents must be reported to the appropriate reporting agency, e.g., Adult Protective Services (APS), Child Protective Services (CPS), NYS Justice Center, OPWDD, OASAS, OCFS, law enforcement, etc., by the CMA, when applicable.

5. CCMP analyzes incident trends and reviews them in Quality Committee and Governance Committee at least annually.

Incident Reporting for Adult Home Plus and AOT Members

1. Members enrolled in the Adult Home Plus and AOT programs are required to report incidents to the Health Home as described above, and to report incidents to the Adult Home Plus or AOT program, respectively.

2. Adult Home Plus and AOT have their own definitions of a reportable incident, and their own reporting procedures.

3. It is possible that a member event would be considered reportable to the Health Home, the Adult Home Plus/AOT program, or to both.

4. Although the AOT/Adult Home Plus program may have primary responsibility to investigate incidents involving these members, the Health Home will assist as necessary.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits, per the Quality Management Program Policy.

Sources:

DOH Policy HH0005 Health Home Monitoring: Reportable Incidents Policies and Procedures
Email guidance from DOH – 6.26.23
IRAMS User Guide
IRAMS FAQ

K. Child Abuse and Neglect Reporting Policy

First issued: 12/7/12
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

PURPOSE: To ensure that all staff know how and when to make an appropriate report of suspected child abuse. New York State Law mandates that suspected child abuse or maltreatment be reported if there is a reasonable cause. Failure to report is a Class "A" misdemeanor. The person or agency that fails to report is civilly liable for damages resulting from such failure. Immunity from civil or criminal liability is granted to those who in good faith report a case of abuse or maltreatment. Additionally, an institution, facility or agency is expressly prohibited from retaliating against or imposing conditions upon employees regarding required reporting, including requiring prior approval or notification.

POLICY:
Effective 4/1/18, all staff of a Health Home or CMA expected to have the potential for regular and substantial contact with children are mandated reporters and must report all cases of suspected abuse and maltreatment to the appropriate authorities. This applies to all Health Home programs; it is not limited to HHSC.

CMAs are responsible for training their staff in their Mandated Reporter responsibilities. Additionally, staff who work with HIV+ members, or members at risk of HIV must complete Mandated Reporter training annually. CMAs are responsible for maintaining records of these trainings.

PROCEDURE:

1. CMA staff either observes injuries, behaviors, and/or events which form a basis of suspicion of abuse, maltreatment or neglect or hears from any individual who has personal knowledge or factors which might lead to reasonable cause that abuse or neglect has occurred.

2. CMA staff discusses the case with a Supervisor **within 24 hours** and receives guidance regarding a decision to report suspicion of abuse, neglect, or death.

3. CMA calls the State Central Register ("SCR") for Child Abuse and Maltreatment at 1-800-342-3720. Reports may be made seven days a week, 24 hours per day. Mandated reporters must make required reports of child abuse or maltreatment to the SCR themselves, and then notify the person in charge or the designated agent of the institution/organization.
   - 3.1. Caller asks SCR for the case number, which indicates that the case is accepted for investigation, entering it in the chart immediately.
   - 3.2. The relevant staff member must complete form DSS-2221-A in a precise and factual manner, stating:
     - Specific date(s) and time(s) the event/observations occurred

- Describe injuries, behaviors, events in factual terms
- Give direct quotes when possible
- The reporter's name and title must appear on the form
- The date listed is the day on which the form was prepared and mailed
- The name, title, and contact information for every staff person of the institution/agency believed to have direct knowledge of the allegations

3.3. Staff sends triplicate form (DSS-2221-A) to the Local Registry for Child Abuse and Maltreatment of the Borough Field Office, Administration for Children's Services (ACS).

3.4. A photocopy of report is kept in a separate location on file at the care management agency that treats the member involved (such as the Binder for ACS reports).

4. Staff person documents activities surrounding the suspicion and reports it in the member record. If SCR refuses to accept the case, this must be clearly documented in the member record.

5. The designated agent (Supervisor) of the facility may then conduct follow-up activities related to the initial report from the mandated reporter.

Sources:

NYC ACS How to Make a Report

New Background Checks and Other Requirements for Health Home Care Managers 4.25.18

L. Elder Abuse and Neglect Reporting Policy

First issued: 12/7/12
Reviewed by Quality Committee:

PURPOSE:
To ensure that all staff know how and when to make an appropriate report of suspected elder abuse.

The suspected abuse of the elderly, in any form, must be investigated and appropriate action must be taken to prevent further abuse. Abuse can include, but is not limited to:

- Emotional abuse: causing mental anguish and despair by name calling, or by insulting, ignoring, threatening, isolating, demeaning, and controlling behavior.
- Financial abuse: illegally or unethically exploiting an older person through use of his or her cash, credit cards, funds or other assets without permission or through coerced permission.
- Physical abuse: slapping, bruising, coercing (including sexual coercion), cutting, burning, or forcibly restraining an older person.
- Neglect: refusing or failing to carry out care-taking responsibilities such as: withholding food, medicine, glasses, or dentures; and abandoning a dependent older person.

Suspected abuse or neglect should be reported to Adult Protective Services (APS), when deemed appropriate. APS is a state mandated agency which provides protective services to individuals 18 years of age or older who, because of physical or mental impairments:

- Are unable to meet their needs for food, shelter, clothing or medical care, secure entitlement due to them or protect themselves from physical or mental injury, neglect, maltreatment or financial exploitation; and
- Need protection from actual or threatened harm, neglect, or hazardous conditions caused by action or inaction of either themselves or other individuals; and
- Have no one available who is willing and able to assist them responsibly.

POLICY:
CMA staff working with an elderly member or observing an elderly person in the member's home must report all cases of suspected abuse and maltreatment to the appropriate authorities. In addition, CMA staff will report all deaths suspected to be the result of elder neglect or abuse to a Supervisor. In cases where an elderly person resides in the home of an adult member, the Care Plan shall incorporate ongoing responsibilities for the care of an elderly adult.

PROCEDURE:

1. Identify the potential or actual harmful situations which meet the criteria outlined above.

2. Obtain impressions and information from other health workers (i.e. clinics and physician, etc.).

3. CMA staff must discuss the case with a Supervisor **within 24 hours** and to decide on how to proceed with the suspicion of abuse, neglect or death. The Supervisor and staff should determine:
    - Whether a crisis or psychiatric evaluation is necessary.
    - Whether to conduct a Care Team Meeting to discuss the situation.
    - Whether to contact APS immediately via phone at (212) 630 1853.
    - Whether to contact other organizations / services available to victims of elderly abuse and their families.

4. If the staff and Supervisor determine it is necessary to report the allegations, staff must make a written (online) and verbal referral to APS immediately at (212) 630 1853. Staff should document name of contact called in member record. Staff must verify final disposition with APS and document in member record.

5. If determined by staff and Supervisor that it is not necessary to report allegations to APS immediately, staff must schedule a meeting including the Supervisor and member. Family, caregivers and other Care Team Members should be included as deemed appropriate. The Care Manager and Supervisor should:
    - Inform the member and caregiver of an actual/potential harmful situation.
    - Provide options which will safeguard member health, including referral to APS.
    - Secure member/caregiver agreement to plan for continuing care
    - Be documented along with outcome in the member record.

6. If problem(s) which present hazard to the member is not resolved, the staff member will make a verbal and written (online) referral to APS and document name of contact called in member record.

Additional Information:

- After contacting APS via phone and the completion of the referral information online, APS is mandated to do the following:
- If APS determines a life-threatening situation exists, an investigation will be initiated within 24 hours of the referral. For potential APS cases which are not life threatening, an investigation is initiated within 72 hours and a visit is made to the member within three working days of the referral.
- An APS Supervisor / Director should be contacted if resolution is not reached
with the APS staff member contacted. Any contact with an APS Supervisor or Director should be documented in the member record

Additional New York State helplines, hotlines and referral resources for suspected elder abuse and neglect include:

- 1 (800) 342 3009 / option #6 to report suspected elder mistreatment in the home

- 1 (888) 201 4563 for suspected elder mistreatment in nursing home facilities
- 1 (866) 893 6772 for complaints concerning assisted living facilities
- 1 (800) 628 5972 for complaints concerning home care

Additional organizations that can provide services and aid to victims of elderly abuse include:

- Carter Burden Center for the Aging at (212) 879 7400 ext. 116
- RAIN One Stop Elder Abuse Program at (718) 239 4358 or at email: rain1stop@raininc.org
- Jewish Association for Services for the Aged at (212) 273 5272

M. Compliance Policy

CCMP's Compliance Policy is a separate document.

N. Notice of Determination and Fair Hearing Policy

First Issued: 1/25/18
Reviewed by Quality Committee:
Revised Effective: 6/14/24

Purpose
To outline the requirements for CMAs to communicate to members about any decisions made regarding enrollment and disenrollment from the Health Home program, and how to ensure members understand their Fair Hearing rights.

Policy
CCMP CMAs notify all members of decisions made about their enrollment, denial of enrollment, or disenrollment (not including voluntary disenrollments) using New York State issued forms, and CMA created letters, within set timeframes. All forms and letters that must be "issued" to the member may be issued in person, mailed, e-mailed, or texted, in accordance with the member's preferences and relevant state and federal privacy laws. Documentation of issuing these forms and letters to the member, or attempts to do so, are documented in encounter notes, and copies of the forms and letters are uploaded to FCM Documents tab.

Procedure:

1. Form DOH-5234, Notice of Determination for Enrollment in the New York State Health Home Program, is issued to a member with a Health Home/CMA Welcome letter within 48 hours of the decision to enroll the member.
   1.1. The form is completed to indicate both the notice date and the effective date of enrollment, member demographic information, and CCMP contact information.
   1.2. All enrollments are effective the first day of the month, matching the start date of the enrolled segment.
   1.3. The form is signed by the CMA as the Health Home Representative.
   1.4. Both sides of the form are issued to the member and uploaded to FCM.
   1.5. The form is explained to the member, including their right to request a conference, a fair hearing, or both if they disagree with the decision.

2. The Health Home/CMA Welcome letter includes contact information for the CMA, for CCMP, and for the CMA's 24/7 crisis line. CCMP has a template Welcome/Enrollment letter for CMAs to use. CMAs may further customize the letter. The letter is uploaded to FCM.

3. Encounter notes document the issuance of the DOH-5234 and Welcome letter, or any attempts or barriers to issuance.

4. Form DOH-5236, Notice of Determination for Denial of Enrollment in the New York State Health Home Program, is issued to a potential member within 48 hours of the decision not to enroll the potential member.
    4.1. The form is issued to those potential members who completed an intake or enrollment meeting and indicated a desire to enroll into the program by signing a DOH-5055 consent form.
    4.2. The form is completed to indicate both the notice date and the effective date of the denial, member demographic information, CCMP contact information, and the reason for the decision.
    4.3. The reason for decision indicated on the form must match the End Reason code on the Outreach segment in FCM, and encounter notes.
    4.4. Both sides of the form must be issued to the potential member and uploaded to FCM.
    4.5. The form is explained to the potential member, including their right to request a conference, a fair hearing, or both if they disagree with the decision.

5. CMAs may issue a corresponding letter explaining the decision, but this is not required.

6. Encounter notes document the issuance of the DOH-5236 and any attempts or barriers to issuance.

7. Form DOH-5235, Notice of Determination for Disenrollment in the New York State Health home Program, is issued to a member at least 10 business days before the effective date of disenrollment, with a corresponding Health Home/CMA Disenrollment letter, and other required Disenrollment paperwork.
    7.1. This form is not used for voluntary disenrollments, which do not require a DOH form.
    7.2. The DOH-5235 form is completed to indicate both the notice date and the effective date of the disenrollment, member demographic information, CCMP contact information, and the reason for the decision.
    7.3. All disenrollments are effective on the last day of the month of disenrollment, matching the end date of the Enrolled segment.
    7.4. The reason for the decision to disenroll indicated on the form must match the End Reason code on the Enrolled segment in FCM, and encounter notes.
    7.5. Both sides of the form must be issued to the member and uploaded to FCM.
    7.6. The form is explained to the member, including their right to request a conference, a fair hearing, or both if they disagree with the decision. The CMA explains the right to request Aid Continuing if a Fair Hearing is requested.

8. The Health Home/CMA Disenrollment letter includes the reason for and date of disenrollment, along with other requirements specific to the type of Disenrollment. CCMP has template Disenrollment letters for CMAs to use. CMAs may further customize the letter. The letter is uploaded to FCM, along with the other Disenrollment documentation given to the member. See Disenrollment Policy for more details on required documentation at Disenrollment.

9. Encounter notes document the issuance of the DOH-5235 and any attempts or barriers to issuance.

10. If a member or potential member indicates to the CMA that they are requesting an Informal Agency Conference, or that they have or are planning to complete the second side of the Notice of Determination form to request a Fair Hearing, CMA notifies CCMP.
    10.1. Informal Agency Conferences can be done with representative(s) from the CMA, representative(s) from CCMP, or both, per the member or potential member's preference.
    10.2. Results of Informal Agency Conferences are documented in FCM.

11. If a member or potential member requests a Fair Hearing to contest a CMA decision of enrollment, denial of enrollment, or disenrollment, both the requestor and CCMP will receive written notice from the Office of Temporary and Disability Assistance (OTDA) of the date of the Fair Hearing.
    11.1. A CCMP representative will attend the fair hearing and has authority to make decisions at the fair hearing.
    11.2. CCMP will ensure that any evidence and/or documents requested by the member or their authorized representative are sent to them within 10 business days of receiving the request, per the OTDA Notice of Fair Hearing (OAH-457).

12. Fair Hearing decisions are binding and supersede CCMP policy.

13. If CCMP is directed to provide Aid Continuing to a member who is contesting a disenrollment, the member will be put into a Pended – Aid Continuing status and services will continue until the Fair Hearing decision has been made.
    13.1. This segment status change is done by DOH via MAPP and allows for the CMA to continue billing core services, without any billing blocks related to Plan of Care, Initial Appropriateness, or Continued Eligibility for Services Tools.
    13.2. In cases where the CMA is unwilling or unable to continue to provide services the member may be transferred to another CMA or continue with their current CMA but with adjusted provision of services at the discretion of CCMP in communication with DOH.

14. If Aid Continuing is not granted by OTDA but a Fair Hearing has been granted, the member is pended in FCM until a decision has been made regarding the Fair Hearing[3].

15. CCMP may ask for a representative of the CMA to attend the Fair Hearing as well, or for the CMA to provide records in advance of the Fair Hearing.

16. CCMP tracks all requests for Informal Agency Conferences and Fair Hearings internally and documents any interaction with the member in the members FCM case record.

[3] It is unclear if DOH will manage this pend as well.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

Source:

Health Home Notices of Determination and Fair Hearing Policy #HH0004

iv.SERVICE MODELS

A. Standard Care Management Model Policy Set

First issued: 12/7/12
Reviewed by Quality Committee:
Revised Effective: 6/14/24

Policies in this set apply to staff serving members within the Standard Care Management Model. Staff serving members within Health Home Plus models must meet these AND additional requirements outlined in the Health Home Plus Policy Set.

This policy set includes six Policies that apply to the Standard Care Management Model.

Standard Care Management model

Staff Qualifications Policy
Staff Training Policy
Supervision Policy
Level of Service Policy
Telehealth Policy
Caseload Requirements Policy

1. Staff Qualifications Policy

PURPOSE:
To ensure that network CMAs have qualified and skilled professionals who can effectively engage members and assist in coordinating their care to address all their behavioral health, medical, and social support service needs. While the exact title of staff members may vary, the following policy outlines the necessary credentials for each functional role of care management staff.

POLICY:
CMAs will ensure that their staff meet the requirements for their functional roles, as described below. CMAs may set more stringent qualifications requirements as they see fit. For most roles, CCMP allows "equivalent experience/expertise to substitute for educational requirements. This is done to provide CMAs with the flexibility they need to hire the best staff for the position. The CMA leadership, in conjunction with their HR departments, determine whether a potential hire has the equivalent experience/expertise. If CCMP has concerns about the quality of a CMA's work, suspects it is tied to the staff being under- educated, CCMP will raise that with the CMA as a larger programmatic issue, typically during a site visit.

The **Supervisor/Team Leader** role is responsible for monitoring and advising a team of Care Managers as well as systematically reviewing member documentation on an on-going basis. A staff member in this role requires, at a minimum, a master's degree (or the equivalent experience/expertise) in a related field (MPH, Social Work, Human Services, etc.) and experience working with populations with complex medical, mental health and psychosocial needs.

The **Care Manager** role is responsible for assessing a member's needs and coordinating with the member's Care Team to develop and execute a care plan, and then carry out the tasks as designed. A staff member in this role requires, at a minimum, a bachelor's degree (or the equivalent experience/expertise) and experience working with populations with complex medical, mental health and psychosocial needs.

The **Care Navigator** role is responsible for assisting the Care Manager with members but cannot be the primary staff assigned to the member or completing member assessments and care plans. A staff member in this role requires, at a minimum, an associate or bachelor's degree or equivalent experience/expertise.

The **Enrollment/Intake** role is responsible for engaging and enrolling members into the program. A staff member in this role requires, at a minimum, a high school diploma and community experience working with populations with complex medical, mental health and psychosocial needs.

Peer Supports- CMAs are encouraged to use peers in their network as an extra qualification that staff may hold. All peers must meet the same staffing requirements that non-peer staff in the same positions are required to hold. Peers may not be actively receiving Health Home services from CCMP while supporting CCMP members.

CCMP recommends using peers for multiple areas of work within the CMA.

The benefit of having peers in the Enrollment/Intake role is that they may be better able to connect with those individuals that may benefit from the service but are hesitant to engage in needed services. The peers are able to outline the benefits of receiving assistance to individuals that do not see the value as they are able to speak about how similar supports may have benefited them.

Peers have also been found to be helpful in Care Navigator roles, particularly with escorting members to appointments. Care managers are not always able to accompany their members to various appointments, whether it is to a doctor/specialist or to a public assistance meeting, and a peer can escort them so that the member feels supported and the peer can relay any further needs as a result of the appointment to the case manager.

Peers can also provide insight into the obstacles/challenges that a member may be facing and how to better approach and service that member. There is also a knowledge base of resources that the peer staff are aware of that the health home program may not have thought of using and they will share these options with the program and the member to establish needed linkages.

Peers can also bring their experiences as recipients of various healthcare and social services system to their work in other roles, such as Care Manager, Supervisor, Director, QA, etc.

Background Checks:
Each CMA's HR Department is expected to maintain records of employment history, references, work record, and qualifications of all job applicants, consultants, and volunteers that work at the CMA with CCMP members. This includes copies of current license or certification for those staff whose positions require it, a copy of the diploma earned from the appropriate academic program and/or experience or documentation of expertise.

CMAs serving members under the age of 21 are subject to three additional background checks:

Staff Exclusion List (SEL) through the NYS Justice Center for the Protection of People with Special Needs (Justice Center)

- ➢ NYS Social Services Law 495
- ➢ For HH and CMA employees that will have regular and substantial contact with individuals under the age of 21

Criminal History Record Check (CHRC) through NYS Department of Health (DOH)

- ➢ NYS Public Health Law Article 28-E

➢ For unlicensed HH and CMA employees who provide direct care to members under the age of 21 or have access to their property and belongings

Statewide Central Register Database Check (SCR) through the Office of Children and Family Services (OCFS)

➢ NYS Social Service Law 424-a

➢ For HH and CMA employees that that will have the potential for regular and substantial contact with members under the age of 21

Procedures:

1. CCMP may review personnel documentation to determine compliance with Staff Qualifications policies at the time of annual site visit or can request them at any time.

2. CCMP reviews personnel documentation during initial CMA Onboarding into the CCMP network but does not provide ongoing review for new hires after the CMA has completed their Onboarding.

3. If a CMA's HR department is not comfortable sharing personnel records and clearances with CCMP, they may complete an attestation form, documenting the staff qualifications for their positions.
    - Attestation of SCR, SEL, and CHRC Clearances

4. Agencies that provide direct healthcare services (medical care, mental health care, HCBS/CORE etc.) in addition to care management services must meet the following requirements:
    - CMA staff may not provide direct services.
    - CMA staff must be under a different supervisory structure than the direct service providers.

Sources:

Mandatory Background Check Requirements for HCBS Providers and Health Homes - Webinar April 2018

Background Check Requirements for Health Homes and Care Managers #HH0010

2. Staff Training Policy

CCMP uses TalentLMS to offer a suite of trainings to CCMP care managers, intake workers, supervisors, and other staff.

The following trainings must be completed within six months of beginning to work with CCMP members:

CCMP's Policies and Procedures Trainings

- Intro to Health Homes, CCMP, TalentLMS, and FCM
- Eligibility Training
- Enrollment Training
- Plan of Care Training
- Comprehensive Assessments Training
- Core Service Definitions Training
- Care Conferencing Training
- Continuity of Care Training
- Disenrollment Training
- Billing Support Questionnaire Training
- Gaps in Care Training
- DOH CES Tool Training
- Chart Audit Tool Training (Auditors Only)
- Incident Reporting Training (IRAMS reporters only)

CCMP HHSA Specific Trainings

- Intro to HARP Training
- Referral to HCBS Training
- Referral to CORE Training
- Screening for Special Populations Training
- Health Home Plus Training

Medicaid Compliance Trainings – Required ANNUALLY

- Compliance Policy Training

AIDS Institute Required Trainings: FOR ALL STAFF WORKING WITH HIV+ OR HIV AT RISK MEMBERS

REQUIRED ANNUALLY

- Child Abuse & Neglect Mandated Reporting (upon hire/annual update)
- HIV Disclosure and HIV/AIDS Confidentiality Law Overview (upon hire/annual update)

REQUIRED UPON HIRE

- The Role of Health Home Care Manager in Improving Health Outcomes for People Living With HIV/AIDS or At-risk of HIV
- Sexual Health and Gender Orientation (SOGI)

REQUIRED WITHIN 18 MONTHS OF HIRE

Core Competency content areas listed below are intended to serve as a training resource guide for all Health Home staff who work with individuals living with HIV. Many of these trainings have been offered in multiple formats, including live trainings (pre-pandemic), webinars, and online.

Priority Content Areas listed below are supplemental content areas that could be used to satisfy the annual training hours requirement (20 hours for CMs working with HIV+ or HIV at Risk, 40 hours for HH+ HIV CMs).

Core Competency Content Area List

- Ending the Epidemic (EtE)
- Introduction to HIV, STIs, and HCV
- Overview of HIV/AIDS
- Introduction to co-occurring disorders for PLWHA
- Harm Reduction Approach
- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) and Transgender/Gender Nonconforming Cultural Competencies
- Transgender Health
- Primary Care and Treatment Adherence for HIV+ Individuals
- Role of Non-Clinicians in Promoting PrEP/PEP
- HIV/AIDS and Adolescents
- Drug User Health

Priority Content Areas

- HIV clinical guidelines, viral load, CD4, suppressed, unsuppressed, undetectable=untransmittable (U=U)
- HIV/STI risk assessment, testing, treatments, prevention, and condom use
- HIV and mental health; mental health issues (not SMI), treatments, risk behaviors
- HIV and pregnant persons
- HIV and housing
- Hepatitis C/HCV basics, prevention, treatment
- PrEP/PEP and condom use
- Adolescents/minors, confidentiality, and Public Health Law
- Substance use and Harm Reduction services
- Sexual health; reproductive health
- Transgender identity; gender non-conforming; cis gender; gender identity
- Families with LGBTQIA+ parents, children, members
- Children (young), adolescents who self-identify as gender non-conforming or LGBTQIA+
- Suicide prevention; stigma
- Cultural diversity
- Health Equity
- Motivational Interviewing

Trainings can be taken via live Zoom sessions, watching recordings of prior trainings, or by reviewing training content slides. CMAs are responsible for retaining training records for all their Health Home Care Management staff in TalentLMS and managing staff access to TalentLMS. Training records will be reviewed by CCMP during annual site visits and can be requested at any time.

Training requirements are subject to change as trainings are developed and updated. The most updated list of required trainings will be found in TalentLMS.

TalentLMS also offers thousands of other trainings that may be applicable for CMA staff.

Sources:
Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations
Program Guidance- Health Home Care Management for People Living with HIV and Persons at Risk for HIV

3. Supervision Policy

First issued: 11/22/16
Reviewed by Quality Committee:
Revised Effective: 5/14/19

Supervision is an important aspect of care management service provision and oversight. The following are minimum requirements for care management supervision:
Supervisor to care manager ratio is expected to be 1:8 and must never exceed 1:12

Supervisors must have one on one meeting with each care manager monthly to review cases, address issues, and provide feedback.

The work of supervisors must include oversight and documentation of the delivery of quality care management services (i.e., must go beyond administrative functions related to personnel management).

Supervisors must have oversight over all "status change" decisions. These include decisions to enroll/not enroll, transitions to/from Health Home Plus, designation of Disengaged Status/Re-Engagement, and Disenrollment.

Supervisors must be available to their care managers during established work hours for any crisis.

Source:
Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations

4. Level of Service Policy

CMAs serving members in the Standard Care Management model must provide at least one Core Service (or Diligent Search) per month to meet minimum billing requirements.

The mode of contact may include but is not limited to: In person meeting(s), mailings, secure emails/texts, or phone calls, and video calls.

Sources:
Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations
Health Home Provider Manual - Policy and Billing (version 2019–2)

5. Telehealth Policy

First issued: 6/14/24

Reviewed by Quality Committee: 6/11/24

During the COVID Public Health Emergency (PHE) several Health Home Policy requirements were suspended or altered. One was that all Health Home services could be provided via telehealth. At the end of the PHE, DOH issued guidance on the use of telehealth moving forward.

Per the *MEMORANDUM RE: TELEHEALTH GUIDANCE for the Health Home Program 5/3/24*, the General Medicaid telehealth policy outlined in the New York State Medicaid Update - January 2023 Volume 39 applies to Health Home Care Management in person requirements outside of the Health Home Plus programs.

This means that for the HHSA Standard Care Management model, any in person requirements may be replaced with telehealth (video) if requested by the member, and clearly documented in the record.

Presently, the only in person requirements in the HHSA Standard Care Management model are for the initial Comprehensive Assessment to be completed at least partially in person, and for in person contact to be attempted during a member's stay at a detox facility, and within 24 hours of discharge from such a facility[4].

[4] The in person detox requirements are not mentioned in the 5/3/24 memorandum, but are still active in the Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations.

6. Caseload Requirements Policy

There are no caseload requirements for members served in the Standard Care Management model.

New York State recommends that members being billed at the Standard Health Home Rate and the High-Risk Health Home Rate be on caseloads of:

Standard: 45:1
High Risk: 25:1

CMAs with caseloads exceeding 10% of the caseload recommendations may be targeted for audit, to ensure Quality standards are still able to be met.

B. Health Home Plus Model Policy Set

First issued: 11/29/16
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

Health Home Plus is a model that provides a higher level of care, at a higher billing rate, for specialized populations of Health Home members. The higher level of care is supported by explicit caseload ratios, level of service provision, staff qualifications, and staff training.

CCMP Health Home has three types** of Health Home Plus service models available within its CMA Network:

Health Home Plus for SMI	Health Home Plus for HIV	Health Home Plus for AOT

This policy set includes three Policies that apply to all Health Home Plus service models, and then outlines policies unique to each model.

General Health Home Plus Policies
Quality Management for Health Home Plus
Billing and Tracking for Health Home Plus
Referrals for Health Home Plus

HH+ for SMI Policies	**HH+ for HIV Policies**	**HH+ for AOT Policies**
CMA Eligibility for Health Home Plus	CMA Eligibility for Health Home Plus	CMA Eligibility for Health Home Plus
Attestation for Non-Legacy CMAs	Attestation for Non-Legacy CMAs	Attestation for Non-Legacy CMAs
Eligibility Requirements	Eligibility Requirements	Eligibility Requirements
Staff Qualifications	Staff Qualifications	Staff Qualifications
Staff Training	Staff Training	Staff Training
Level of Service	Level of Service	Level of Service
Caseload Requirements	Caseload Requirements	Caseload Requirements

**Health Home Plus can also be provided to members who are transitioning out of State Psychiatric Centers and Forensic Psychiatric centers, however, CCMP is not currently serving these members. If CMAs are referred any such members, they must contact CCMP so that we can facilitate a referral to a Health Home that is serving that population.

Sources:
Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness

Specialty Mental Health Care Management Agency (MH CMA) Attestation to Serve Health Home Plus (HH+) Individuals with Serious Mental Illness (SMI)
Requests for Specialty Mental Health Care Management Agency (SMH CMA) Designation
Specialty Mental Health Care Management- Questions and Answers
Health Home Plus Program Guidance for Individuals with HIV

1. Quality Management for Health Home Plus (AOT/HIV/SMI)

Policy:

CMAs billing for HH+ members must adhere to all program requirements within the Health Home Plus Policy Set and will be subject to monitoring to ensure compliance with HH+ standards. CCMP and CMAs who bill the HH+ rate are subject to audit by the State and other Medicaid authorities.

Procedure:

1. MH CMAs and HH+ for HIV Attested CMAs are responsible for providing staff education, experience, and qualification documentation to CCMP upon request and/or at regular intervals.
   1.1. CCMP will review these records at the time of site audit, or as necessary.
   1.2. If a CMA's HR department is not comfortable sharing personnel records with CCMP, they may complete an attestation form, documenting the staff qualifications for their positions.
      - Attestation of Qualifications for HARP and HH+ SMI
      - Attestation of Qualifications for HH+ HIV

2. MH CMAs and HH+ for HIV Attested CMAs are responsible for providing caseload information to CCMP upon request and/or at regular intervals.
   2.1. CCMP requires each CMA to maintain a record of caseloads for all staff providing HH+ services, inclusive of members from other Health Homes (PHI can be redacted). CMAs may use the CCMP HH+ Caseload Tracker if they would like, or any other system of record keeping.
   2.2. CCMP will review these records at the time of site audit, or as necessary.

3. All CMAs are responsible for identifying all HH+ Eligible members on the monthly Billing Support Questionnaire – this is documented in the question "EXPANDED HH+ POPULATION?".
   3.1. All CMAs must screen all members for HH+ Eligibility at enrollment and be able to identify when someone who was previously not eligible for HH+ becomes eligible for the program.

4. MH CMAs and HH+ for HIV Attested CMAs must use the FCM HH+ Flag to identify when a member is on a HH+ caseload with the goal of receiving the HH+ level of service.
   4.1. The SMI, AOT, and HIV flags are used in conjunction with the HH+ flag to specify which type of caseload the member is on.
   4.2. The CMA must remove the flags when the member has left the HH+ program and has been stepped down to the standard Health Home level of care.

Referral Management:

1. MH CMAs and HH+ for HIV Attested CMAs must notify CCMP when their capacity to accept referrals for HH+ eligible members has changed.
   1.1. This is done via responding to the Monthly Lead Health Home Referral Capacity Request (Survey Monkey).

1.2. If CMAs are receiving referrals from SPOA through Maven, they must also notify SPOA to halt referrals.

2. MH CMAs and HH+ for HIV Attested CMAs who do not adhere to HH+ requirements may jeopardize the CMAs opportunity to be referred HH+ members, and potentially affect a CMAs status as a CCMP Network CMA.

2. Billing and Tracking for Health Home Plus (AOT/HIV/SMI)

Policy:
The HH+ rate code can be billed if the minimum required HH+ Core Services were provided, and all other programmatic requirements were met. The HH+ rate code can also be billed for HH+ members in Diligent Search5.

Procedure:

1. For reimbursable HH+ services delivered, CMAs attest that billable services were provided in a given month by completing the Billing Support Questionnaire in FCM.

2. If the minimum required HH+ Core Services were not provided in a given month, but at least one Core Service was provided, and all other programmatic requirements were met, then the Health Home High Risk/Need Care Management rate code may be billed for that given month.

3. The HH+ rate code can be billed for 12 consecutive months starting from the point an individual's HH+ (HIV/SMI) eligibility becomes known to the HHCM and HH+ (HIV/SMI) services have been provided.
   3.1. If a HH+ individual continues to meet eligibility requirements at the end of the twelve-month initial time frame, HH+ billing may continue for 12 more months with supporting documentation.

4. The HH+ rate code can be billed for any number of months in which an AOT member has an active AOT order, and for up to 12 months after the end of the AOT order.

[5] Confirmed for AOT per Health Home Plus (HH+) for AOT; pending confirm from DOH for HH+ for SMI/HIV

3. Referrals for Health Home Plus (AOT/HIV/SMI)

Policy:
Health Home Plus (HIV/SMI) eligible members may be identified by any referral source at the time of enrollment, or by the CMA after they have been servicing the member within the standard Adult Health Home Care Management model. If a member is identified by a referral source to be eligible for and in need of the Health Home Plus (HIV/SMI) level of service, the following procedures apply:

Procedure:

1. The referral source can supply documentation to support that the potential member meets high need indicators for HH+.
   1.1. The MH CMA or HH+ for HIV Attested CMA is still required to assess eligibility for HH+ and document accordingly.

2. If the referral comes through CCMP, CCMP will ensure that the potential member is assigned to a CMA qualified to serve the HH+ population.
   2.1. HH+ referrals will be assigned to MH CMAs and HH+ for HIV Attested CMAs no later than two business dates after receipt.

3. The MH CMAs and HH+ for HIV Attested CMAs should initiate contact with the potential member and/or referral source upon receiving the referral. The CMA is to contact the potential member no later than two business days after receiving a Health Home Plus referral.

4. It is expected that the MH CMAs and HH+ for HIV Attested CMAs and the referral source will coordinate efforts in a way that provides for warm hand-off and/or immediate engagement when working with high-need individuals.

5. A warm hand-off is best practice to ensure optimal transition to HH+ (HIV or SMI) services when a potential member is being discharged/transitioned from either a program or facility. An introduction with the potential member prior to discharge/transition can help orient the potential member to HH+ (HIV or SMI) program services while allowing the CMA to be a participant in the discharge planning.

NYC SPOA

1. NYC SPOA is the exclusive referral source for HH+ AOT members. NYC SPOA may also refer non-AOT HH+ SMI members directly to MH CMAs.
2. To receive referrals directly from NYC SPOA, the MH CMA must be registered in the Mental Health Provider Database and have access to Maven. Staff must also be trained in how to use the Maven system.

3. The referrals will be sent to the MH CMA through Maven, and the CMA must document directly into Maven when the member is no longer receiving HH+ SMI services.

C. HH+ for SMI

1. CMA Eligibility for Heath Home Plus for SMI

Policy:
Only Specialty Mental Health CMAs (MH CMAs) can provide HH+ for SMI care management services and bill at the HH+ rate.

Procedure:
1. The NYS Office of Mental Health (OMH) decides which CMAs are designated, or provisionally designated, as MH CMAs, and maintains a list of the NYS Specialty Mental Health Case Management programs.

2. Effective 3/8/21, only MH CMAs can enroll new members who are HH+ for SMI Eligible. MH CMA status is visible in MAPP and is tied to the CMA, i.e., once a CMA is designated as a MH CMA, that status is applicable to all their network Health Homes.

3. CMAs who are not designated or provisionally designated MH CMAs may still serve HH+ for SMI Eligible members within the Adult Health Home model, and bill at the High-Risk Health Home rate, if the member was enrolled prior to 3/8/21, or the member was not HH+ for SMI Eligible at the time of enrollment.

4. All CMAs are responsible for identifying HH+ SMI Eligible members on the monthly Billing Support Questionnaire – this is documented in the question "EXPANDED HH+ POPULATION?".

5. All CMAs must screen all members for HH+ SMI Eligibility at enrollment and be able to identify when someone who was previously not eligible for HH+ SMI, becomes eligible for the program.

6. When a non-designated CMA identifies an already enrolled member who has newly become HH+ for SMI eligible, they must:
   - Inform the member of their HH+ for SMI Eligibility
   - Offer the member a transfer to a MH CMA
   - Document the member's choice
   - Facilitate a transfer to a MH CMA (per member choice)

2. Designation of MH CMAs

Policy:
CMAs are designated as MH CMAs by OMH when they have demonstrated the ability to serve at least 50% of their HH+ for SMI Eligible members at the HH+ for SMI Level of Care, and when they have identified at least 50% of their HH+ for SMI Eligible members as such on the monthly Billing Support Questionnaire. CMAs start off provisionally designated at HH+ program start up and become fully designated once they have met the OMH metrics above.

Although OMH is responsible for designation, the request for designation goes through Health Home, and CCMP will not request designation for any CMA that we do not believe can provide the HH+ for SMI level of service. CMA takes many factors into consideration, including performance on Quality Metrics, Performance Improvement Plans, history of working with high need members, etc.

Procedure:

1. Email CCMP stating that you would like to apply for designation as a MH CMA.

2. We will have a brief call to better understand your program and readiness to do HH+ for SMI. Be prepared to share information such as:
   - How many qualified HH+ for SMI CMs do you have on staff?
   - How many qualified HH+ for SMI Supervisors do you have on staff?
   - How many HH+ for SMI eligible members are already enrolled in your CMA?
   - What referral streams do you have that are likely to produce HH+ for SMI Eligible referrals?
   - Will you commit to taking CCMP HH+ for SMI Eligible referrals, as capacity allows?
   - Do you have experience providing something like the HH+ for SMI level of care already?

3. If CCMP is ready to recommend you for provisional designation, CCMP will send you a Provisional Designation Action Plan to complete and return.

4. CCMP will submit a request on your behalf to OMH, including your Provisional Designation Action Plan, and describe why we think you should get Provisional Designation.

5. OMH will review the request, run a data analysis out of MAPP/PSYCKES, and hold a Technical Assistance call with the CMA.

6. If approved, OMH will issue a Provisional Designation Letter and the CMA can begin enrolling HH+ SMI members and serving them at the HH+ rate.
   6.1. All Health Homes the CMA is in network with are copied on the letter, CMAs do not need to complete a Provisional Designation Action Plan for each Health Home.
   6.2. CCMP will add the CMA to their HH+ Attestation Form and submit to OMH via the BML.

6.3. CCMP will instruct FCM to update the CMA's configuration in FCM to be able to bill at the HH+ rate.

7. The CMA's HH+ leaders participate in the Specialty CMA Director's Meeting every other month, run by OMH. The HH+ staff and/or leaders participate in the HH+ Support Group quarterly, run by CCMP.

8. The CMA's HH+ leadership, program supervisors, and quality oversight staff view the **Provisional MH-CMA Kick-Off Webinar** to learn more about the Specialty MH CMA provisional designation status and requirements.

9. The CMA adds their Specialty Mental Health CMA program into the **Mental Health Provider Database (MHPD)**: This database gives the CMA access to Maven, which allows them to receive HH+ SMI SPOA referrals.
   9.1. The CMA has a Technical Assistance call with NYC SPOA, to review expectations and how to use Maven.

10. OMH will share monthly reports with the CMA and CCMP to track the CMA's progress towards meeting the HH+ metrics and provide technical assistance as needed.
   10.1. CMAs who do not meet criteria for full designation may have their Action Plan target dates extended to maintain their provisional designation.
   10.2. If the CMA is not making sufficient progress towards designation, CCMP may withdraw our support for provisional designation, OMH may revoke the provisional designation, or the CMA may withdraw their request for provisional designation.

11. Once the CMA has met the metrics, OMH will issue a Specialty Mental Health Designation Letter, and ask the CMA to complete and return the **Specialty Mental Health Care Management Agency (MH CMA) Attestation to Serve Health Home Plus (HH+) Individuals with Serious Mental Illness (SMI)**.
   11.1. All Health Homes the CMA is in network with are copied on the letter; CMAs must cc all Health Homes when they return their completed Attestation.

3. Eligibility Requirements for HH+ for SMI

Policy:
To be eligible for HH+ for SMI, potential members must meet the same Medicaid and Consenting requirements as members receiving traditional Adult Care Management. Their diagnostic and appropriateness requirements are different, and are outlined as follows:

Procedure:

1. Individuals with SMI (see Definition of SMI for Health Homes Eligibility) who fall within at least one of the following categories are eligible for HH+ SMI services, hereafter referred to as “High-Need SMI” populations:
   1.1. Individuals meeting High-Need SMI HH+ criteria as outlined below may also receive court ordered Assisted Outpatient Treatment (AOT). These individuals are eligible for the HH+ rate[6] for as long as the active AOT order is in place and must be served by a MH CMA eligible to provide AOT

Assertive Community Treatment (ACT) step down: Individuals transitioning off ACT to a lower level of service.

Enhanced Service Package / Voluntary Agreement: Identified by the Local Government Unit (LGU).
An agreement signed by individuals otherwise considered for AOT by the LGU but agreeing that he/she will adhere to a prescribed community treatment plan rather than be subject to an AOT court order.
These agreements are most frequently used as trial periods before initiating a formal AOT order. The agreement can also be used following a period of AOT when the individual is deemed ready to transition off an AOT order.

History of an expired AOT court order within the past year

Homeless: Meeting the Housing Urban Development’s (HUD) Category One (1) Literally Homeless definition:

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- Has a primary nighttime residence that is a public or private place not meant for human habitation; or
- Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, and local government programs); or

[6] Effective 4/1/24 there is an additional $210 (downstate) AOT supplemental rate.

- Is exiting an institution where they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

High utilization of inpatient/emergency department (ED) services. This population is typically known to staff in emergency departments, inpatient units, as well as to providers of other acute and crisis services. Individuals will have had the following:

- Three (3) or more psychiatric inpatient hospitalizations within the past year; or
- Four (4) or more psychiatric ED visits within the past year; or
- Three (3) or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar.

Criminal Justice involvement: Release from incarceration (jail, prison) within the past year and requires linkage to community resources to avoid re-incarceration. Eligible individuals have been incarcerated due to poor engagement in community services and supports.

Ineffectively engaged in care:

- No outpatient mental health services within the last year and two (2) or more psychiatric hospitalizations; or
- No outpatient mental health services within the last year and three (3) or more psychiatric ED visits.

Clinical Discretion: SMI individuals who do not fall within at least one of the above high need categories could still be eligible for HH+ services based on the clinical discretion of the local Single Point of Access (SPOA) and/or Managed Care Organization (MCO). See Additional Guidance on Clinical Discretion for more information.

2. Care Management Agencies (CMAs) need to develop a protocol for safely transitioning individuals on and off HH+ SMI services, based on individual need.
   2.1. Individuals transitioning off from HH+ will receive the Health Home High Risk/Need Care Management rate for a period of six (6) months to support the transition to a less intensive level of care management.
   2.2. Individuals transitioning off from HH+ will have their CES Tool due 12 months after they were last eligible for HH+, as indicated on the monthly Billing Support Questionnaire.

3. All CMAs are required to identify HH+ for SMI eligibility status monthly on the Billing Support Questionnaire.
   3.1. Documentation of screening for HH+ must be present in the chart at enrollment, and at any point where a previously ineligible member becomes HH+ Eligible. The documentation requirement can be met with an uploaded screening form, a custom assessment screening form, or an encounter note (could be included in the enrollment note) indicating the member was screened for HH+ SMI

eligibility, the result of the screening, whether the member wants to join the HH+ for SMI program, and whether the member will be placed on a HH+ caseload or transferred to a MH CMA (if the CMA is not a MH CMA).

4. When a member is enrolled into a MH CMA, there must be an encounter note to document the start of HH+ for SMI services, before billing the HH+ rate. The encounter note must be entered in the month the HH+ for SMI Eligible member is assigned to a HH+ for SMI qualified caseload and must:
   - Identify that the member is HH+ for SMI eligible and which High Need Special Population(s) justifies eligibility.
   - Identify the verification document(s) uploaded to FCM.
   - Identify the supervisor that confirmed eligibility and date of supervisory review
   - Identify when the 12-month HH+ for SMI service authorization will expire.

For example,
"Member is SMI HH+ eligible, due to having schizophrenia, and was released from jail 3 months ago. A letter from the member's parole office has been uploaded on July 5, 201,8 named "Parole Officer Verification". Supervisor NAME reviewed this HH+ identification on July 3, 2018. Member has been placed on a HH+ for SMI Qualified caseload and is authorized for 12 months of HH+ services, July 2018-June 2019."

Annual Re-Determination of HH+ SMI Eligibility

1. At the 11 month point of a member receiving HH+ services, the HH+ CM should evaluate with the member and their Care Team, whether they would benefit from continuation of HH+ services for another 12 months.

2. If there is agreement on a desire to continue with HH+, the HH+ CM must re-determine eligibility for the program.
   2.1. The High Need SMI populations eligible for continuation of HH+ services are the same as those used for initial HH+ screening.
   2.2. Documentation requirements for the Re-Determination of HH+ SMI Eligibility are the same as for initial determinations of HH+ SMI Eligibility (encounter note, documentation upload, etc.)
   2.3. This annual re-determination process may be repeated as long as the member continues to benefit from and remains eligible for the HH+ program.

Tools to Support Eligibility Determinations:

CCMP has developed several tools that CMAs can use or customize to help with routine screening for HH+ for SMI eligibility, and documentation of HH+ for SMI eligibility.
JOINT HH+ Screening and Documentation of Eligibility Form - SMI and HIV

4. Staff Qualifications for HH+ for SMI

Health Home Care Managers that provide Health Home Plus for SMI services must meet the following Education, Experience, and Supervision qualifications:

Education:

1. A Master's degree in one of the qualifying fields[7] and one (1) year of Experience; OR
2. A Bachelor's degree in one of the qualifying fields[3] and two (2) years of Experience; OR
3. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two (2) years of Experience; OR
4. A Bachelor's degree or higher in ANY field with either: three (3) years of Experience, or two (2) years of experience as a Health Home care manager serving the SMI or SED population

Experience:

1. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism, or substance abuse, and/or children with SED; OR
2. Linking individuals with Serious Mental Illness, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing, and financial services).

Supervision:

Supervision from someone meeting any one of the following:

1. Licensed level healthcare professional[8] with prior experience in a behavioral health setting; OR
2. Master's level professional with two (2) years prior supervisory experience in a behavioral health setting.

Waiver Request of Health Home Plus for SMI Qualifications

In rare circumstances, staff may have unique education and/or experience to adequately serve the high need behavioral health population but do not meet the updated qualifications outlined in this memo. CMAs may apply for a waiver for such staff.

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[7] **Qualifying fields** include education degrees featuring a major or concentration in: social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.

[8] **Licensed level healthcare professional** includes: Physicians, Psychiatrists, Physician's Assistants, Nurse Practitioners, Psychiatric Nurse Practitioners, Registered Professional Nurses, Licensed Practical Nurses, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Mental Health Counselors, Licensed Marriage

Waivers are not intended to be the sole approach for an agency looking to expand capacity in serving these populations. Agencies should be prudent in selecting staff to pursue a waiver of qualifications. Waivers should only be submitted for those staff whose unique qualifications allow them to adequately serve the population.

Please submit all waiver requests online here: Waiver of Qualifications for HH+ SMI and NYS EA Assessors for Adult BH HCBS

IMPORTANT:
Waiver approval alone does not authorize an agency to provide/bill for Health Home Plus for SMI. All CMA attestations and trainings are STILL required and cannot be waived. CMAs who receive waiver approvals are responsible for providing them to CCMP in advance of site visits.

5. Staff Training for HH+ for SMI

There are no explicit training requirements associated with the HH+ for SMI model. There are required staff Core Competencies, as follows:

Supervisors will be responsible for ensuring care managers receive adequate support and access to resources that encourage development of skills necessary to improve quality of life and outcomes for high-need individuals with SMI.

Supervisors and direct care management staff must be proficient in the following areas:

Conduct appropriate screening and either performing or arranging for more detailed assessments when needed (e.g., high-risk substance use or mental health related indicators, harm to self/others, abuse/neglect and domestic violence).

- This includes the CMA's demonstrated ability to complete the required New York State Eligibility Assessment for Health and Recovery Plan (HARP) enrolled members.

Plan and coordinate care management needs for high-need SMI individuals including:

- Navigate the mental health service system-including ability to make referrals to mental health housing services, crisis intervention/ diversion, peer support services
- Knowledge of the behavioral health managed care benefit package
- Collaborate with inpatient staff and MCO (as applicable) to affect successful transitions out of inpatient or institutional settings
- Address the quality, adequacy and continuity of services to ensure appropriate support for individuals' mental health and psychosocial needs
- Complete plans of care and coordinate with MCOs for HARP members utilizing the Home and Community Based Services (HCBS) benefit package
- Maintain engagement with individuals who are often disengaged from care and have difficulty adhering to treatment recommendations.

Key skills and practices to engage high-need SMI individuals include:

- Motivational Interviewing
- Suicide Prevention
- Risk Screening
- Trauma Informed Care
- Person-centered care planning and interventions
- Recovery-Oriented Approaches (e.g., WRAP)

6. Level of Service for HH+ for SMI

Level of Service requirements for HH+ for SMI are different from standard Adult Health Home Care Management, as regards frequency and type of member core service provision, and frequency of Care Team Meetings.

All other program requirements such as Assessment, Care Planning, Disenrollment, Crisis Management, etc. are the same as for members receiving standard Adult Health Home Care Management.

Core Service Provision:
A minimum of four Health Home core services must be provided per month, two of which must be in person contacts, or more when the individual's immediate needs require additional contacts.

- If the individual is AOT, at least four (4) in person contacts must be made within the month.

There are no telehealth allowances for HH+ SMI in-person requirements.

Each CMA is required to have a quality assurance process in place to confirm the minimum encounters are met, including a single point of accountability overseeing the HH+ compliance.

Care Team Meetings :
Due to the intensive needs of the HH+ population, there is an expectation that HH+ Care Managers will be engaged actively with the care team members and at a minimum facilitating one Care Team Meeting quarterly.

7. Caseload Requirements for HH+ for SMI

1. CMAs must use one of the DOH required caseload models to serve the HH+ for SMI population.

Single Care Manager Approach: Traditional model of care management where services are provided by one qualified HHCM and caseload capacity is determined by a fixed number of cases. Program requirements that apply to this model include:

The maximum caseload ratio for HH+ enrollees shall be one full-time employee (FTE) to 20 HH+ recipients. The qualified HH+ care manager must provide a minimum of four (4) Health Home core services per month, two of which must be face-to-face contacts, or more when the member's immediate needs require additional contacts.

- If the member is AOT, at least four in person contacts must be made within the month.

Team Approach: A CMA may choose to use a team approach to serve a caseload consisting of HH+ members. However, use of this approach mandates that the following requirements are met:

The team caseload must maintain the ratio of no more than twenty (20) HH+ members for each FTE on the team. For every forty (40) HH+ members, the team must have at least one qualified HH+ care manager. For example, a team serving 50 HH+ members shall have two (2) qualified HH+ care managers on the team.

- A qualified HH+ care manager must provide at least two (2) Health Home core services per month, one (1) of which must be an in person contact for HH+ members. The remaining contact requirements can be provided by the additional team members.
- The CMA must have a reporting or auditing system to ensure that a qualified HH+ care manger is providing at least two of the core services per month.
- A primary care manager meeting the DOH/OMH required staff qualifications to serve HH+ members shall be identified and will conduct the Comprehensive Assessment, develop the Plan of Care, and provide oversight regarding coordination of interventions in accordance with the Plan of Care. The care manger is to be listed in FCM including phone number and email address.

2. Either the Single Care Manager Approach or the Team Approach can be implemented with a 100% HH+ Caseload or a Mixed Caseload.

100% HH+ Caseload:
All members on the caseload are eligible for Health Home Plus for SMI

Mixed Caseload (HH+ and non-HH+ members):
If using a Mixed Caseload, within either Single Care Manager Approach or a Team Approach, the CMA must use a point system to ensure caseload balance.

To maintain a level of service intensity consistent with a maximum ratio of 1:20, the point maximum is 60 points. This point maximum is based on the following calculation:

Ratio	Calculation (using HH+ cases only)	Points
1:20	20 HH+ individuals x 3 (point value) =	60 points

Using the table below, identify the member's category and the point value

Category	Description	Point Value
HH+	For any individual receiving HH+ services.	3
High Touch	For individuals not receiving HH+ services but require a high level of service intensity. Some factors a CMA could consider for this category include: non-SMI Homelessness, HARP Enrollment, HH+ step down, chronic Substance Abuse etc. May include individuals that meet the Health Home High Risk/Need rate.	2
Low Touch	For individuals not receiving HH+ services and require a low level of service intensity. May include individuals that meet the Health Home Care Management rate.	1

Assign members to a caseload and add the subsequent point values to equal no more than the established maximum.

Below is an example of a mixed caseload for one care manager formulated using the weighted point system:

Example of mixed caseload using weighted point system			
Category	Number of Individuals	Calculation	Points by Category
HH+ (3 points)	10	10 (individuals) x 3 (points) =	30
High Touch (2 points)	6	6 (individuals) x 2 (points) =	12
Low Touch (1 point)	9	9 (individuals) x 1 (point) =	9
	Total: 25 Individuals		Total: 51 points

In this example, the caseload ratio is 1:25 composed of a mix of 10 HH+ (3 points each), 6 High Touch (2 points each) and 9 Low Touch (1 point each) totaling 42 points, which is below the recommended maximum mixed caseload of 60 points.

MH CMAs may design their own point system based on their unique member mix, as long as they can demonstrate how the 1:20 maximum HH+ for SMI caseload is maintained.

Since member high risk needs and billing rates can change month to month, CMAs must maintain monthly caseload records for HH+ CMs that are inclusive of their full caseload. CMAs may be asked to provide

caseload records during their site visits, or upon request, to demonstrate that a given HH+ claim met the caseload requirement for that month.

Tools to Support Caseload Tracking:
CCMP has developed a tracking tool that MH CMAs can use or customize to help with balancing and maintaining a record of HH+ for SMI caseloads.
CCMP HH+ Caseload Tracker

D. HH+ for HIV

1. CMA Eligibility for Heath Home Plus for HIV

Policy:
Only former COBRA HIV Targeted Case Management providers, and CMAs that are attested by the Health Home are eligible to provide HH+ for HIV services and bill at the HH+ rate.

Procedure:

1. The Health Home determines which non-legacy CMAs in their network can be attested to do HH+ for HIV. HH+ HIV Attestation status is visible in MAPP and is tied to the CMA, i.e., once a CMA is attested to do HH+ HIV, that status is applicable to all their network Health Homes.
   - CMAs who are not legacy providers or attested for HH+ for HIV may still serve that the HH+ for HIV Eligible population within the Standard Health Home model, and bill at the High-Risk Health Home rates, if that is the member's choice.

2. All CMAs are responsible for identifying HH+ HIV Eligible members on the monthly Billing Support Questionnaire – this is documented in the question "EXPANDED HH+ POPULATION?".

3. All CMAs must screen all members for HH+ HIV Eligibility at enrollment and be able to identify when someone who was previously not eligible for HH+ HIV, becomes eligible for the program.

4. If a non-HH+ HIV CMA identifies a HH+ for HIV Eligible member at enrollment, or an already enrolled member who has newly become HH+ for HIV eligible, they must:
   - Inform the member of their HH+ for HIV Eligibility
   - Offer the member a transfer to a HH+ HIV CMA
   - Document the member's choice
   - Facilitate a transfer to a HH+ HIV CMA (per member choice)

2. Attestation Process for Non-Legacy CMAs for HH+ for HIV

Policy:
Non-Legacy CMAs can service the HH+ for HIV Population if they demonstrate compliance with DOH/AI staffing qualifications, caseload size, and meet the HH+ for HIV CMA Criteria, and CCMP adds them to our Health Home HH+ HIV Attestation Form.

CCMP will not support any CMA that we do not believe can provide the HH+ for HIV level of service. CCMP takes many factors into consideration, including performance on Quality Metrics, Performance Improvement Plans, history of working with high need members, etc.

HH+ (HIV) CMA Criteria:

The CMA is housed within an Article 28 or 31 provider, certified home health agency, community health center, community service program, or other community-based organization with:

- Two years' experience in the case management of persons living with HIV or AIDS; or
- Three years' experience providing community based social services to persons living with HIV or AIDS; or
- Three years' experience providing case management or community based social services to women, children, and families; substance users; MICA members; homeless persons; adolescents; parolees, recently incarcerated; and other high-risk populations and includes one year of HIV related experience

Procedure:

1. Email CCMP that you are interested in starting a HH+ for HIV program.

2. We will schedule a call to review program requirements and assess your readiness for HH+ for HIV. When the CMA is determined to be ready, we will send the CMA the Health Home Plus HIV Attestation Form for CMAs to complete and return.

3. CCMP will update our Health Home HH+ HIV Attestation with Department of Health (DOH)/AI to add the new CMA who is approved to do HH+ HIV.

4. CCMP may choose to remove from the attestation any CMA who CCMP thinks does not have the ability to provide the HH+ for HIV level of care per DOH/AI policy.

5. CCMP will instruct FCM to update the CMA’s configuration in FCM to be able to bill at the HH+ rate.

3. Eligibility Requirements for HH+ for HIV

Policy:

To be eligible for HH+ for HIV, potential members must meet the same Medicaid and Consenting requirements as members receiving traditional Adult Care Management.

Their diagnostic and appropriateness requirements are different, and are outlined as follows:

Procedure:

1. Individuals with HIV who fall within at least one of the following three categories are eligible for HH+ services, hereafter referred to as "High-Need HIV" populations:

Not Virally Suppressed: having viral load >200 copies/mL

Have behavioral health conditions (SMI, and/or engage in Intravenous Drug Use) regardless of viral load status, and one of the following:

- Have had three or more inpatient hospitalizations in the last 12 months; or
- Have had four or more Emergency Department visits in the last 12 months; or
- At the time of HH+ for HIV Eligibility determination, meets the Housing Urban Development's (HUD) Category One Literally Homeless definition[9]; or
- At the time of HH+ for HIV Eligibility determination, are involved with the criminal justice system; or
- Have been released from prison or jail in the last 12 months

Clinical Discretion: Inclusion in the HH+ (HIV) population may also be determined through the Clinical Discretion of the MCO or medical provider. Clinical Discretion should be made based on:

Status of an individual's viral load, AND

Factors that indicate the need for referral into HH+ or a continuation of services such as:

- newly diagnosed HIV status
- viral load suppression is not stable
- housing instabilities,
- poor adherence to treatment plan, etc.

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[9] Literally Homeless: Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; or(ii) Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. Care Management Agencies (CMAs) need to develop a protocol for safely transitioning individuals on and off HH+ HIV services, based on individual need.
   2.1. Individuals transitioning off from HH+ will receive the Health Home High Risk/Need Care Management rate for a period of six (6) months to support the transition to a less intensive level of care management.
   2.2. Individuals transitioning off from HH+ will have their CES Tool due 12 months after they were last eligible for HH+, as indicated on the monthly Billing Support Questionnaire.

3. All CMAs are required to identify HH+ for HIV eligibility status monthly on the Billing Support Questionnaire.
   3.1. Documentation of screening for HH+ must be present in the chart at enrollment, and at any point where a previously ineligible member becomes HH+ Eligible. The documentation requirement can be met with an uploaded screening form, a custom assessment screening form, or an encounter note (could be included in the enrollment note) indicating the member was screened for HH+ HIV eligibility, the result of the screening, whether the member wants to join the HH+ for HIV program, and whether the member will be placed on a HH+ caseload or transferred to a HH+ HIV CMA (if the CMA is not a HH+ HIV CMA).

4. When a member is placed onto a HH+ for HIV caseload, there must be an encounter note to document the start of HH+ for HIV services, before billing the HH+ rate.
   4.1. The encounter note must be entered in the month the HH+ for HIV Eligible member is assigned to a HH+ for HIV qualified caseload and must:
      - Identify that the member is HH+ for HIV eligible and which High Need HIV Population(s) justifies eligibility.
      - Identify the verification document(s) uploaded to FCM.
      - Identify the supervisor that confirmed eligibility and date of supervisory review
      - Identify when the 12-month HH+ for HIV service authorization will expire.

For Example: *"Member is HIV HH+ eligible, due to viral load greater than 200 copies/mL. A lab report dated June 20, 2018, from the member's PCP {NAME} has been uploaded on July 5, 2018, named "June 2018 Lab Report - Verification". Supervisor {NAME} reviewed this HH+ identification on July 3, 2018. Member has been placed on a HH+ for HIV qualified caseload, and is authorized for 12 months of HH+ services, July 2018-June 2019".*

Annual Re-Determination of HH+ HIV Eligibility

1. At the 11 month point of a member receiving HH+ services, the HH+ CM should evaluate with the member and their Multidisciplinary Care Team, whether they would benefit from continuation of HH+ services for another 12 months.

2. If there is agreement on a desire to continue with HH+, the HH+ CM must re-determine eligibility for the program.
    2.1. The only High Need population eligible for continuation of HH+ services is **Clinical Discretion** (MCOs and medical providers)
    2.2. Documentation requirements for the Re-Determination of HH+ HIV Eligibility are the same as for initial determinations of HH+ HIV Eligibility (encounter note, documentation upload, etc.)
    2.3. This annual re-determination process may be repeated as long as the member continues to benefit from and remains eligible for the HH+ program.

Tools to Support Eligibility Determinations:
CCMP has developed tools that CMAs can use or customize to help with documentation of HH+ for HIV eligibility.

JOINT HH+ Screening and Documentation of Eligibility Form - SMI and HIV

4. Staff Qualifications for HH+ for HIV

Care Management Supervisor:
1. Master's Degree in Health, Human Services, Mental Health, Social Work, and one (1) year of supervisory experience and one (1) year of qualifying experience; or
2. Bachelor's degree in Health, Human Services, Mental Health, Social Work and two (2) years of supervisory experience and three (3) years of qualifying experience[10].

Care Manager/Coordinator:
1. Master's or Bachelor's degree in Health, Human Services, Education, Social Work, Mental Health, and one (1) year of qualifying experience; or
2. Associate's Degree in Health, Human Services, Social Work, Mental Health, or certification as an R.N. or L.P.N. and two (2) years of qualifying experience.

Navigator/Community Health Worker/Peer:
1. High School Diploma or GED, or
2. CASAC, or
3. Certification as a Peer, or
4. Community Health Worker (CHW) and
5. Ability to read, write and carry out directions.

There is no waiver process for staff qualifications for HH+ HIV.

[10] Qualifying Experience: means verifiable work with the target populations defined as individuals with HIV, history of mental illness, homelessness or substance abuse.

5. Staff Training for HH+ for HIV

Care Manager/Coordinator and Navigator/Community Health Worker/Peer level staff providing the HH+ for HIV Level of Service (both legacy and non-legacy providers) must meet training requirements established by the AIDS Institute (AI).

Some of the trainings are offered by the AIDS Institute and designed for Health Home Care Managers. Others may be offered by other entities. Agency trainings can also meet these requirements if they match the content area.

Supervisors should use discretion, look for trainings that addresses the core competency and priority content areas, and choose the format that best fits the needs of individual staff.

Training Resources:
AIDS Institute Training Centers: https://www.hivtrainingny.org/Home/About Us
AIDS Institute Training Initiative: https://www.hivtrainingny.org
Empire Justice Center: https://empirejustice.org/training/
Legal Action Center: Legal Action Center | Training and Technical Assistance
NYS Office of Children and Family Services: NYS Mandated Reporter Training
courses
NYS Clinical Education Initiative support@ceitraining.org
National Council for Mental Wellbeing Communications@TheNationalCouncil.org
Mountain West AETC aetcinfo+uw.edu@ccsend.com
National Coalition on Sexual Health https://nationalcoalitionforsexualhealth.org
Health HIV: https://healthhiv.org/
MCTAC mctac.info@nyu.edu

TalentLMS:
Although CCMP does not provide trainings on these topic areas, the required trainings are listed in TalentLMS for staff who indicate that they were with HIV+ members on their TalentLMS Profile. Instead of training content, each course provides a place for staff to document when they have completed the training. If CCMP is aware of a resource that provides that particular training, it will be included for reference in the course listing.

AIDS Institute Required Trainings: HH+ HIV Staff

REQUIRED ANNUALLY

- Child Abuse & Neglect Mandated Reporting (upon hire/annual update)
- HIV Disclosure and HIV/AIDS Confidentiality Law Overview (upon hire/annual update)

REQUIRED UPON HIRE

- The Role of Health Home Care Manager in Improving Health Outcomes for People Living With HIV/AIDS or At-risk of HIV
- Sexual Health and Gender Orientation (SOGI)

REQUIRED WITHIN 18 MONTHS OF HIRE

Core Competency content areas listed below are intended to serve as a training resource HH+ HIV staff. Many of these trainings have been offered in multiple formats, including live trainings (pre-pandemic), webinars, and online.

Priority Content Areas listed below are supplemental content areas that could be used to satisfy the annual training hours requirement (40 hours)

Core Competency Content Area List

- Ending the Epidemic (EtE)
- Introduction to HIV, STIs, and HCV
- Overview of HIV/AIDS
- Introduction to co-occurring disorders for PLWHA
- Harm Reduction Approach
- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) and Transgender/Gender Nonconforming Cultural Competencies
- Transgender Health
- Primary Care and Treatment Adherence for HIV+ Individuals
- Role of Non-Clinicians in Promoting PrEP/PEP
- HIV/AIDS and Adolescents
- Drug User Health

Priority Content Areas

- HIV clinical guidelines, viral load, CD4, suppressed, unsuppressed, undetectable=untransmittable (U=U)
- HIV/STI risk assessment, testing, treatments, prevention, and condom use
- HIV and mental health; mental health issues (not SMI), treatments, risk behaviors
- HIV and pregnant persons
- HIV and housing
- Hepatitis C/HCV basics, prevention, treatment
- PrEP/PEP and condom use
- Adolescents/minors, confidentiality, and Public Health Law
- Substance use and Harm Reduction services
- Sexual health; reproductive health
- Transgender identity; gender non-conforming; cis gender; gender identity
- Families with LGBTQIA+ parents, children, members
- Children (young), adolescents who self-identify as gender non-conforming or LGBTQIA+
- Suicide prevention; stigma
- Cultural diversity
- Health Equity
- Motivational Interviewing

6. Level of Service for HH+ for HIV

Level of Service requirements for HH+ for HIV are different from standard Adult Health Home Care Management, as regards frequency and type of member core service provision, place of Assessment and Plan of Care Review, frequency of Care Team Meetings, and Duration of Service.

All other program requirements such as Assessment, Care Planning, Disenrollment, Crisis Management, etc. are the same as for members receiving standard Adult Health Home Care Management.

Core Service Provision:
Minimum of four core services must be provided each month.

- At least two of the four core services must be in person contacts.
- At least one in person contact each month must be with the care manager (if team model is implemented)

There are no telehealth allowances for HH+ HIV in-person requirements.

Location of Assessment and Plan of Care Review
Home visits must occur at assessment/reassessment and plan of care revisions/update every six months and as needed based on the needs of the member.

Care Team Meeting:
A Care Team Meeting with all consented Care Team Members and the member must be scheduled every six months or as needed based on the needs of the member.

Duration of Service:
HH+ for HIV members may stay in the program a maximum of 12 months, and then transition to standard Adult Care Management if services are still needed.

MCOs and medical providers also have the discretion to request continuation of HH+ (HIV) services for a member, based on the status of an individual's viral load, AND factors that indicate the need for referral into HH+ or a continuation of services such as: newly diagnosed HIV status, viral load suppression is not stable, housing instabilities, poor adherence to treatment plan, etc.

7. Caseload Requirements for HH+ for HIV

1. The required caseload ratio for HH+ (HIV) members is one full-time employee to a maximum of 20 HH+ members.
   1.1. If the program implements a team model (team is defined as one care manager/coordinator and peers/navigators/community health worker), then the case load may increase by 10 for each additional team member.

2. One care manager/coordinator may supervise no more than two team members.

3. CMAs must utilize one of the DOH/AI required caseload models to serve the HH+ (HIV) population.

HH+ only caseload: caseload comprised only of individuals with HH+ (HIV) levels of need

MODEL 1: HH+ with Care Manager Only

- One Health Home care manager/coordinator – maximum case load of 20 members.

MODEL 2: HH+ with Care Management Team

- One Health Home care manager/coordinator plus one peer/navigator/community health worker – maximum case load of 30 members.
- One Health Home care manager/coordinator plus two peer/navigator/community health worker – maximum case load of 40 members.
- One care manager/coordinator may supervise no more than two team members.

Mixed Caseloads: The case load comprised of HH+ (HIV) and non-HH+ (HIV) individuals
To allow flexibility, medium or low acuity members may be part of a HH+ case load, especially at the beginning of forming HH+ caseloads and teams, in rural areas where fewer cases occur, or as members move to stability but need continuity of care.

One Health Home care manager/coordinator with 10 or more HH+ members – max caseload 40 members (inclusive of HH+ members).

Note: When the number of HH+ (HIV) members is extremely low, the care manager supervisor should use discretion to build an appropriately sized caseload. Example: if a CMA has only three members eligible for HH+, (HIV) the care manager supervisor can work with the care manager to build a caseload that does not exceed NYSDOH caseload limits and allows for the HH+(HIV) members to receive the necessary intensive level of services.

For technical assistance with caseloads, please contact the NYSDOH AIDS Institute at HIVCareMgt@health.ny.gov

Since member high risk needs and billing rates can change month to month, CMAs must maintain monthly caseload records for HH+ CMs that are inclusive of their full caseload. CMAs may be asked to provide caseload records during their site visits, or upon request, to demonstrate that a given HH+ claim met the caseload requirement for that month.

Tools to Support Caseload Tracking:

CCMP has developed a tracking tool that HH+ for HIV CMAs can use or customize to help with balancing and maintaining a record of HH+ for HIV caseloads.

CCMP HH+ Caseload Tracker

E. HH+ for AOT

1. CMA Eligibility for Heath Home Plus for AOT

Background:
The original HH+ program model was for AOT members and was provided by TCM Legacy CMAs since the beginning of Health Homes in 2012.

In 2018 OMH expanded the HH+ program to include non-AOT populations (HH+ SMI and HH+ HIV), and AOT members continued to only be served by the legacy CMAs.

In March 2021 OMH transformed the HH+ SMI program by establishing Specialty Mental Health CMAs (MH CMA). Those TCM Legacy providers serving the AOT population became fully designated MH CMAs.

From March 2021-March 2023, only MH CMAs that were former Office of Mental Health (OMH) Targeted Case Management (TCM) providers (legacy) could provide HH+ for SMI services to AOT members.

Beginning in March 2023, OMH allowed Non-Legacy MH CMAs to provide HH+ for SMI services to AOT members.

Policy:
Only MH CMAs that are attested to do AOT may serve AOT members.

The AOT Attestation is tied to the MH CMA, i.e., once a MH CMA is Attested for AOT, that status is applicable to all their network Health Homes. Although MAPP shows MH CMA status, it does not show which MH CMAs can serve AOT members.

Procedure:
1. Non-Legacy MH CMAs that are eligible to serve the HH+ AOT population and bill at the HH+ rate if they complete an attestation process, described in the Attestation for Non-Legacy Providers for AOT policy.

2. CMAs serving members who, in the course of service, are put on an AOT order must transfer the member to an AOT Attested MH CMA as identified on the court order.

2. Attestation Process for Non-Legacy Providers for HH+ for AOT

Background:
Per the most recent revision of Health Home Plus (HH+) Program Guidance for Assisted Outpatient Treatment (AOT), "Once program and training requirements are completed and verified by the State, Non-Legacy CMAs will also be able to serve and bill for the HH+ population. Further guidance will follow regarding specific training requirements for Non-Legacy providers."

Per the Health Home (HH) Care Management Agency (CMA) Credentials to Serve Health Home Plus (HH+) for Members with Serious Mental Illness (SMI) May 1, 2018, "At this time, the ability to serve Assisted Outpatient Treatment (AOT) individuals will remain limited to former OMH Legacy CMAs, unless otherwise indicated by the State."

In March 2023 OMH notified CCMP that they had put in place a process for non-legacy MH CMAs to attest to serve members with AOT and outlined the procedures for such[11].

Policy:
Designated MH CMAs who have approval from their local SPOA and OMH may attest to serve AOT members at the HH+ SMI level of care. Any training on local AOT program requirements required by the SPOA and/or OMH must be completed by the MH CMA prior to approval and attestation.

Procedures:

1. The CMA completes the process to become a Fully Designated MH CMA.

2. The CMA notifies CCMP that they would like to work with AOT members.
   2.1. A recommendation for a MH CMA to work with AOT members is made at CCMP's discretion. CCMP takes many factors into consideration, including performance on Quality Metrics, Performance Improvement Plans, history of work with HH+ members, etc.

3. If CCMP recommends the CMA work with AOT members, CCMP will schedule a call with the CMA and the local SPOA to review the SPOA's AOT Requirements.

   In NYC, the SPOA requires that MH CMAs have:
   - Access to Maven
   - Access to the AOT Portal
   - AOT Training with DOHMH

[11] Although the relevant state policies have not been updated, CCMP's policies reflect what was communicated via emails from Angelina Olivares, Katherine O'Sullivan, and Stacey Hale on 3/8/23, and from Melissa Beale 3/17/23.

4. Once the CMA has SPOA approval, CCMP will notify OMH Central Office to request the CMA's MH CMA designation be revised to include AOT.

5. OMH Central Office will review the request with AOT program staff at the regional Field Office and Central Office, and may request a call to include the CMA, CCMP and others as needed to discuss the request before issuing final approval.

6. Once the CMA has OMH approval, the MH CMA will update their Specialty Mental Health Care Management Agency (MH CMA) Attestation to Serve Health Home Plus (HH+) Individuals with Serious Mental Illness (SMI) to indicate that their "CMA meets the additional requirements for serving AOT individuals" and submit it to CCMP.

7. CCMP will update our HH+ SMI Attestation to indicate that the MH CMA is now working with AOT members and resubmit to DOH/OMH.

3. Eligibility Requirements for HH+ for AOT

Policy:
To be eligible for HH+ for AOT, potential members must meet the same Medicaid requirements as members receiving traditional Adult Care Management.

Their consenting, diagnostic, and appropriateness requirements are different, and are outlined as follows:

Consenting:
1. Consent for HH enrollment is needed for any member admitted under an AOT order.
   1.1. If a HH+ AOT member refuses to enroll in the HH program, the court order mandating HHCM is then considered to be 'consent for enrollment.
   1.2. A copy of the order must be obtained by the HHCM to secure enrollment, and uploaded to the FCM Documents tab.
   1.3. The AOT order does not substitute for the member's consent to share PHI.

2. Absent the Patient Information Sharing Consent (DOH-5055) the HHCM may share clinical information for care coordination purposes to the extent permitted by section 33.13(d) of the Mental Hygiene law, which provides a limited treatment exception for the exchange of clinical information between mental health providers and HHs.
   2.1. HHCMs must work with HH members under an AOT order to obtain consent, especially when the member requires care coordination that falls outside the scope of the AOT treatment plan/order.
   2.2. The HHCM must educate the member regarding their court order and the importance of signing a consent which includes the HHCM's ability to advocate on behalf of the member, when necessary.

Diagnosis:
HH+ for AOT services are only available for adults with SMI.

Appropriateness:
1. Members must have an active AOT court order mandating them to receive Health Home Care Management services.
   1.1. CMA must obtain a full copy of the court order, and upload it to the FCM Documents tab.
   1.2. Members with enhanced or voluntary service agreements that serve as step-up or step-down from court ordered AOT are not eligible for HH+ for AOT but are instead eligible for HH+ for SMI.
   1.3. Once a member's AOT order expires, they are no longer eligible for HH+ for AOT, but are instead eligible for HH+ for SMI. At that point, all policies for HH+ for SMI must be followed.
   1.4. Individuals transitioning off from HH+ AOT will have their next DOH Continued Eligibility for Services Tool due 12 months after they were last eligible for HH+, as indicated on the monthly Billing Support Questionnaire.

4. Staff Qualifications for HH+ for AOT

Health Home Care Managers that provide Health Home Plus for AOT services must meet the following Education, Experience, and Supervision qualifications, which are the same standards as Health Home Plus for SMI:

Education:

1. A Master's degree in one of the qualifying fields[12] and one (1) year of Experience; OR
2. A Bachelor's degree in one of the qualifying fields[3] and two (2) years of Experience; OR
3. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two (2) years of Experience; OR
4. A Bachelor's degree or higher in ANY field with either: three (3) years of Experience, or two (2) years of experience as a Health Home care manager serving the SMI or SED population

Experience:

1. Providing direct services to people with Serious Mental Illness, developmental disabilities, alcoholism or substance abuse, and/or children with SED; OR
2. Linking individuals with Serious Mental Illness, children with SED, developmental disabilities, and/or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing and financial services).

Supervision:

Supervision from someone meeting any one of the following:

1. Licensed level healthcare professional[13] with prior experience in a behavioral health setting; OR
2. Masters level professional with two (2) years prior supervisory experience in a behavioral health setting.

Waiver Request of Health Home Plus for SMI Qualifications

In rare circumstances, staff may have unique education and/or experience to adequately serve the high need behavioral health population but do not meet the updated qualifications outlined in this memo. CMAs may apply for a waiver for such staff.

Waivers are not intended to be the sole approach for an agency looking to expand capacity in serving these populations. Agencies should be prudent in selecting staff to pursue a waiver of qualifications. Waivers

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[12] **Qualifying fields** include education degrees featuring a major or concentration in: social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.

[13] **Licensed level healthcare professional** includes: Physicians, Psychiatrists, Physician's Assistants, Nurse Practitioners, Psychiatric Nurse Practitioners, Registered Professional Nurses, Licensed Practical Nurses, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Mental Health Counselors, Licensed Marriage

should only be submitted for those staff whose unique qualifications allow them to adequately serve the population.

Please submit all waiver requests online here: Waiver of Qualifications for HH+ SMI and NYS EA Assessors for Adult BH HCBS

IMPORTANT:
Waiver approval alone does not authorize an agency to provide/bill for Health Home Plus for SMI. All CMA attestations and trainings are STILL required and cannot be waived. CMAs who receive waiver approvals are responsible for notifying CCMP.

5. Staff Training for HH+ for AOT

There are no explicit training requirements associated with the HH+ for AOT model. There are required staff Core Competencies, which are largely the same as those required for HH+ for SMI:

Supervisors will be responsible for ensuring care managers receive adequate support and access to resources that encourage development of skills necessary to improve quality of life and outcomes for high-need individuals with SMI.

Supervisors and direct care management staff must be proficient in the following areas:

Understanding the statutory basis of the AOT program, or Kendra's Law (§9.60 of NYS Mental Hygiene Law).

Conduct appropriate screening and either performing or arranging for more detailed assessments when needed (e.g., high-risk substance use or mental health related indicators, harm to self/others, abuse/neglect and domestic violence).

- This includes the CMA's demonstrated ability to complete the required New York State Eligibility Assessment for Health and Recovery Plan (HARP) enrolled members.

Plan and coordinate care management needs for high-need SMI individuals including:

- Navigate the mental health service system-including ability to make referrals to mental health housing services, crisis intervention/ diversion, peer support services
- Knowledge of the behavioral health managed care benefit package
- Collaborate with inpatient staff and MCO (as applicable) to affect successful transitions out of inpatient or institutional settings
- Address the quality, adequacy and continuity of services to ensure appropriate support for individuals' mental health and psychosocial needs
- Complete plans of care and coordinate with MCOs for HARP members utilizing the Home and Community Based Services (HCBS) benefit package
- Maintain engagement with individuals who are often disengaged from care and have difficulty adhering to treatment recommendations.

Key skills and practices to engage high-need SMI individuals include:

- Motivational Interviewing
- Suicide Prevention
- Risk Screening
- Trauma Informed Care
- Person-centered care planning and interventions
- Recovery-Oriented Approaches (e.g., WRAP)

6. Level of Service for HH+ for AOT

Level of Service requirements for HH+ for AOT are different from standard Adult Health Home Care Management, as regards frequency and type of Core Service Provision, Assessment, Care Planning, Diligent Search, and Duration of Service.

All other program requirements such as Care Team Meetings, Disenrollment, Crisis Management, etc. are the same as for members receiving standard Adult Health Home Care Management.

Core Service Provision:

1. MH CMAs serving AOT members shall provide a minimum of four Core Services a month, all of which must be AOT.
   1.1. If the care manager made effort to provide four (4) in person contacts and the individual was not home, did not show up for an appointment or was otherwise not available, the MH CMA must report all efforts made to follow up with the individual using notification procedures as developed by the Local Government Unit (LGU). All efforts must be documented in the individual's record.
   1.2. There are no telehealth allowances for AOT in-person requirements.

2. The MH CMA must ensure timely delivery of services as listed in the court order. Such services must include coordination of all categories of service listed in the AOT treatment plan.

Assessment:

In addition to following the Comprehensive Assessment Policy, MH CMAs providing HH+ for AOT service must report assessment and follow-up data to the Office of Mental Health (OMH) through the Child and Adult Integrated Reporting System (CAIRS) at 6-month intervals

Care Planning

1. In addition to following the Plan of Care Policy, all categories of service listed in the court ordered AOT treatment plan shall also be included in the individual's integrated health home plan of care.
   1.1. The MH CMA and/or other members of the treatment team must consult with the treating physician and the LGU's Director of Community Services or County AOT coordinator, who can then petition to the court for any material change needed to be made to the AOT treatment plan. Any additions or deletions of categories of service are considered material changes.
   1.2. Changes needed to other services in the HH plan of care that are not listed in the AOT treatment plan (e.g., primary care services not listed in the AOT treatment plan), are not considered material changes and therefore do not require consultation with the LGU.

Communication with CCMP, MCOs, and the Local Government Unit

1. The MH CMA must inform CCMP when a member has been placed on court ordered AOT, or when a court order has expired and has not been renewed.

1.1. CCMP will inform the Managed Care Plan of the members' AOT status (information provided in MAPP can be used to satisfy this requirement)
1.2. The MH CMA shall comply with all reporting requirements of the AOT Program as established by the Local Government Unit, and Kendra's Law.

Diligent Search

1. If the individual with an AOT court order cannot be located and has had no credibly reported contact within 24 hours of the time the care manager received either notice that the individual had an unexplained absence from a scheduled treatment appointment, or other credible evidence that the AOT individual could not be located, the individual will be deemed Missing.
   1.1. A diligent search shall commence, as outlined in the OMH guidance "Assisted Outpatient Treatment Program: Guidance for AOT Program Operation":

2. If the care manager made effort to provide four (4) in person contacts and was unable to due to Missing status, HH+ rate can continue to be billed if the diligent search procedures referenced above are followed and clearly documented in the individual's care management record.
   2.1. The individual's record shall also clearly indicate when the determination was made that the individual was missing. The diligent search shall continue until either the person is located, or the court order is no longer active.
   2.2. If all activities for performing a diligent search cannot reasonably be completed within the same month the individual is deemed Missing, the HH+ rate may still be billed for that month so long as the diligent search process commenced within timeframes specified in AOT Program Operation guidance.
   2.3. A missing AOT individual is considered a significant event that must be reported to the LGU within 24 hours, following the LGU's protocol for reporting significant events. Continued communication with the LGU should be made to determine what additional follow-up efforts may be required and should also be documented clearly in the individual's record.

7. Caseload Requirements for HH+ for AOT

1. Effective 3/8/21, the maximum allowable caseload ratio for HH+ for AOT members shall be 1 staff to 20 HH+ recipients.

2. CMAs must use a Single Care Manager Approach; Team Approaches are not allowed.

3. The Single Care Manager Approach can be implemented with a 100% HH+ Caseload or a Mixed Caseload.

Mixed Caseload (HH+ for AOT and non-HH+ for AOT members):

1. For the purposes of case load stratification and resource management, a caseload mix of HH+ and non HH+ is allowable if and only if the HH+ ratio is less than 20 recipients to one Health Home Care Manager.

2. Caseload sizes should always allow for adequate time providing care management as outlined in this guidance, while allowing for thoughtful consideration of the care coordination needs of non HH+ recipients.

3. Use of a point system to balance mixed caseloads is required, see the HH+ for SMI Caseload Requirements Policy for examples of how to set up a point system.

Tools to Support Caseload Tracking:

CCMP has developed a tracking tool that MH CMAs can use or customize to help with balancing and maintaining a record of HH+ for SMI caseloads.

CCMP HH+ Caseload Tracker

F. Adult Home Plus Model

First issued: 6/14/24
Reviewed by Quality Committee: 6/11/24

Adult Home Plus is not a type of "Health Home Plus" program, but it shares many similarities. It is a high intensity care management model designed for specific members of a class action lawsuit against the New York State Office of Mental Health.

Class members are people with Serious Mental Illness living in Adult Homes in New York City. They are entitled to assistance moving out of the Adult Home, into a Community Based setting, if they would like it.

When a class member expresses interest in moving out, the case is referred to an Adult Home Plus CMA, through the CCMP Health Home.

Adult Home Plus cases follow all requirements of Standard Health Home, in addition to the Adult Home Plus requirements and the AH+ Reference Guide.

When members transition out of Adult Home Plus, they are often eligible for Health Home Plus – SMI, at which point they follow all requirements of the HH+ SMI program.

v.SERVICE PROVISION

A. Referrals Policy Set

Referrals come into the CCMP Health Home and CMAs in three different ways; each referral stream has slightly different procedures, outlined in this section:

Lead Health Home Referrals- Individual or small batch potential members referred to CCMP by MCOs, community partners, hospitals, or other Health Homes. These referrals are "warm" or "hot", i.e. the potential member knows they are being referred to CCMP and has already expressed interest in the services. They come into CCMP and are referred to CMAs throughout the month, in real time.

Bottom-Up Referrals- Individual potential members found in the community by the CMA, where the CMA has chosen to enroll the potential member into CCMP. These referrals are "warm" or "hot", i.e. the CMA already found the potential member, completed an intake meeting, and consented the potential member.

Bulk Referrals- Small or large batch members already enrolled in a CCMP CMA, which CCMP transfers to other network CMAs. This may occur when a CMA has a significant capacity limitation or closes their Care Management program. These referrals may be "hot" i.e. member is aware that the program is changing/closing and willing to transfer, or they may be "cold", i.e. the member may not realize the program is changing/closing due to not being fully engaged in CMA services but is technically enrolled and is afforded the opportunity to transfer to a new CMA.

Sources:
DOH Policy #HH0009 Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
DOH Policy Eligibility Requirements: Identifying Potential Members for Health Home Services
DOH Guidance: Elimination of Health Home Billing for Outreach

1. Lead Health Home Referrals Policy

First Issued: 5/14/19
Reviewed by Quality Committee: 3/9/21
Revised Effective: 3/8/21

CCMP receives referrals for Health Home services from a multitude of places and is responsible for accepting referrals and assigning them to CMAs in a timely manner; these types of referrals are called "Lead Health Home Referrals".

Lead Health Home Referrals can come from the following sources:

- Hospital staff (usually social workers or discharge planners)
- MCOs
- Other community providers (food pantries, shelters, outpatient clinics, etc.)
- Self-Referrals
- CMAs who have limited language resources or otherwise cannot serve the member
- Health Homes who have limited language resources or otherwise cannot serve the member

CCMP may receive referrals via fax, email, or MAPP assignments, using the CCMP Adult Health Home Referral form or bulk spreadsheets.

Policy:
CCMP will screen for pre-eligibility criteria and assign to an appropriate CMA for outreach within two business days of receipt of completed referral. CCMP will log all Lead Health Home referrals to track referral sources, timeliness, and outcomes. CCMP will communicate referral outcomes promptly to the referral source.

Procedure:

1. CCMP keeps a record of all referrals received.

2. CCMP checks referrals in MAPP to determine Medicaid status (pre-eligibility) and Health Home/CMA segment status and checks referrals in PSYCKES to determine eligibility for Health Home Plus.

3. If the potential member has an open enrolled segment with another Health Home, or another CMA, CCMP lets the referral source know of the pre-existing segment and gives them the contact information to help the member re-connect to their existing Care Manager.

4. If the potential member has an open outreach segment with a CCMP CMA, CCMP checks to see if the referral is still active, this is evidenced by recent encounter notes (within 10 days), or a

pending intake appointment. If so, CCMP lets the referral source know of the pre-existing segment and gives them the contact information for the CMA that is already trying to enroll the potential member. If not, CCMP closes the outreach segment with End Reason Code 03-Transfer to a new CMA and sends the referral to a new CMA.

5. If the potential member has an open outreach segment with another Health Home CCMP contacts the Health Home and asks them to transfer the case to CCMP.
   5.1. If the Health Home declines to transfer the case, CCMP lets the referral source know of the pre-existing segment and gives them the contact information for the other Health Home that is already trying to enroll the potential member.
   5.2. If the Health Home agrees to transfer the case to CCMP, CCMP will not send the referral to one of our CMAs until the other Health Home has ended their outreach segment.

6. If the potential member does not have Medicaid, or has a Health Home exclusion code (EMEDNY R/E codes and Health Home Eligibility) and (FIDA/PACE and Health Homes Eligibility), CCMP contacts the referral source and lets them know that the potential member is not currently eligible for Health Homes.

7. If the potential member had a prior Enrolled segment, CCMP checks the discharge reason code against the Disenrollment End Reason Codes Definitions Chart and follows instructions in the "Re-Assign to a CMA post Discharge?" column.

8. CMAs complete the monthly Lead Health Home Referral capacity survey. If survey is not completed by indicated deadline, no referrals will be sent that month.

9. CCMP consults monthly Lead Health Home Referral capacity survey results to determine the appropriate CMA for assignment.

   Considerations are:

   - CMA self-identified ability to accept Lead Health Home referrals, and any volume caps
   - CMA ability to serve High Risk members (HARP, HH+)
   - CMA Performance Improvement Plan status, including HCBS/CORE Benchmarks
   - CMA catchment area
   - CMA population served (*ex. age, language, HH+*)
   - Potential member provider affiliation (*ex. someone already using Brightpoint clinics may be most appropriate for the Brightpoint CMA)*
   - Effective 3/8/21, CCMP only refers HH+ for SMI Eligible members to OMH Designated (or Provisionally Designated) Mental Health CMAs. See the HH+ for SMI Policy for more details.

10. CCMP sends a secure email to the CMA notifying them of the referral and asking them to confirm that they will accept the case. Email will include the CCMP referral form and any other information about the referral provided by the referral source.
    10.1. If the CMA rejects the referral or does not respond to the referral within two business days, the referral is reassigned to another CMA.
    10.2. Once a referral is accepted, CCMP will assign the existing record to the CMA in FCM or if it is a new potential member with no existing record, the CMA will add the case as a new patient in FCM.
    10.3. The CMA must open an Outreach Segment[14] in FCM, and attempt contact with the potential member within two business days from date of acceptance of the referral.

11. Once a CMA accepts the referral, CCMP contacts the referral source as follows:
    - Notifies them that the potential member has been assigned to a CMA for intake
    - Provides them with contact information for the CMA
    - Encourages the referral source to have the potential member sign a HIPAA compliant authorization form between the referral source and the CMA so that they can communicate prior to DOH-5055 consenting.
    - Advises the referral source to be prepared to provide proof of diagnoses (if available) to the CMA.

12. CMAs must close the Outreach segment when a member enrolls, decides not to enroll, is determined to not be eligible for enrollment, or is not responsive to CMA efforts to schedule an intake appointment using an appropriate End Reason Code (See Referral Closure Policy for more details).
    12.1. Outreach segments will automatically close after 60 days (two segment months). If the CMA is still actively pursuing enrollment, they may immediately open a new Outreach segment.

All contacts regarding receipt of referral, attempts to contact the potential member, intake of the member, and/or decisions to cease engagement with the potential member must be documented in FCM within one business day.

12.2. CMAs determine their own intake process, including how they attempt to contact the potential member (phone calls, letters, home visits, etc.), and for how long they will continue trying to engage a potential member to schedule an intake meeting.

12.3. CCMP may request copies of the CMAs intake procedures and timeframes to assist with decision making around referrals.

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[14] Effective 7/1/20, there is no Administrative Fee from CCMP for using an Outreach segment.

13. If a potential member is interested in and eligible for enrollment, they must be enrolled into the CCMP Health Home.
    13.1. If a CMA completes an intake/enrollment meeting (including a signed DOH-5055 with CCMP) with a potential member, and decides not to enroll them into CCMP, they must issue a Notice of Determination for Denial of Enrollment (DOH-5236) per the Notice of Determination and Fair Hearing Policy.

14. If a CMA enrolls a member from an excluded setting, they must follow the Excluded Settings Policy.
    15.1 It is recommended that CMAs enroll from excluded settings only when there is a plan for discharge/release to the community.
    15.2 CMAs will need to work closely with the discharge/release planning staff and Medicaid to ensure that any institutional Medicaid Restriction Codes are removed.

15. CCMP monitors data in FCM regularly to track CMA responsiveness to the referral, whether referrals enrolled into the Health Home, and whether CMAs are appropriately ending Outreach Segments.

16. On a quarterly basis CCMP will report on CMA performance (e.g., responsiveness to referral, conversion rate for Lead Health Home Referrals, ending Outreach Segments, etc.). This data may be incorporated into CCMP decisions about special projects and partnerships with CMAs, and ongoing eligibility for CMAs to receive Lead Health Home Referrals.

2. Bottom-Up Referrals Policy

First issued: 8/4/15

Reviewed by Quality Committee: 6/11/24

Revised Effective: 6/14/24

Policy:

CMAs may enroll potential members into the CCMP Health Home that were self-referred to them, referred to them by their parent agency, or were referred to the CMA directly by outside referral sources. These are called "Bottom-Up Referrals".

Procedures:

1. All bottom-up referrals "found" by the CMA, must be determined to be eligible and appropriate for Health Home services prior to enrollment.

2. Prior to opening either an Outreach or an Enrolled segment for a Bottom-Up Referral in FCM, the CMA must check MAPP and FCM to confirm that the potential member is eligible for enrollment.

3. CMAs must also screen for HH+ for SMI/HIV eligibility. CMAs should use the CCMP JOINT HH+ Screening and Documentation of Eligibility Form - HIV/SMI.
   3.1 Only MH CMAs may enroll HH+ SMI Eligible members – Non-MH CMAs may refer such members to CCMP for reassignment to a MH CMA.
   3.2 Non-HH+ HIV CMAs may enroll a HH+ HIV Eligible member, as long as they have educated them on their eligibility to join the HH+ HIV program with a different CMA, and the member has chosen to stay with the non-HH+ HIV CMA and receive the Standard Health Home level of care.

4. If a CMA learns that a potential member has an open Outreach or Enrolled Segment with another CMA or Health Home, they will need to communicate with the other CMA and/or Health Home directly. These communications are sometimes referred to as "negotiations".
   4.1 CMAs will need to come to a shared understanding, driven by the preferences and needs of the potential member as to:
   - Which CMA will enroll the member, or continue to serve the member?
   - Which CMA will disenroll the member, or cease the enrollment process for the member?
   - What will the start/end dates of the segments be?
   - When needed, CCMP can be a resource in connecting CMAs with other CMAs or Health Homes to facilitate negotiations.

5. If a CMA informs another CMA that one of their members wishes to enroll with the new CMA, the original CMA may need to consult with the member directly prior to processing the disenrollment.

6. CMAs may open Outreach segments[15] for their bottom-up referrals and document pre-enrollment work in FCM, or not open an Outreach segment and document their pre-enrollment work only in their internal records.

7. CMAs tend not to use Outreach Segments for Bottom-Up Referrals when they are contracted with more than one Health Home, and do not know which Health Home the member would be enrolled in at the outset of the intake process. Another common reason is when a potential member "walks-in" and requests services; it may be most efficient to intake and enroll the member that same day, making an Outreach segment irrelevant.

8. CMAs using an Outreach segment must close the Outreach segment when a member enrolls, decides not to enroll, is determined to not be eligible for enrollment, or is not responsive to CMA efforts to schedule an intake appointment using an appropriate End Reason Code (See Referral Closure Policy for more details).
   8.1 Outreach segments will automatically close after 60 days (two segment months). If the CMA is still actively pursuing enrollment, they may immediately open a new Outreach segment.

9. All contacts regarding receipt of referral, attempts to contact the potential member, intake of the member, and/or decisions to cease engagement with the potential member must be documented in FCM within one business day.

10. CMAs who did not open an Outreach segment for a Bottom-Up Referral are required to back enter all notes into FCM documenting the member's referral, intake, and enrollment, once the Enrolled segment is opened.

11. CMAs determine their own intake process, including how they attempt to contact the potential member (phone calls, letters, home visits, etc.), and for how long they will continue trying to engage a potential member to schedule an intake meeting.

12. If a CMA completes an intake/enrollment meeting (including a signed DOH-5055 with CCMP) with a potential member through a Bottom-Up process, and decides not to enroll them into the Health Home, they must issue a Notice of Determination for Denial of Enrollment (DOH-5236) per the Notice of Determination and Fair Hearing Policy.

[15] Effective 7/1/20, there is no Administrative Fee from CCMP for using an Outreach segment.

12.1 CMAs who did not open an Outreach segment are required to maintain notes on the issuance of the DOH-5236 within their internal records and may be required to produce internal case records if the potential member applies for a Fair Hearing.

13. If a CMA enrolls a member from an excluded setting, they must follow the Excluded Settings Policy.
    13.1 It is recommended that CMAs enroll from excluded settings only when there is a plan for discharge/release to the community.
    13.2 CMAs will need to work closely with the discharge/release planning staff and Medicaid to ensure that any institutional Medicaid Restriction Codes are removed.

14. CCMP monitors data in FCM regularly to track Bottom-Up Enrollments and whether CMAs are appropriately ending Outreach Segments.
    14.1 On a quarterly basis CCMP will report on CMA performance (number of Bottom-Up Enrollments, ending Outreach Segments, etc.). This data may be incorporated into CCMP decisions about special projects and partnerships with CMAs.

3. Bulk Referrals Policy

First Issued: 10/31/19

Reviewed by Quality Committee: 11/12/19

Purpose:

To describe the process for bulk transfers of members – defined as the need in a short period of time (less than 120 days) for a substantial or full roster of members to be reassigned from a CMA to (an)other CMA(s). To outline the responsibilities of the Health Home, the original CMA, and the new CMA(s). This Policy is to be used in conjunction with the Case Transfers of Enrolled Members Policy.

Policy:

While owner CMAs have preferential opportunity to enroll members above non-owner CMAs, (1) member choice and then (2) CMA quality are the most important criteria the guide the reassignment of members. CCMP develops and implements transfer strategies and procedures which protect and ensure member choice.

Procedure:

1. CCMP staff assesses owner CMAs to see if they meet the quality, performance, and oversight ability required to be eligible for a given allocation of members.
   1.1. Assessment criteria is determined for each Bulk Transfer scenario based on the original CMA's population and service needs, and unique areas of quality concern.

2. Owner CMAs that meet these criteria are asked for and provide to CCMP their anticipated capacity to absorb transfers.
   2.1. CCMP verifies capacity requests and may refine capacity numbers accordingly.
   2.2. CCMP determines if any owner CMAs have pre-existing relationships with the original CMA that may promote improved continuity of care for members and adjusts capacity accordingly.

3. Bulk transfer members are allocated proportionally, according to ownership stake.
   3.1. For example, if four owners met criteria to accept a bulk transfer, each would be assigned up to ¼ of the original CMA's members, up to their stated capacity.
   3.2. If additional members exist for allocation, then the remaining members are distributed among the previously identified owners who still have capacity.
   3.3. If additional members exist for allocation after all owners have met their maximum capacity, then the remaining members are allocated among non-owner CMAs up to their stated (and verified) capacity, following the same procedures outlined above.

4. CCMP ensures that all routine policies related to the transition, including but not limited to the Continuity of Care Policy, Disenrollment Policy, and Notice of Determination and Fair Hearing Policy are followed.

4.1. CCMP ensures that all communications to members about such transfers provide explicit language offering the member choices including transfer to another CMA of their preference, transfer to another Health Home, disenrollment from the Health Home program.

5. Depending on the unique situation of the Bulk Transfer, and member ability to meet with the new CMA for intake/enrollment prior to disenrollment from the original CMA, the new CMA may open an Outreach Segment, or may open an Enrolled Segment.
   5.1. The new CMA is responsible for following all routine policies that may apply, including but not limited to the Intake and Enrollment Policy, Eligibility Requirements Policy, and the Notice of Determination and Fair Hearing Policy.

4. Case Transfer Request Policy

First Issued: 7/1/20

Reviewed by Quality Committee:

Revised Effective 6/1/22

Applicability:

This policy applies to situations where a Health Home or CMA who does not have an active segment with a member asks CCMP transfer a member's case to them. It does not apply to members who contact CCMP asking to have their cases transferred, or CCMP CMAs who are trying to transfer a member enrolled with them to a different CMA (see Case Transfer of Enrolled Members Policy).

Policy:

CCMP will honor all requests for case transfers in an expeditious manner but will not transfer cases out if they are being actively engaged by a CCMP CMA. CCMP will honor member choice above all else and will provide CMA contact information as appropriate so that cases can be transitioned seamlessly.

Procedure:

1. If CCMP is asked by another Health Home or CMA to transfer a case to them CCMP will check if there is an active Outreach or Enrolled Segment with a CCMP CMA.

2. If there is no active Segment with a CCMP CMA, CCMP will transfer the case within two business days.

3. If there is an active segment (Outreach or Enrolled) with a CCMP CMA, CCMP will ask the requesting Health Home or CMA if they have already consented the case.
   3.1. If they have already consented the case, CCMP will request a copy of the enrollment paperwork, and inform the CCMP CMA that the case has been consented with another Health Home/CMA. The requesting Health Home/CMA and the current CCMP CMA will need to come to a shared understanding, driven by the preferences and needs of the member as to:
   - Which CMA will enroll the member, or continue to serve the member?
   - Which CMA will disenroll the member, or cease the enrollment process for the member?
   - What will the start/end dates of the segments be?
   - The CCMP CMA may need to consult with the member directly prior to closing the segment.

   3.2. If they have not already consented the case, CCMP will:

ACTIVE OUTREACH SEGMENT:

4. Check to see if the referral is still active, this is evidenced by recent encounter notes (within 10 days), or a pending intake appointment.
   4.1. If the referral is not active, CCMP will end the outreach segment with End Reason Code 03- Transfer to a new CMA or 01-Transfer to a new Health Home as applicable and transfer the case to the requesting Health Home or CMA within two business days.

4.2. If the referral is active, CCMP will inform the requesting Health Home or CMA that the case is not available for transfer within two business days, because a CCMP CMA is trying to enroll the referral already.

ACTIVE ENROLLED SEGMENT:

5. CCMP lets the requesting Health Home/CMA know that the member is already enrolled and gives them the contact information for the CMA to help the member re-connect with their existing Care Manager within two business days.

B. Intake and Enrollment Policy

First issued: 12/7/12

Reviewed by Quality Committee:

Revised Effective: 56/14/24

Purpose:

To outline the requirements of the enrollment process, inclusive of the Intake/Enrollment meeting.

Policy:

When meeting a potential member referred to a CMA through any means, the CMA conducts an enrollment process. This process includes an Intake/Enrollment meeting. This meeting can be facilitated by a Care Manager, Supervisor, or dedicated Intake Staff. It can take place wherever the potential member is most comfortable, but ideally in the potential member's home.

Procedures:

At the intake/enrollment meeting the enrolling worker:

1. Assesses the potential member to determine if they meet eligibility requirements for the program.

2. Explains the purpose and function of the Health Home Care Manager, to see if the potential member wants to enroll into the program.

3. Explains and completes the DOH-5055 (Information Sharing Consent Form) with the potential member.

4. Provides the potential member with a Notice of Privacy Practices (DOH-5055 or agency NPP), reviews the Member Rights, and explains the process to file a grievance or complaint. Determines if the potential member has any immediate needs that need to be addressed in the moment and provides any needed crisis numbers or emergency referrals as indicated.

5. Identifies initial Care Management Needs and/or Goals; doing this ensures that the prospective member understands what types of things the Care Manager will be able to help with, and they will form the basis for the Health Home Plan of Care.
   5.1. This includes a discussion about eventual graduation from the program once the Care Management Needs have been met, Step-Down from the program if the member's only Care Management Needs can be addressed by a lower intensity of service, Withdrawal of Consent if the member does not want to continue in the program for any reason, and the other reasons disenrollment could occur, such as ineligibility for Medicaid, institutionalization, moving out of state, safety concerns, etc.

6. Educates the potential member about the next steps. The enrolling worker should be able to explain the procedures specific to their CMA, such as:

- When/how will the determination on enrollment be made?
- When/how will this determination be communicated to the potential member (inclusive of issuance of Enrollment Letter and DOH-5234 vs. DOH-5236)?
- If enrolled, when will the member be assigned to a Care Manager?
- Who can the potential member contact with questions while waiting for an enrollment decision or Care Manager Assignment?

7. If at any point the potential member does not want to enroll into the program, and does not want to continue being outreached, the Care Manager ends the Outreach Segment and informs the referral source.

8. Once the decision to enroll is made, the CMA opens an Enrolled Segment in FCM.
   8.1. Enrolled Segments start on the 1st of the month; they must be opened for the 1st of the month of the month in which the Health Home Consent form was signed.
   8.2. Per DOH email communications, the date of the consent is the date of enrollment.
   8.3. Due to MAPP enforcing policy and billing requirements based on the start of the enrolled segment (1st of the month) as opposed to the date of consent, CCMP considers the start of the enrolled segment (1st of the month) to be the date of enrollment and counts due dates for policy requirements from that date.
   8.4. Some due dates built in MAPP in 2024, use the date of consent or the segment start date as the date of enrollment (whichever is most recent), and generate a specific due date based on that calculation. If a due date is generated by MAPP, and surfaces within FCM, that is the source of truth.

C. Eligibility Requirements Policy

First Issued: 8/4/15
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

To be eligible for Health Home Care Management within the Standard Adult Care Management model, potential members must meet requirements in four areas:

- Medicaid
- Diagnosis
- Initial Appropriateness
- Consent

This policy has a sub-section dedicated to each of the four eligibility requirements.

Initial Eligibility
All four eligibility areas are documented at enrollment within the intake/enrollment note[16]. Supporting documents are uploaded to FCM.

Continued Eligibility
Medicaid status is visible to Care Managers in FCM, and Care Managers are expected to ensure the Medicaid case is active prior to providing services each month. Ongoing eligibility and appropriateness for the program is documented 12 months after enrollment, and every 6 months thereafter using the DOH Continued Eligibility Tool.

Training and Compliance
CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits, per the Quality Management Program Policy.

Sources:
DOH Policy #HH0009 Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents
Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016
Health Home Program Chronic Condition Update with Developmental Disabilities Conditions
Interim Guidance Addressing Outreach Modifications

[16] CMAs may choose to use an intake/enrollment form to document all eligibility requirements instead of including them in the intake/enrollment note. There must still be a note describing the intake/enrollment meeting with the member, and that note should not contradict information on the intake/enrollment form.

1. Medicaid:

1. Members must have active Medicaid, either Fee for Service (FFS) or through a Managed Care Organization.
   1.1. MLTC (Managed Long-Term Care) is a type of Managed Care Organization that is designed for members who need long term supports in the community. It includes case management, and therefore the CMA needs to determine if the member truly needs the HHCM in addition to there MLTC Care Manager.
   1.2. There are two kinds of MLTC, Partial Capitation and MAP (Medicaid Advantage Plus). They cover different services, and have different ways of coordinating with the HHCM, particularly as relates to the Plan of Care.
   1.3. The type of MLTC that the member is in must be clearly documented, with evidence that the HHCM is coordinating care with the MLTC care manager in the appropriate way.

2. There are certain Medicaid restriction codes that are incompatible with Health Home Care Management.
   Health Homes Restriction Exemption Codes
   Medicaid Coverage Codes[17]
   PACE/FIDA Programs

3. Medicaid status must be checked prior to enrollment and documented in the enrollment note/form. If Medicaid status lapses during the Enrolled Segment, Care Managers are required to work with the member and/or their MCO to determine what needs to happen to re-activate it and support the member in doing so.
   3.1. If the CMA determines that there is no way to re-activate the Medicaid case, or if the member is unwilling to re-activate their case, the Care Manager should disenroll the case, with appropriate referrals.
   3.2. CMAs may establish limits for how long they will work with a member to re-establish a Medicaid case.

[17] 17 Per HH/MCO Workgroup slide deck dated 5.17.24, coverage code 37 is compatible with Health Home services, but the Coverage Codes document has not been updated.

2. Eligible Diagnoses:

1. Members must have either:

   Two chronic conditions (see list of Qualifying Chronic Conditions – Appendix A)

   OR

   HIV/AIDS

   OR

   One Serious Mental Illness (see Definition of SMI for Health Homes)

   OR

   Sickle Cell Disease (effective 4/4/22)

2. The member's Qualifying Diagnoses must be documented in the enrollment note/form and specify whether they are eligible due to Two Chronic Conditions, or a Single Qualifying Condition.
   2.1. Qualifying Diagnoses are also documented on the monthly BSQ and FCM Diagnosis Widget. Unless the member's diagnoses changes over time, there should be consistency between what is in the enrollment note/form, the Diagnosis Widget, and the monthly BSQ.

3. In limited circumstances, an MCO or a Medical Provider may want to make a referral without disclosing qualifying diagnoses. If they provide a written "Waiver of Diagnostic Requirements", the CMA could document that they were given such a waiver in the enrollment note, and then gather diagnostic information after enrollment, once consent to share PHI was in place.
   3.1. In this case, qualifying diagnoses would be visible on the monthly BSQ and the FCM Diagnosis Widget.

4. Verification of Qualifying Diagnoses must be uploaded to the FCM Documents tab within three months of enrollment and must match the Qualifying Diagnoses identified in the enrollment note/form.
   4.1. There are certain cases where the HHCM's understanding of the member's diagnosis changes over time.
   For example: at intake member said they had "Anxiety", but after talking with their psychiatrist, the HHCM learns they have Schizophrenia. In this case VOD from the psychiatrist might not match the enrollment note but would match the note from the conversation with the psychiatrist.

5. Sources of verification can be, but are not limited to:

Pharmacy Data	PSYCKES Reports	Discharge summaries	Psychiatric Evaluations
Other Medical Assessments	Clinical Notes/Documentation	Demographic Data	Other

6. If verification cannot be found within three months of enrollment, billing must cease, and the Care Manager should make a referral to a more appropriate level of care.

3. Initial Appropriateness:

1. Members must have at least one significant behavioral, medical, or social risk factor making them appropriate for Health Home Care Management services. The Significant Risk Factor(s) is also referred to as Initial Appropriateness.

2. Significant Risk Factors – Appendix B for Adults are:

Significant Risk Factor
ADVERSE EVENTS RISK: Current H-code in EMEDNY (HARP Eligible/Enrolled)
ADVERSE EVENTS RISK: Current POP flag in PSYCKES
ADVERSE EVENTS RISK: Current Quality or HH+ flag in PSYCKES or equivalent from RHIO or MCO
ADVERSE EVENTS RISK: Direct Referral from Adult Protective Services
ADVERSE EVENTS RISK: Direct referral from an MCO, LGUs (Local Governmental Unit), or SPOAs (Single Point of Access)
HEALTHCARE RISK: Member (or guardian) is unable to appropriately navigate the healthcare system for the member's chronic conditions.
HEALTHCARE RISK: Member does not have a healthcare provider or specialist to treat a chronic health condition
HEALTHCARE RISK: Member has not seen their provider (e.g., PCP, BH, etc.) in the last year
RE-ADMISSION/RECIDIVISM RISK: Released from inpatient Medical, Psych, or Detox within the last six months. Must specify name of institution and date of release.
RE-ADMISSION/RECIDIVISM RISK: Released from Jail/Prison or other justice program within the last six months. Must specify name program and date of release.
SOCIAL DETERMINANTS RISK: Current Intimate Partner Violence or Family Violence in the home of the member
SOCIAL DETERMINANTS RISK: Currently cannot access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc.
SOCIAL DETERMINANTS RISK: Currently homeless (HUD 1, 2, or 4) or for youth 14-21, has no stable living arrangement (living with different friend/family)
SOCIAL DETERMINANTS RISK: Member does not have needed benefits (SSI, SNAP, etc.)
SOCIAL DETERMINANTS RISK: Member has had a recent change in guardianship/caregiver within the last 6 months
SOCIAL DETERMINANTS RISK: Recent institutionalization or nursing home placement of member's primary support person
SOCIAL DETERMINANTS RISK: Member has fewer than 2 people identified as a support by the member
TREATMENT NON-ADHERANCE RISK: Member/care team member report of non-adherence…Must specify WHICH medication(s) and/or treatment(s) are involved.
TREATMENT NON-ADHERANCE RISK: PSYCKES flag related to non-adherence or equivalent from RHIO or MCO

4. The member’s Significant Risk Factor(s) must be documented in the enrollment note/form, one of them must be uploaded to MAPP within 30 days of member consent.

4.1. In FCM the Significant Risk Factor is documented on the segment screen. The enrollment note/form may contain multiple risk factors, but only one is documented on the segment screen. Whatever is on the segment screen must be supported by the enrollment note.

5. If the CMA cannot identify at least one Significant Risk Factor during intake/enrollment, the enrollment cannot be processed, and the Care Manager should make a referral to a more appropriate level of care.

4. Consent:

1. Health Homes is a voluntary program; therefore, members must consent[18] to enroll into the program.

2. Care Coordination and Care Management can only occur if the Care Manager can share Protected Health Information (PHI) with the other Care Team Members. Members must consent to share PHI with, at minimum:
   - The primary treatment provider treating their Qualifying Condition(s)
   - Their MCO (unless member has FFS Medicaid)
   - The CMA

3. If the member enrolls without a treatment provider for their Qualifying Condition(s), this consent would not be applicable at enrollment. Once the Care Manager successfully links the member to such a provider, the member would need to consent the provider to remain eligible for the program.

4. The Health Home Consent Form must be uploaded to the FCM Documents tab, and the enrollment note/form should list all consented Care Team Members.
   4.1. Everyone listed on the Health Home Consent is a Care Team member and must be listed on the FCM Care Team Widget.

5. If the potential member wants the CMA to be able to share PHI with an entity in a limited way, i.e., they do not want them on their Care Team, they should not list that entity the Health Home Consent. Instead, they should complete a HIPAA compliant authorization for release of information form.
   5.1. CMAs may use any authorization form if it complies with HIPAA and state privacy regulations. A DOH issued form is available for use here: Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS related Information
   5.2. Entities consented this way are not Care Team members and should not be listed on the FCM Care Team Widget.

6. Consent status is transmitted to MAPP through the FCM database, triggered by uploading the Health Home Consent to the FCM Documents tab under "Health Home Consent".

7. Consent for PHI Sharing (Care Team Members) can be updated throughout the Enrolled Segment. Members can add additional members to their Care Team, or revoke consent for a Care Team member at any time.
   7.1. Sharing PHI with an entity not listed on the Health Home Consent, or a valid 2-way authorization form, may constitute a PHI Breach.

[18] See exceptions for HH+ for AOT in Eligibility Requirements for HH+ for AOT Policy

8. If a member revokes consent for any of the entities required to coordinate care (CMA, MCO, primary provider treating qualifying diagnoses), they may be considered for disenrollment, as they no longer meet eligibility criteria for the program.
   8.1. In this circumstance, CMAs should consult with CCMP as to what can be done to help the member understand the purpose of the program and the benefits of consenting.

9. Any changes to Health Home Consent form must be <u>dated</u> and <u>initialed</u> by **both** the member and the HHCM staff assisting/witnessing the member making the change.
   9.1. Changes to the Health Home Consents are also documented in FCM Encounter notes.
   9.2. Changes to consented Care Team Members must be updated in the FCM Care Team widget.

10. Revoking consent for an entity previously listed on the Health Home Consent is done by ~~striking through~~ the listed entity, and the member/staff initialing and dating the change.

11. The Health Home Consents do not expire, but should be reviewed at least annually with the member, in conjunction with the Comprehensive Assessment, to ensure that the list of Care Team members has been kept up to date.

12. To ensure that informed consent has been obtained, Care Managers should ensure members understand all forms and should – when necessary - read forms aloud with the member. Care Managers should answer any questions the member may have.

13. CMAs may have many other consent forms that they use for various reasons.
   13.1. With any consent form, the instructions for that form must be followed.
   13.2. With any consent form, all required fields on the form must be filled out.
   13.3. It is never acceptable to have a member sign a blank form, or a form where there is no information listed about who will disclose the information, or to whom the information will be disclosed.

<u>Adult Consenting Procedure</u>

1. Consent to enroll and consent to share PHI is documented within the enrollment note/form, and on the DOH-5055 Patient Information Sharing Consent Form.

2. Consent forms, and all forms, must be provided to the member in the language of their choice. There are several different translations of the DOH-5055 consent form available for CMAs to use.

3. Pages 1 and 2 of the DOH-5055 function as a Notice of Privacy Practices for the Health Home.

4. Without completion of a DOH-5055, a potential member cannot enroll into the program.
   4.1. Care Management Core Services cannot be billed without an appropriately completed and signed DOH-5055.

5. When completing the DOH-5055, the enrolling worker reviews all material on Page 1 and Page 2, including that the member may disenroll or withdraw consent at any time, that all PHI can be shared with all Care Team Members on Page 3, and who to contact if a member feels their PHI has been misused or disclosed without their authorization.

6. The potential member checks the check box, signs, and dates Page 1 of the DOH-5055 to indicate their consent to enroll into the program, and authorization for the entities on Page 3 (Care Team Members) to share the potential member's PHI.

    6.1. The member's name and date of birth are also listed on Page 1
    6.2. If the member has a personal representative who has the ability to consent the member – they must sign instead of the member and must print their name and relationship to the member.
    6.3. The member is still encouraged to sign the consent form, but only the personal representative can sign official documents for the member.

7. The potential member and the enrolling worker list all members of the Care Team on Page 3[19][20].

8. In CCMP, CMAs have a choice of four different versions of the Health Home Consent page 3, described below.
    8.1. The different versions are set up so that they can be filled out by the CMA staff electronically – however, for fields that the member and CM must complete, such as signature lines, initials, and dating, these must be done by the actual member, and the actual staff witnessing form completion.
    8.2. The forms may be partly pre-filled, and then printed and brought to the member/staff to initial/sign/date, or the member/staff may initial/sign/date through a signature system like Adobe Sign or DocuSign.

NETWORK PROVIDER LIST PAGE 3

    8.3. CCMP, Member's Name, Member's date of birth, and Member's Medicaid CIN must be indicated at the top of each page.
    8.4. "Page 3" spans several pages, pre-filled with the CMAs in CCMP's network, area MCOs/MLTCs, area hospitals, etc., along with blank rows at the end. Identify the entities the member wants to consent that are already listed and have the member and staff both initial and date next to the entity.
    8.5. Any entities not already listed, such as family, other providers and supports, etc. should be added on the blank rows, and have the member and staff both initial and date next to the entity.

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[19] *The procedures for completing Page 3 were updated effective 9/1/18 with the use of new DOH-5055 forms; all members enrolled prior to that date are requirement to be re-consented with the new forms and procedures by 8/31/19.*

BLANK PAGE 3

8.6. CCMP, Member's Name, Member's date of birth, and Member's Medicaid CIN must be indicated at the top of each page.
8.7. Have the member initial and date at the top of the page.
8.8. Write the names of the entities the member wants to consent on the blank rows.

DROP-DOWNS PAGE 3

8.9. CCMP, Member's Name, Member's date of birth, and Member's Medicaid CIN must be indicated at the top of each page.
8.10. Have the member initial and date at the top of the page.
8.11. Identify the entities the member wants to consent.
8.12. There are specific drop-down fields for CMA, MCO, MLTC, and BHO, as well as specific blank fields for PCP, Mental Health Provider, and HCBS Provider. Select the appropriate drop downs and complete the blank fields. If a field doesn't apply to the member, indicate N/A, or select the appropriate drop down indicating "N/A".
8.13. In the lower half of the page, there are blank rows. Write the names of any other entities the member wants to consent on the blank rows, such as family, other providers and supports, etc.

FCM ELECTRONIC HEALTH HOME CONSENT

8.14. Within the FCM Documents tab, an Electronic Health Home Consent can be completed.
8.15. The Electronic Health Home Consent covers all pages of the DOH-5055, and prepopulates the member's demographic information, as well as the name of their CMA on page 3.
8.16. Identify the additional entities the member wants to consent and type them into the form.
8.17. Have the member and staff initial on a tablet/phone or use a mouse to sign from a desktop/laptop.
8.18. The initials and dates will auto-populate next to all the consented entities on page 3.

D. Continued Eligibility for Services Policy

First Issued: 12/8/20

Reviewed by Quality Committee: 12/8/20

Revised Effective: 5/20/24

Background:

Health Home Care Management is a voluntary program that should be provided to members only for as long as they continue to want the service and continue to need the service. Ongoing provision of Health Home Services by way of passive "monitoring" is not an acceptable practice. There are several obvious ways that a CMA will know someone is appropriate for disenrollment:

- Member asks to close their case
- Member disengages from care and cannot be found despite Diligent Search
- Member is in or is expected to be in an excluded setting for more than six months
- Member dies
- Member is no longer eligible for Medicaid
- Etc.

This policy is meant to address situations where the member may be appropriate for disenrollment, but it is not immediately obvious, i.e. the member no longer wants or needs the service but does not proactively ask to leave the program and may appear (at a surface level) to be participating in and benefiting from the program. CCMP CMA's use the DOH Continued Eligibility for Services (CES) Tool to identify these cases.

Definitions:

DOH Continued Eligibility for Services (CES) Tool- A screening tool to identify members who no longer want or need the Health Home level of service. The DOH CES Tool screens for ongoing desire and need for service, identifies members who no longer want or need the service, and ensures such members are safely disenrolled.

Voluntary Disenrollments: Member knowingly and voluntarily leaves the program.

Involuntary Disenrollments: Member either does not know about or does not agree with the CMA's decision to disenroll the member.

Graduation: A member no longer needs any care management support.

Step-Down: A member needs a lower-level intensity of care management support.

Step-Up: A member needs a higher-level intensity of care management support.

Policy:

CCMP Adult CMA's will screen members using the DOH CES Tool after 12 months of enrollment, and every 6 months thereafter. The CMA will endeavor for disenrollments recommended by the CES Tool to be Voluntary, but there are certain circumstances where they may be Involuntary. The CMA will determine, with the member and their care team, whether disenrollments recommended by the CES Tool will be Graduations, Step-Downs, or Step-Ups.

Procedure:

1. The CMA will complete a DOH CES Tool in FCM for enrolled members 12 months after enrollment.
    1.1. Due dates for DOH CES Tools are auto generated in MAPP and surfaced in FCM.
    1.2. Members in a pended segment or who are eligible for HH+ SMI/HIV (including members in AOT/AH+ programs) are excluded from DOH CES Tool requirements.
    1.3. If a member is re-engaged following a Diligent Search pended segment or returns to the community following an Excluded Setting pended segment, their next DOH CES Tool is due 12 months from the start of the new Enrolled segment.
    1.4. If a member is no longer eligible for HH+, their next DOH CES Tool is due 12 months from the last time they were eligible for HH+ (as indicated by the CMA on the monthly BSQs)..
    1.5. If a member transfers CMAs/HHs, or has a CIN change, their next DOH CES Tool is due 12 months from the start of the new enrolled segment.

2. The CM and Supervisor must ensure that all documentation in the chart is up to date and accurate prior to the completion of the DOH CES Tool – as the screening is entirely based on what is documented in the chart.

3. The DOH CES Tool examines whether the member has Significant Risk Factors, Additional Risk Factors (General Risk, Stability, and Self-Management), and is fully Engaged in the Health Home level of service.

4. The DOH CES Tool identifies a member as falling into one of three possible "buckets":
    - Recommend Continued Services
    - Recommend Disenrollment (with appropriate Transition Planning)
    - More Information Needed

5. If the recommendation is "Continue Services", all usual processes for assessment, care planning, and ongoing service should be followed.
    5.1. The risk factors that lead to the "recommendation to continue services" on the DOH CES Tool should be incorporated into the Plan of Care if they are not there already.
    5.2. The next DOH CES Tool will be due 6 months from the date of the prior tool.

6. If the recommendation is to disenroll, the Care Manager follows the following steps:
    6.1. Review the reason disenrollment is recommended with the member/care team and supervisor and collaboratively determine whether the member will be disenrolled as a Graduation, Step-Down, or Step-Up.
    6.2. Identify whether the member agrees with the disenrollment recommendation (Voluntary) or does not agree (Involuntary).
    6.3. Proceed to disenrollment, following all normal disenrollment processes, including appropriate letters, forms, referrals, and notification to Care Team members.

7. The disenrollment must be completed within 60 days of the recommendation. It is imperative that conversations with the member/care team start immediately after the DOH CES Tool is completed, so that there is enough time for collaborative disenrollment planning.
   7.1. It may make sense to add a Transition Goal to the Plan of Care when complex referrals are needed, or where it would be appropriate to use Motivational Interviewing to help the member feel confident and ready for disenrollment.
   7.2. If a new risk factor emerges during the 60-day period a supervisor may decide to complete a new DOH CES Tool. The new risk factor and supervisory decision must be documented in the chart, and if the new tool recommends "Continue Services", the disenrollment plan may be cancelled or postponed. If the new tool recommends "Disenroll", the original 60-day timeline from the first tool remains.

8. If the recommendation is "More Information Needed", the Care Manager must get whatever information is needed to be able to complete the tool within 60 days to get either a recommendation of "Continue Services" or "Disenroll".
   8.1. This may include conversations with the member/care team members, reviewing PSYCKES, etc.
   8.2. The new information must be documented in the chart so that it can be used in the next DOH CES Tool.

9. The MAPP autogenerated due dates ensure that billing is blocked for cases with a late or overdue CES Tool.
   9.1. This includes cases with a "Disenrollment" recommendation where the case was not disenrolled within 60 days, or a "More Information Needed" recommendation where a new CES Tool was not done within 60 days.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

Sources:

Member Disenrollment From the Health Home Program Policy #HH0007

Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016

Guidance for Use of the Continued Eligibility for Services (CES) Tool

E. Duplication of Services Policy

First Issued: 5/14/19

Reviewed by Quality Committee: 6/14/19

Policy: In general, Health Home Care Management services cannot be provided to someone who is already receiving Care Management, from either a Medicaid or non-Medicaid funded source. In some cases, the member can receive services from both programs if it is clear what interventions are being provided by each care manager, and that they do not overlap.

Procedure:

1. At the time of enrollment, and throughout the enrolled segment, the Care Manager will endeavor to identify all other providers supporting the member, including other Care or Case Managers.

2. The member's MCO should be engaged within the first 60 days of enrollment (during the first Care Team Meeting), and they can share information on any other services in place.

3. If the Health Home Care Manager becomes aware that the member is receiving another Care or Case Management service that may be duplicative to the services in place, the Care Manager should:
   - 3.1. Ask the member to add the other party to the Health Home Consent Form.
   - 3.2. Talk to the other party, to determine the nature of the program they work for, and whether it is duplicative with Health Home Care Management.
   - 3.3. Use CMA supervisors, CCMP staff, member's MCO, and other resources to determine if the services are duplicative.

4. If the determination is that the services are duplicative, inform the member and support them in making an informed choice about which Care Management program they want to use. Assist member with disenrolling from the other service.
   - 4.1. If they choose to disenroll from Health homes, the End Reason code would be "Program Not Compatible with Health Home Services".
   - 4.2. CMA should review whether there are any claims to be reversed.

5. If services are not duplicative, engage in a collaborative Care Planning process with the member and the other party to ensure that both providers are working in tandem, and interventions of each are correctly reflected on each other's Care Plans.

6. Some Care Management Programs incompatible with Health Home are listed here:
   - Assertive Community Treatment
   - PACE and FIDA Programs
   - MLTC Care Management- Can be compatible only if strict processes are followed, outlined here: Guidance for MLTCs and Health Homes

Care Planning and Coordination for MLTC Plans and Health Homes form

There are two kinds of MLTC, Partial Capitation and MAP (Medicaid Advantage Plus). They cover different services, and have different ways of coordinating with the HHCM, particularly as relates to the Plan of Care.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits, per the Quality Management Program Policy.

F. Assignment to Care Managers Policy

First issued: 11/29/16
Reviewed by Quality Committee: 9/17/19
Revised Effective: 6/14/24

Policy:
Once a member has been enrolled by a CMA, the member is assigned to a care manager who is well equipped to manage the member's needs. CMAs assign care managers to enrollees based upon care manager experience and defined member characteristics including, but not limited to, primary language, acuity, diagnostic needs, and patterns of service use.

Procedure:

1. If the CMA uses separate intake staff from the care manager who will handle the case once enrolled, they must facilitate a smooth "warm handoff". This includes but is not limited to:
   - 1.1. Giving the member the contact information for the Care Manager assigned to their case.
   - 1.2. Offering an introductory meeting in which the intake worker and care manager are both present.
   - 1.3. The Care Manager must reach out to the member within three business days of case assignment. If the care manager is unable to make this call, the care manager's supervisor must reach out in their place.
   - 1.4. The intake worker must be available to the care manager to discuss the case within two business days of case assignment.

2. CMAs should assign cases to Care Managers who can provide services in the member's primary language, can travel to the member's home when needed, and can provide services on days/hours when members are available.
   - 2.1. Although all CMAs are required to maintain language translation services, this is not an ideal way to provide Case Management and should be a short-term intervention.
   - 2.2. If a CMA is unable to provide services to a member in the location, language, and schedule that they need, the CMA should discuss the possibility of transfer to another CMA that could better serve the member.

3. CMAs may have their own policies about how they respond to member requests for specific types of Care Managers. Based on member experiences they may prefer to work with Care Managers of specific genders, for example, or Care Managers with Peer Certification, etc.
   - 3.1. Such member requests should be responded to promptly and explored, with consideration for both member experiences and staffing capacity.
   - 3.2. CMAs are under no obligation to honor requests for specific types of Care Managers that are reflective of discrimination/bias related to protected characteristics.

G. HARP Policy

First issued: 9/9/15
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

Background:
A "HARP member" is someone who is enrolled in as MCO Plan called Health and Recovery Plan (HARP) or Special Needs Plan (SNP), and has access to extra services, such as a dedicated HARP/SNP Care Manager, Home and Community Based Services (HCBS), and effective 2/1/22, Community Oriented Recovery & Empowerment Services (CORE).

There are no additional staff qualifications to serve HARP members; however, to complete the HCBS Eligibility Assessment, staff and supervisors must meet criteria described below to be considered Qualified HARP Assessors/Supervisors.

Additionally, to request and receive HCBS services, HARP members must have specific elements on their Plan of Care. There is one Plan of Care for all Health Home Members, and then when a HARP member wants to be referred for HCBS, the CM adds additional HCBS related items to their existing Plan of Care[21].

Applicability:
This policy applies to members who are HARP Eligible or HARP Enrolled. HARP status is indicated in real time by "H codes". See the "CCMP Introduction to HARP" training for details on how to identify HARP members.

Purpose:
To outline how CCMP CMAs educate HARP members to determine their interest in and eligibility for Home and Community Based Services (HCBS) and/or Community Oriented Recovery & Empowerment Services (CORE) and ensure expeditious referral to those services when members are found eligible and interested.

Policy:

1. Health Home care managers that perform HCBS assessments or reassessments must be Qualified HARP Assessors, meeting specific Education, Experience, and Supervision qualifications, in addition to completing required trainings in UAS-NY. These requirements are the same as those required for HH+ SMI.

2. Members who are HARP Eligible, but not HARP Enrolled, must be educated about the HARP Plan and HCBS/CORE services, and assisted with enrolling into a HARP Plan per their choice.

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[21] Prior to January 2024, there was a separate Health Home Plan of Care and a HARP Plan of Care.

2.1. If a member does not want to be in a HARP Plan, the Care Manager should help them contact their MCO or Medicaid Choice to disenroll from the plan.

3. All HARP related Goals and Tasks must be reflected on the Plan of Care regardless of whether the member is HARP Eligible, HARP Enrolled, pursuing HCBS/CORE, receiving HCBS/CORE, or not interested in HCBS/CORE.

4. For all HARP/SNP Enrolled members, the Care Manager must:
   4.1. Educate the member about their HARP Plan and the HCBS and CORE services available to them.
      - CMAs may use or customize the CCMP HARP Brochure to assist with this education.
      - For a new member this will most naturally occur as part of the Comprehensive Assessment but can be done at any time.

   4.2 Ask the member if they are interested in a referral to one or more HCBS and/or CORE services.
   4.3 Document the member's choice in FCM encounter notes, the HCBS-CORE Tab, and the Plan of Care.

5. If the member is not interested in being referred for HCBS or CORE services, the Care Manager should continue to engage the member around the benefits of HCBS/CORE, as appropriate to their needs, and may initiate an HCBS or CORE referral at any time if the member changes their mind.
   5.1. The HCBS-CORE Tab is only updated with the member's interest in a referral when they member changes their mind – it is not updated every time the member is educated.
   5.2. The member's current interest in and eligibility for HCBS and/or CORE services is also documented on the Comprehensive Assessment, and Annual Reassessments.

1. HCBS Referrals

1. When a HARP/SNP member requests a referral to HCBS services the Care Manager must:
   1.1 Complete the HCBS Eligibility Assessment in the Uniform Assessment System-New York (UAS-NY) and upload the “Eligibility Summary Report” to the HCBS-CORE tab in FCM.
      - If the member’s Care Manager is not a Qualified HARP Assessor, the Eligibility Assessment may be conducted by someone else within the CMA who is a Qualified HARP Assessor. The Care Manager should be included in the assessment process so that they understand the assessment results, and member HCBS goals (if applicable), and the use of a separate HARP Assessor cannot delay the referral to HCBS.
      - The Qualified HARP Assessor who conducts the assessment data enters and signs the assessment in UASNY.
      - In certain circumstances a CMA may have someone else do the data entry, as long as they follow the procedures in the UAS-NY Policies on Data Entry of HCBS Eligibility Assessments.

2. The Eligibility Assessment may be completed in person or telephonically (phone or video), but cannot be completed via text/email or solely on the basis of the Assessor’s knowledge of the member.
   2.1. Eligibility Assessments must ONLY be done for members who want to be referred to HCBS services.

3. After the HCBS Eligibility Assessment is done, with an “Eligible” result, complete the HCBS parts of the Plan of Care, and ensure it syncs to MAPP. See the “Referral to HCBS” training for details.
   3.1 Notify the MCO that the POC is ready for review and that you are requesting a LOSD (Level of Service Determination).
   3.2 CMAs must use the MCTAC Matrix to ensure they are contacting the MCO the right way, unless they already have a relationship with the member’s assigned MCO Care Manager.

4. The MCO will review the Plan of Care and determine if the request for HCBS services is approved.
   4.1. The MCO will let the CMA know if there is information missing from or unclear on the Plan of Care.
   4.2. Approval is communicated via a Level of Service Determination (LOSD), which is sent by the MCO to the Care Manager contact information listed on the Plan of Care.

5. Schedule the member for an intake appointment with the member’s chosen HCBS provider(s) and document the referral in the FCM Care Team Widget. The LOSD may include a list of up to three in-network HCBS providers. The Care Manager must offer the member a choice of at least three HCBS providers in their area – they cannot automatically refer members to the same provider.
   5.1. Once a member is accepted by the HCBS provider for services, find out from the HCBS provider what the scope, duration, and frequency of the service will be.
   5.2. Update the Plan of Care to reflect the approved HCBS services with Frequency, Scope, and Duration.
   5.3. Update the HCBS/CORE Tab to reflect the start date of the HCBS services and add an end date when the member is no longer receiving the services.

6. The member may change their mind about the HCBS referral at any point in the process. If the member is no longer interested in an HCBS referral, the Care Manager documents their choice on their Health Home Plan of Care, in Encounter Notes, and on the FCM HCBS-CORE Tab. The date on the HCBS-CORE tab that the member "*Declined HCBS"* must correspond to an Encounter note describing the conversation wherein the member changed their mind about the referral.
   6.1. If a referral was already in progress, or the member was already receiving HCBS services, the Care Manager must notify the HCBS provider(s) and MCO of the change.

7. Once a member is receiving HCBS services, the Care Manager must complete an annual HCBS Eligibility Assessment in UASNY and upload the "Eligibility Summary Report" to the HCBS-Core tab in FCM. If the Annual Eligibility Assessment is not completed within 12 months of the prior Eligibility Assessment the member's HCBS services will stop.
   7.1. Once a member is receiving HCBS services, the Care Manager must complete an annual update to the HCBS parts of their Plan of Care, and ensure it syncs to MAPP so that the MCO can review.
   7.2. MCOs and HCBS Providers may request earlier updates to the HCBS fields on the Plan of Care if member needs or HCBS services change.

2. CORE Referrals

1. When a HARP/SNP member requests a referral to CORE services the Care Manager must:

2. Refer the member to the CORE provider(s) of the member's choice. There is no standardized referral form. The CORE Provider may have their own referral forms and may request that the referral include an LPHA Form authorizing CORE services, or they may have an onsite LPHA to assess members at intake.
   - 2.1. Document the referral in the FCM Care Team Widget.
   - 2.2. Follow up on the referral to find out the result of the intake, and work to remove any barriers to accessing care.
   - 2.3. Update the member's Plan of Care with the CORE services they will be receiving once they have been accepted by the CORE provider.
   - 2.4. Document the start date of CORE services on the FCM Care Team Widget and add an end date when the services stop.
   - 2.5. Monitor services ongoing, as with any other referrals made by the HHCM.

Compliance Incentives:

Compliance Element: HCBS/CORE Educated Rate

CMAs with a HCBS/CORE Educated Rate below 80% cannot enroll HARP/SNP members into their CMA – this includes referrals from CCMP and referrals directly to the CMA.

$$\frac{\text{HARP members educated about HCBS/CORE}}{(\text{Total } HARP \text{ members enrolled } 60 + \text{days})}$$

Compliance Element: HCBS/CORE Referral Rate

CMAs with an HCBS/CORE Referral Rate below 30% cannot enroll HARP/SNP members into their CMA – this includes referrals from CCMP and referrals directly to the CMA.

$$\frac{\text{HARP members referred to HCBS/CORE}}{(\text{Total } HARP \text{ members enrolled } 60 + \text{days who expressed interest in an HCBS Referral } 30 + \text{days})}$$

Compliance Element: HCBS/CORE Enrollment Rate

CMAs with an HCBS/CORE Enrollment Rate below 30% cannot enroll HARP/SNP members into their CMA – this includes referrals from CCMP and referrals directly to the CMA.

$$\frac{\text{HARP members Enrolled in HCBS/CORE}}{\left(\begin{array}{c}\text{Total HARP members enrolled } 60 + \text{days } who\ expressed\ interest\ in\ and \frac{HCBS}{CORE} Referral \\ and\ were\ referred\ to \frac{\text{HCBS}}{\text{CORE}} 30 + days\end{array}\right)}$$

These metrics are run once a month and inform enrollments/referrals for the following month.

At CCMPs discretion, CMAs who are functionally unable to serve HARP/SNP members and connect them to HCBS/CORE may be asked to offer their currently enrolled members transfers to other CMAs that have the capability to serve the population.

Training and Compliance

CCMP provides training on the HARP Policy, Referring to HCBS, and Referring to CORE in the TalentLMS Learning Platform. New CMAs are not allowed to enroll HARP/SNP members until they are no longer in Provisional Status and all staff have completed the three HARP trainings.

Compliance with this policy is monitored with chart audits and metrics, per the Quality Management Program Policy.

Sources:

Federal Adult Behavioral Health HCBS Plan of Care (POC) Documentation Requirements
Adult BH HCBS Plan of Care Template 2018
Updated Staff Qualifications to Serve Health Home Plus (HH+) SMI and Assessor Qualifications for Administering the NYS Eligibility Assessment (NYS EA) for Adult BH HCBS
UAS-NY Policies on Data Entry of HCBS Eligibility Assessments
CORE Benefit and Billing Guidance

H. Comprehensive Assessment Policy

First issued: 12/7/12

Reviewed by Quality Committee: 11/10/20

Revised Effective: 6/14/24

Purpose:

To describe all required components and timeframes around the Health Home Comprehensive Assessment.

Policy:

CCMP CMAs are required to complete a Comprehensive Assessment on all enrolled members, to determine the member's needs. Needs identified through the Comprehensive Assessment process are the foundation of the Plan of Care, which guides the ongoing Care Management services.

Procedure:

1. The Care Manager assigned to the member completes the Comprehensive Assessment within sixty days of enrollment, concurrently with the Plan of Care.
   1.1 This "Initial Assessment" can be completed over any number of days, but at least partially in person with the member[22].
   1.2 The assessment is data entered into FCM, using the "Initial" tag.

2. The Care Manager assigned to the member completes an annual Re-Assessment, due 365 days from the completion date of the prior assessment.
   2.1. The assessment is data entered into FCM, using the "Re-assessment" tag.

3. If the member experiences a significant change in their medical, behavioral, or social needs prior to the annual Re-assessment, a full Re-assessment is not required; however, the Care Manager performs an abbreviated evaluation of the member's status, including re-screening for risk factors.
   3.1. The abbreviated evaluation can be documented in the following ways:
      - Uploading a CMA created "abbreviated evaluation" document, with a supervisory signature.
      - Documenting the abbreviated evaluation process in an encounter note and indicating that the evaluation results were reviewed with a supervisor.

   3.2 Any changes in goals or service needs based on the abbreviated evaluation are updated on the Plan of Care.

4. The "Complete Assessment" section includes a "Mark as Done" button, which the Care Manager clicks when they believe they are done with data entry into the assessment.

[22] The Initial Assessment may be partially completed via telehealth (video) rather than in person, if the member requests it and the request is documented in the record. - *MEMORANDUM RE: TELEHEALTH GUIDANCE for the Health Home Program 5/3/24*

4.1. This button cannot be clicked until all required fields in the assessment are complete.

4.2. Clicking this button generates a record of the Care Manager's name, and date/time that the assessment was marked as done.

5. Supervisors are strongly encouraged to review and sign off on all Initial Assessments, Annual Re-Assessments, and abbreviated evaluations, within 14 days of the assessment being marked as "done".
   5.1 The "Complete Assessment" section includes a "Supervisor Approval" button, which the Supervisor clicks when they have reviewed the assessment and they approve of all the content.
   5.2 This button cannot be clicked until the "Mark as Done" button has been clicked.
   5.3 Clicking this button generates a record of the Supervisor's name, and date/time that the assessment was approved.

6. The assessment is not considered complete until it is locked. Locking the assessment turns it into a read-only document.
   6.1 This button cannot be clicked until the "Mark as Done" button has been clicked.
   6.2 The assessment completion date, for the purposes of chart audit and quality metrics, is the date that the document was locked.
   6.3 Once the assessment has been locked, an Addendum feature will become available. This is an optional feature that can be used to document additional information if necessary.

7. Any changes that need to be made to the assessment, such as those identified by a supervisor during their review, must be made prior to locking the assessment. Changes to the assessment that are made after the Case Manager clicks "Mark as Done" and/or the supervisor clicks "Approve" but before the assessment is locked, will reset the "Mark as Done" and "Supervisor Approval" features.

8. Although the assessment can technically be locked by any user, CCMP recommends that CMAs develop workflows where only supervisory or administrative staff lock the assessments, and only do so after a supervisor has approved the assessment.

9. The locations of DOH required data points within the Comprehensive Assessment are outlined in the Health Home Comprehensive Assessment Crosswalk.

10. The Comprehensive Assessment in FCM captures additional information that is not required in the DOH Comprehensive Assessment Policy but is required in the DOH Person Centered Plan of Care Policy, and which CCMP considers to be more appropriately documented within the Comprehensive Assessment.

Such information includes:

- Disaster Plan
- Plans for outreach and engagement activities that will support engagement and continuity of care
- Treatment Preferences

11. Data for the assessment should be gathered from the member and consented members of their Care Team, including their MCO.
    11.1. A Care Team Meeting with the MCO and other Care Team members during the initial 60 day period is required, so that they can contribute to the Comprehensive Assessment and Plan of Care.
    11.2 Clinical Databases such as Healthix, PSYCKES, etc. can also be used. CMAs can use data from other assessments done by member's care team, such as medical summaries and psychosocial assessments to inform the Comprehensive Assessment, but these cannot be used in place of the Comprehensive Assessment.
    11.3 If data for the assessment is obtained from sources other than the member, it should be shared with the member during the comprehensive assessment discussion. For example: *"According to your last physical examination your doctor is recommending that you get annual mammograms, is that correct?"*

12. All providers and family members identified in the Comprehensive Assessment should be reflected on the Health Home Consent (DOH-5055), unless it is clearly documented that the member refused to provide consent, or only wanted to provide limited consent.
    12.1. If limited consent is provided, then there should be a corresponding HIPAA compliant authorization for release of information form uploaded to the FCM Documents Tab.

13. Care managers must discuss advanced directives with the member at minimum once per year; this is captured in the Comprehensive Assessment, section "Legal". The purpose of this discussion is to educate the member on the process and assist in scheduling a meeting with the member's PCP.
    13.1. Advanced directives are to be completed by the PCP, not the Care Manager.
    13.2. All Needs related to advanced directives are documented on the Plan of Care, with corresponding Goals and Tasks.
    13.3. Care Managers should attempt to get copies of all Advanced Directives and upload them to the FCM Documents Tab.

14. The Comprehensive Assessment document may be shared with the member's Care Team since they are listed on Page 3 of the DOH-5055. If the member wants this document shared with anyone not already on the DOH-5055 (and that they do not want to add to the DOH-5055), this must be documented on a HIPAA compliant authorization for release of information form.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

SOURCES:

Comprehensive Assessment Policy #HH0002

Health Home Plan of Care Policy #HH0008

Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009

I. Plan of Care Policy

First Issued: 12/7/12
Reviewed by Quality Committee: 1/10/23
Revised Effective: 6/14/24

PURPOSE: To outline the required process and elements of the Plan of Care (POC).

Procedures:

1. An individualized, person-centered POC is created concurrently with the Comprehensive Assessment within 60 days of enrollment for all consented Health Home members.
   1.1. The POC must be written in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency. It must reflect the cultural considerations of the member.
   1.2. The member should play a central and active role in the development and execution of their POC.

2. The Health Home Care Manager must hold a Care Team Meeting during the initial 60 days of enrollment to inform the development of the POC, and during the annual review of the POC.

3. The Health Home care manager will be the single point of contact for the member's care coordination and will take full responsibility for the overall management of the member's POC.

<u>Required Elements of the POC</u>

4. The POC must contain goals and tasks that address the member's qualifying diagnoses for Health Home, as the member deems necessary.
   4.1. If the member does not have at least one active Need, Goal, or Task related to their qualifying diagnoses that they are willing to work on with the Care Manager, this may be an indication that they are appropriate for disenrollment.
   4.2. Refusal to identify a Care Plan Need, Goal, or Task related to their qualifying diagnoses is not in and of itself a reason for disenrollment. The CMA must review the case and determine if the member meets criteria for disenrollment, would prefer to be referred to a different type of service, or should continue with the Health Home program.

5. The POC must identify all active **Needs** that the member chooses to work on. These needs are elicited through the comprehensive assessment process and member choice.

Possible types of needs are[23]:

- Primary Care
- Home Care
- Advanced Directives
- Substance Use Disorder

[23] This list is taken from the NYS DOH Health Home Re-Designation Scoring Tool

- Mental Health
- HIV/AIDS
- Specialist (Chronic Conditions)
- Housing (Utilities)
- Transportation
- Food (Security)
- Financial/Entitlements (Benefits)
- Education (Vocation)
- Literacy
- Language Preference
- Cultural Preferences
- Employment
- Health Promotion Service
- Legal
- Durable Medical Equipment
- Independent Living Skills/Instrumental Activities of Daily Living
- Social Service Needs
- Interpersonal Safety
- Medication
- Natural Supports
- Gender Expression and/or Gender Identity

6. For each active need area, identify one or more **Goals** that the member will attempt to meet, that would contribute towards addressing the need.
   6.1. Goals must be: Specific, measurable, time framed, and obtainable.

7. For each active goal, identify one or more **Tasks** that the member, the Care Manager, and/or members of the Care team will take to achieve the goal.
   7.1. Tasks must be: Specific, measurable, time framed, and realistic.
   7.2. Tasks must clearly identify who is responsible for the Action (i.e., the member, the Care Manager, or a specific Care Team member)

8. Needs, Goals, and Tasks are all built from a foundation of the member's identified **strengths**, **barriers**, **strategies to overcome barriers**, and **preferences**.
   8.1. Member strengths and barriers are documented in the Background Tab, which auto-populates onto the POC.
   8.2. Strategies to Overcome Barriers, and Preferences, are documented on the Comprehensive Assessment.

9. There must be description of planned care management interventions and time frames, i.e., will the member be served within the Standard Health Home Care Management service model or a Health Home Plus model (AOT/HIV/SMI)?
   9.1. This may be documented on the Comprehensive Assessment, the Plan of Care, or elsewhere in the case record.

10. There must be clear documentation of Care Team Member (inclusive of family members, community members, natural supports, healthcare providers, social service providers, and/or MCO) participation or non-participation in POC development and updates.
    10.1. Participation/Non-Participation is documented in the encounter note describing the development/revision/signing of the POC and/or the Care Team Meeting note.

10.2. Care Team Members are documented in the Care Team Widget, which auto-populates onto the POC.

11. There must be clear documentation of the outreach and engagement activities that will support engaging individuals in their care and promote continuity of care, i.e., when will the member be considered "Disengaged" from care, and what Diligent Search Activities will be used to re-engage them?
    11.1. These are documented in the Comprehensive Assessment.

12. POCs must be signed by the member, to document agreement with the POC, and by the Care Manager who explained and witnesses the member agreement.
    12.1. This can be done via document upload or using the FCM e-signature functionality. Document upload signatures may be done by hand, or electronically using a system like Adobe-Sign or DocuSign.
    12.2. If a member has a Personal Representative with broad authority over healthcare decisions, they must sign the POC. The member is still encouraged to review and sign the POC, but only the Personal Representative can sign official documents for the member.
    12.3. Applicable paperwork must be uploaded to FCM, and anyone who is not a Personal Representative with broad authority over healthcare decisions cannot sign for the member.

13. CCMP strongly recommends that Care Managers use the "send to supervisor for review" function in FCM, and supervisors can either "approve" or "request changes" to the POC, and then sign off as approving the POC.
    13.1. POCs sent to supervisors for review, approved, or with changes requested, are identified as such in the Caseload Overview page of FCM.

Relationship of the Plan of Care to Health Home Billing

1. Effective 11/1/20, a signed POC is required to bill past the third month of enrollment.
    1.1. FCM transmits the date the CCMP Plan of Care was first signed by the member to MAPP, regardless of which CMA was assigned at the time of signature. See DOH Plan of Care and Billing Instances in MAPP for more details.

2. Effective 11/1/23, the entire POC must be transmitted to MAPP.

3. Effective 5/31/24 if all required fields are not completed within 60 days of enrollment and every 12 months thereafter (including signature), Health Home billing is blocked. See Plan of Care in MAPP HHTS for more details.
    3.1. The POC billing requirements and due dates do not apply during pended segments, or to enrolled segments that were enrolled transfers in MAPP.

3.2. If a member is re-engaged following a diligent search pended segment or returns to the community following an excluded setting pended segment, or has a CIN change, the POC must be updated and signed within 60 days of the new enrolled segment.

3.3. In the case of a CIN change, CMAs may ask FCM to copy the POC from the prior segment, including the signature date.

Distribution of the POC

1. The member must be offered a copy of their POC. Any refusal to accept a copy of the POC must be documented.

2. Upon request, and contingent upon the member's consent, the POC will be made available to the member's:
   - family member(s) or other supports
   - care team members
   - service providers

Contingent upon the member's consent, the POC will be distributed to:
   - BH HCBS providers (adults)

3. Medicaid MCOs, inclusive of HARPs, SNPs, and MLTCs have automatic access to the synced POC within MAPP, and may use it for case reviews, service authorization requests (HCBS), etc.
   3.1. Medicaid MCOs may gain direct read-only access to FCM through CCMP.

Frequency of Plan of Care Updates

1. At a minimum, the POC must be updated and signed annually, however, updating concurrently with the monthly Billing Support Questionnaire is best practice. Monthly "best practice" updates do not require member signature.

2. If the member experiences a significant change in medical and/or behavioral health or social needs, the care manager must conduct an abbreviated evaluation the member's current status including rescreening for risk factors as discussed in the Comprehensive Assessment Policy; and updates indicated by the abbreviated evaluation are reflected on the POC.

Use of the POC

1. The POC should be used as an active tool to guide day to day care management work, as well as to support the required collaboration with others listed in the POC (Care Team Members) to monitor member progress towards their treatment, wellness, and recovery goals.
   1.1. At minimum, every month the care manager must attempt one task on the POC and document the attempt (successful or unsuccessful). This should be evident in the content of the encounter note, and through the FCM function that "links" encounters with applicable POC Tasks.

BH HCBS Plan of Care and Federal Assurances (HARP Adults Only)

1. All HARP Enrolled, or Eligible members must have a HARP Need or Goal documented on their POC; irrespective of whether they are currently interested in an HCBS or CORE referral[24].
   1.1. The HARP Need or Goal can be used to document Goals and Tasks related to:
   - Contacting Maximus/MCO to enroll in a HARP Plan
   - Contacting MCO to disenroll from HARP
   - Completing an initial or annual HCBS Eligibility Assessment
   - Member recovery and rehabilitation goals
   - Attending an intake appointment for HCBS or CORE
   - Ongoing provision of HCBS or CORE, including conversations with the provider, and Frequency/Scope/Duration of HCBS services
   - Others, as relates to member goals and HARP requirements

2. When a member has completed an HCBS Eligibility Assessment and is both eligible and interested in being referred for HCBS services, additional elements are required for the POC, sometimes referred to as the "HCBS requirements".
   2.1. Currently, FCM captures these within a supplemental document, called a HARP POC. Effective 1/1/24 only certain fields on the HARP POC are required and get synced to MAPP as part of the POC. See the HARP Policy for more details.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

Sources:

Health Home Plan of Care Policy #HH0008

Comprehensive Assessment Policy #HH0002

Adult Behavioral Health and Community Based Services (BH HCBS)

Member Disenrollment From the Health Home Program Policy #HH0007

Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016

[24] Once FCM integrates data from the FCM HARP Tab into the FCM Plan of Care; this requirement will only apply to members pursuing a referral for, or in receipt of, HCBS services.

J. Core Services and Core Health Home Requirements Policy

First issued: 8/4/15
Reviewed by Quality Committee: 1/10/23
Revised Effective: 1/10/23

POLICY:
Health Homes must provide monthly Core Services to meet minimum billing requirements. The number and type of Core Services required are outlined here:
Standard Care Management Level of Service
Health Home Plus for SMI Level of Service
Health Home Plus for HIV Level of Service
Health Home Plus for AOT Level of Service

The mode of contact should include, but is not limited to: face-to-face meetings, mailings, secure texts/emails, phone/video calls. Care management agencies must provide written documentation that clearly demonstrates how the requirements are being met.

Active, ongoing, and progressive engagement with the member must be documented in the care management record to demonstrate progress toward engagement, care planning and/or the member achieving their personal goals.

According to the Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations, Care Management Agencies must meet the following core health home requirements[25]:

Comprehensive Care Management

- A comprehensive health assessment that identifies medical, behavioral health (mental health and substance use), and social service needs is developed.
- The member's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long-term care, and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the member's care.
- The member (or their guardian) plays a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.
- The member's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

[25] CCMP has developed the Core Services Definitions Guidance to help CMAs understand the difference between the different Core Service Types.

- The member's plan of care clearly identifies family members and other supports involved in the member's care. Family and other supports are included in the plan and execution of care as requested by the individual.
- For all members enrolled in a Health Home, the plan of care must include the following specific elements:
- The member's stated **Goal(s)** related to treatment, wellness and recovery
- The member's **Preferences and Strengths** related to treatment, wellness and recovery goals
- **Functional Needs** related to treatment, wellness and recovery goals
- Key **Community Networks and Supports**
- Description of planned **Care Management Interventions and Time Frames**
- The member's **Signature** documenting agreement with the plan of care, along with signatures from the care manager and care management supervisor
- Documentation of participation by all **Key Providers** in the development of the plan of care.
- The member's plan of care includes periodic reassessment at a minimum of every 12 months of the individual needs and clearly identifies the member's progress in meeting goals and changes in the plan of care based on changes in the member's needs.
- Care management agencies must submit plans of care for review and approval by the member's MCO as required.

Care Coordination and Health Promotion

- The CMA is accountable for engaging and retaining Health Home members in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a member's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.
- The CMA will assign each individual a dedicated care manager who is responsible for overall management of the member's plan of care. The Health Home care manager is clearly identified in the member's record. Each member enrolled with a Health Home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the member's care. The member cannot be enrolled in more than one care management program funded by the Medicaid program.
- The CMA must build a relationship and establish communication between the dedicated care manager and the treating clinicians so that the care manager can discuss with clinicians on an as needed basis, changes in the member's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).
- The CMA must define how care will be directed when conflicting treatment is being provided.
- The CMA has policies, procedures, and contractual agreements to support effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

- The CMA supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.
- The CMA supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the CMA. The CMA has the option of utilizing technology conferencing tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect PHI.
- The CMA ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.
- The CMA will ensure the availability of priority appointments for Health Home members to medical and behavioral health care services within their care management agency network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
- The CMA promotes evidence-based wellness and prevention by linking Health Home members with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
- The CMA has a system to track and share information and care needs across providers and to monitor outcomes and initiate changes in care, as necessary, to address the member's needs.
- Comprehensive Transitional Care
- The CMA has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the Health Home prompt notification of a member's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
- The CMA has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for members who require transfers in the site of care.
- The CMA utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the member, family, caregivers, and local supports.
- The CMA has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the member attended the appointment, and a plan to outreach and re-engage the member in care if the appointment was missed.
- Care management agencies must contact members within 48 hours of discharge from an inpatient unit (when they are notified or become aware of the admission), or sooner if clinically indicated, to facilitate the care transition. Health Home care managers shall engage in the discharge planning process, including the review of upcoming appointment dates and times, medication reconciliation, and potential obstacles to attending follow-up visits and adhering to recommended treatment plan.
- When CMAs are notified or become aware of a member's admission to a detox facility they must attempt to make a face-to-face contact 1) during the stay of a member that has been admitted to a

detox facility and 2) within 24 hours of discharge from a detox facility to ensure that the member is aware of follow-up appointments and to provide supports for getting to appointments.

- Enrollee and Family Support
- Member's individualized plan of care reflects member and family or caregiver preferences, education and support for self-management, self-help recovery, and other resources as appropriate.
- Member's individualized plan of care is accessible to the member and their families or other caregivers based on the individual's preference.
- The care management agency utilizes peer supports, support groups and self-care programs to increase members' knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.
- The CMA discusses advance directives with members and their families or caregivers.
- The Health Home provider communicates and shares information with members and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.
- The care management agency gives the member access to plans of care and options for accessing clinical information.

Referral to Community and Social Supports

- The care management agency identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- The care management agency has policies, procedures, and contractual agreements to support effective collaborations with community-based resources, which clearly define roles and responsibilities.
- The plan of care should include community-based and other social support services as well as healthcare services that respond to the member's needs and preferences and contribute to achieving the member's goals.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored validation requirements on the FCM Billing Support Questionnaire, and Billing Audits, per the Quality Management Program Policy.

Sources:

Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations

K. Care Team and Care Team Meetings Policy

First issued: 11/8/19
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

Purpose:
To clarify the definition of a "Care Team", and the expectations around Care Team Meetings.

Policy:
Care Managers will help the member define and consent their Care Team, and then work with the Care Team in a leadership capacity to develop, update, and help the member achieve their goals, as outlined on the Plan of Care. Work with Care Team members is done via informal conversations, and formal Care Team Meetings.

Definitions:
Care Team[26]*: a collection of consented family, friends, healthcare providers, social service supports, and Managed Care Organization(s) that support the member in meeting their goals.*

Care Team Meeting[27]*: A formal meeting scheduled by the CM, at a certain frequency, where the member/personal representative, and all care team members are invited to discuss the member's needs, and review/update the POC as needed.*

Procedure:

1. To be considered a Care Team member, an entity (person or organization) must be listed on the Health Home Consent.
   1.1. The member decides who is on their Care Team. See the Eligibility Requirements Policy (Consent section) for details on the minimum required Care Team members for enrollment in Health Home.
   1.2. The Care Team is documented in FCM using the Care Team widget which syncs to MAPP as part of the POC. The Care Team widget must be updated whenever a Care Team member is added/removed from the Health Home Consent.

2. The Care Team is led by the Health Home Care Manager.
   2.1. Although the Care Manager does not have any direct authority over the Care Team members, they have ownership over documentation of the Plan of Care, and therefore are responsible for ensuring all members of the Care Team are "rowing the boat" in the right direction, and in a coordinated way, to get the member where they want to go.

[26] In various state policies this may also be referred to as a Multidisciplinary Team, Interdisciplinary Team, etc.
[27] In various state policies this may also be referred to as a Multidisciplinary Team Meeting, Interdisciplinary Team Meeting, Child & Family Team Meeting, Case Review Meeting, Care Conference, Case Conference, etc.

3. When Care Team Meetings are scheduled, the Care Manager must document who was invited, who ultimately participated, and that they asked any non-participants to share their feedback directly with the Care Manager.
   3.1. The Care Team Meeting must be scheduled at a time/place that is convenient and accessible for the member.
   3.2. The CMA may use technology conferencing tools, such as Zoom/Webex/GoToMeeting when security protocols and precautions are in place to protect PHI.
   3.3. If an invitee to a Care Team Meeting cannot attend the Care Manager must provide a way for the Care Team Member to share their input outside of the scheduled Care Team Meeting.
   3.4. If the Care Manager has attempted to reach a Care Team Member to schedule a Care Team Meeting, but has not received a response, this should not delay the Care Team Meeting, or the timely completion of the POC.

4. Care Team Meetings are required at the following points during the enrolled segment.
   - During completion of the POC (first 60 days of enrollment), to get Care Team members' insights into the member's needs and goals, and ensure they are aware of all needs and goals identified by the member or other Care Team members.
   - At the time of Annual Care Plan review.
   - Upon member or Care Team Member request.

5. Care Managers should regularly communicate with various Care Team members, as needed, to help move the POC Goals forward. These communications are documented in encounter notes.

6. To document a Care Team Meeting in FCM, in addition to selecting "care conference" on the encounter note that describes the meeting, the Care Manager completes a Care Team Meeting Form in FCM (required or optional?). Or will FCM add another drop down for Care Team Meeting? Or can they include the required info in the body of the note? Could they create a standard Care Team Meeting Form and link it to the note?

Training and Compliance
CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

Source:
Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations
Health Home Plan of Care Policy #HH0008
Comprehensive Assessment Policy #HH0002
Member Disenrollment From the Health Home Program Policy #HH0007

L. Managed Care Organization Policy

First issued: 11/22/16

Reviewed by Quality Committee:

Revised Effective: 6/14/24

Purpose

To ensure CMAs understand the unique roles that Managed Care Organizations (MCOs) play as members of the Care Team.

Policy:

1. Effective 8/1/18, all Health Home members who are enrolled in an MCO, are required to consent the MCO on Page 3 of their DOH-5055, as the MCO is considered an integral part of the member's Care Team.
   1.1. Whenever a policy references communication, coordination, or other work with Care Team Members, the MCO is always included.

2. The following are some but not all of the ways that CCMP CMAs may use MCOs to improve their member's health and wellness:
   - Supplemental information for the purpose of locating a member or a member's providers.
   - Determining all available services that may benefit the member or the CMA.
   - Receiving inpatient notifications.
   - Quality metric information to gauge progress and improve care.

3. The MCTAC Matrix maintains an updated list of MCO contacts specific to Health Home Care Management, and is where Care Managers should go to get MCO contact information:
   MCTAC Matrix New York County

4. There are different kinds of MCOs, and it the Health Home Care Manager must understand which one a given member is in, and what services are available to them.

   Mainstream Plans
   - Member has access to a network of providers and access to all State Plan services.
   - MCO may offer various additional resources to the members to maintain and improve their health, such as incentive programs.
   - MCOs may refer high need members to a Health Home for additional supports, or they may provide Care Management directly.

   Health and Recovery Plans (HARPs):
   - For members with high behavioral health claims histories (Mental Health and Substance Abuse).
   - Members have access to Adult HCBS and CORE services, in addition to State Plan services.

- Some HARP Plans have MCO Care Managers assigned to their HARP members – others do not.
- All HARP members who are not already enrolled in Health Home Care Management are offered a referral to a Health Home, in addition to the support they may receive from an MCO Care Manager.

Special Needs Plans (SNPs):

- For members living with HIV, are homeless, or transgender.
- Members have access to Adult HCBS and CORE services, in addition to State Plan services.
- All SNP Plans have MCO Care Managers assigned to their SNP members.
- Members have an HIV Specialist PCP
- All SNP members who are not already enrolled in Health Home Care Management are offered a referral to a Health Home, in addition to the support they receive from an MCO Care Manager.

MLTC (Managed Long-Term Care)

- For members who need long-term supports in the community and would otherwise need an institutional level of care.
- It includes case management, and therefore the CMA needs to determine if the member truly needs the HHCM in addition to their MLTC Care Manager.
- There are two kinds of MLTC, Partial Capitation and MAP (Medicaid Advantage Plus). They cover different services, and have different ways of coordinating with the HHCM, particularly as relates to the Plan of Care.
- Partial Capitation Members do not have access to Adult HCBS or CORE services.
- MAP Members have access to CORE services, but not Adult HCBS.
- MAP Members have access to behavioral health services through their plan, which MLTC members access behavioral health services as Fee For Service.
- The type of MLTC that the member is in must be clearly documented, with evidence that the HHCM is coordinating care with the MLTC care manager in the appropriate way.

Source:

Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009

M. Gaps in Care Policy

First issued[28]: 5/24/24
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

Policy:
CCMP processes Gaps in Care for the network CMAs. Notifications are managed through the FCM interface, on the Gaps in Care Tab.

Gap in Care- an alert from an MCO that requires Care Manager follow-up. They are based on member claims and population health level standards of care.

Procedures:

1. MCOs send reports of the Gaps in Care for their members directly to CCMP, at various times during a calendar year.
   1.1. Upon receiving Gaps in Care information from an MCO, CCMP will verify that the member is enrolled in CCMP via MAPP and FCM.
   1.2. CCMP will send the Gaps in Care Report for enrolled members to FCM within one business day.
   1.3. The Gaps in Care will populate onto the Member's "Gaps in Care" tab.

2. CM will update the POC with a corresponding Need, Goal, or Task.
   2.1. Whether or not the gap is integrated into the POC as a Need, Goal, or Task depends on the member's understanding of the gap and the barriers to closing it.
   2.2. Gaps can also be linked to existing POC Tasks, if there is already a Task on the POC that is appropriate to address the gap.
   2.3. If the Care Manager is unable to directly communicate with the member about the gap, at minimum a goal could be added to the POC to educate the member on the gap in care and work with the member to close the gap.

3. CM will document gaps in care status by marking the Gap as "In Progress", "Care Provided", "Not Applicable" or "Member Refused", as appropriate.
   3.1. The Gap in Care status must be supported by encounter notes and Plan of Care updates.

Action Needed: All Gaps in Care are auto populated with this status.
In Progress: The Care Manager is actively working with the member and Care Team on closing the gap.
Care Provided: To the best of the Care Manager's knowledge, this gap has been closed. This could be based on conversations with the member, their Care Team, receipt of lab results, claims data, etc.

[28] Content was previously covered in the "Alerts Policy", which has been renamed the "Clinical Event Notifications Policy".

Not Applicable: This gap is not applicable to the member. Possible reasons are that the member's doctor has determined that the screening is not clinically indicated for the member at this time, or member is no longer prescribed the medication that the gap refers to, etc.
Member Refused: Member has been educated on the gap, Care Manager has attempted to identify and/or address barriers, but the member is making an informed choice not to complete the test/screening at this time.

4. CCMP will obtain any information pertaining to status of MCO Care Gaps from FCM as needed.

Training and Compliance
CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

N. Clinical Event Notifications Policy

First issued: 1/19/17
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

CCMP processes Clinical Event Notifications for the network CMAs. Notifications are primarily managed through the FCM interface, on the Transitions of Care tab. Some hospitalization alerts are managed manually.

Definition:
Clinical Event Notification- an alert from an Healthix that requires Care Manager follow-up. They are typically related to hospital admissions and discharges but can include notifications about other things as well.

Healthix Alerts:

1. CCMP is connected to the Healthix RHIO and receives Clinical Event Notifications (CENs) through FCM.

2. Healthix will send basic CENs with limited PHI to FCM based on member attribution, i.e. enrollment with CCMP.
   2.1. Advanced CENs with full PHI, and access to the Healthix portal[29] is only available when a member has provided written affirmative consent. This is done with a DOH-5055 (wet or e-sig only). When a DOH-5055 is uploaded to FCM as a “Health Home Consent”, a “grant access” value is transmitted to Healthix.
   2.2. When a CEN is received by FCM, it populates onto the member’s “Transitions of Care” tab, and a tickler email is sent to the assigned Case Manager, and any other staff the CMA designates to receive such emails.
   2.3. The Case Manager is then responsible for providing Comprehensive Transitional Care to the member, per the Hospital Follow-Up Policy.
   2.4. If the member wants to revoke consent for Healthix, they must complete the Healthix Withdrawal of Consent form. When the form is uploaded to FCM as a “Healthix Withdrawal of Consent Form”, a “deny access” value is transmitted to Healthix. Members can also do this if they want to enroll into the Health Home without providing Healthix access.

3. New CENs are visible to CMs from the Member Overview tab, and eventually will also be on the Care Manager Dashboard.

4. CM’s can merge CENs that are all related to the event together, such as an ER admission alert, transfer to inpatient alert, and inpatient discharge alert.

[29] Access to the Healthix Portal is limited to CCMP Health Home staff only. CMAs may also have access to the portal if they have their own contract with Healthix.

4.1. Merging alerts improves CM ability to manage the member's hospitalizations and allows for reporting and metrics on the CM's response to the overall hospitalization event, rather than each individual alert.

5. CM's can use status changes on individual or merged CEN's, which also helps with work organization, reporting, and metrics.

   Action Needed: All CEN's are auto populated with this status.
   In Progress: The Care Manager is actively working with the member and Care Team on the hospitalization event and follow up.
   Care Provided: The Care Manager has completed all required follow-up related to the event.
   No Action Needed: There is no follow-up needed for this alert. Possible reasons are that alert was for the wrong member, it was a duplicate alert, it was for an event that happened a long time ago, etc.
   Member Refused: This status should not be used in relation to Clinical Event Notifications, because follow up on a CEN does not require member participation or agreement.

6. CMs can link encounter notes documenting their follow up work to individual or merged events from the Encounter Screen or from the Clinical Event Details screen.

Non-Healthix Alerts:

7. CCMP receives ad hoc calls/emails from MCOs about hospitalized members and receives daily emails of hospitalization lists from some MCOs.

8. Upon receiving any such notification that a CCMP member is admitted, pending discharge, or recently discharged from any facility (ER or INP), CCMP will verify the member's status (outreach or enrolled) in MAPP and FCM.
   8.1. CCMP will forward the notification details (admit date, facility address, discharge date, point of contact at facility) to the CMA within one business day.
   8.2. The Case Manager is then responsible for providing Comprehensive Transitional Care to the member, per the Hospital Follow-Up Policy.
   8.3. CCMP will obtain any information pertaining to the hospital follow up from FCM as needed.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

O. Hospital Follow-Up Policy[30]

First issued: 6/8/16
Reviewed by Quality Committee: 8/13/19
Revised Effective: 5/14/19

Purpose:
To outline expectations for CMA response once they learn of a member's hospitalization, and requirements for follow up post-discharge.

Definitions:
Hospitalization: Within this policy, "Hospitalization" refers to any healthcare facility, where a member could theoretically stay overnight. This includes Emergency Rooms/Departments, Hospital Inpatient Units, Nursing Homes, Rehabilitation Centers, and Detoxification centers. The cause of the Hospitalization can be related to medical conditions, psychiatric conditions, or substance use disorders.

Policy:
CMAs learn of hospitalizations in various ways. They may be contacted by the member, the member's family, Care Team Members (including the MCO), the Health Home, or get a Healthix alert through FCM. They may learn of a hospitalization either before admission (e.g., planned surgeries or detox), during the hospital stay, or after discharge. Regardless of when or how the CMA learns of a hospitalization, they are required to provide follow up to improve member health and prevent re-admission as follows:

Procedure:

1. Within two business days of learning that the member is in any hospital setting, Care Manager attempts to provide the *Comprehensive Transitional Care* Core Service, i.e., contact the hospital, member, or appropriate Care Team Members to notify them of the member's Health Home enrollment, confirm the admission date, anticipated length of stay, reason for admission, and to collaborate on discharge planning procedures.
   1.1. For detox admissions, an in-person visit must be attempted during the member's stay and within 24 hours of discharge[31].
   1.2. If length of stay will be longer than six months, or is unknown, follow the Excluded Settings Policy.

2. If the CMA only learns of the hospitalization after the member has been discharged, CMA still provides *Comprehensive Transitional Care*, but in a different way, i.e., contact the hospital, member, or

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[30] Follow up after incarceration is very similar to Hospital Follow Up and is covered in the CCMP Hospitalization Follow Up Training.
[31] It is unclear whether this can be met via telehealth (video), or if the NYS DOH has forgotten this requirement altogether. - *MEMORANDUM RE: TELEHEALTH GUIDANCE for the Health Home Program 5/3/24*

appropriate Care Team Members to find out when the member was hospitalized, when they were discharged, the reason for admission, and to understand what the discharge instructions were.

3. After a member has been discharged, the Care Manager is required to:
   - Review discharge instructions with the member.
   - Ensure member is scheduled for a follow up appointment with the appropriate outpatient provider within seven days of discharge unless the treatment team explicitly recommends an earlier or later timeframe.
   - For psychiatric admissions, ensure member is scheduled for a second follow up with their psychiatric provider within 30 days of discharge, unless the provider explicitly recommends an earlier or later timeframe.
   - Provide support to the member to keep those appointments.
   - Assist member with obtaining new or changed medications.
   - Add/update hospitalization follow up tasks on the Plan of Care as applicable, to prevent future admissions. Depending on member's needs, they may have either a Need or a Goal related to the hospitalization and preventing readmission. If creating a Need related to the hospitalization, there is a "Transitional Care" category that can be used.

     Examples of possible tasks are:
     - ➢ Attend post discharge outpatient appointments (specify dates)
     - ➢ Dispose of discontinued medications
     - ➢ Use MCO Nurse triage line if symptoms return
     - ➢ Educate member about new diagnosis
     - ➢ Increase frequency of glucose monitoring
     - ➢ Refer member for home care services

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and monthly metrics, per the Quality Management Program Policy.

Sources:

Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations

MEMORANDUM RE: TELEHEALTH GUIDANCE for the Health Home Program 5/3/24

P. Medication Reconciliation Policy

First Issued: 5/14/19

Reviewed by Quality Committee: 9/17/19

Purpose:

The Standards and Requirements for Health Homes and Care Managers and Managed Care Organizations refer to Care Managers being required to "assist with medication reconciliation", or "engage in the discharge planning process, including…medication reconciliation…" The purpose of this policy is to clarify CCMP's interpretation of the Health Home Care Manager's role as regards "medication reconciliation".

Policy:

As part of the *Comprehensive Transitional Care*, and the *Care Coordination and Health Promotion* Core Services, the Care Manager can assist with and support medication reconciliation efforts for the member, within the limitations of their role, skill, and training. The member's medical providers are ultimately responsible for completing a medication reconciliation at every transition of care, and the Care Manager can assist with this process. CMAs are not liable for decision making by other medical providers.

Definitions:

There are several different definitions and processes for medication reconciliation. They all stress the role of the Care Team, and the role of communication between Care Team members. Some roles are done by pharmacists (checking for adverse interactions), or prescribers (clinical decision making), others can be done by both licensed and unlicensed care managers (gathering information, documenting information, communicating information).

Medication reconciliation The process of creating the most accurate list possible of all medications a member is taking — including drug name, dosage, frequency, route, and purpose- and comparing that list against any new list of medication the member receives during a transition of care, to help the member identify, understand, and implement changes.

What is the Care Manager's Role?

The care manager is not solely responsible for medication reconciliation; they cannot identify adverse reactions, recommend medication changes, or interpret physician's orders. This is why they work as part of a Care Team.

The Health Home Care Manager is well positioned to document clinical information about the member and their needs, and communicate that information between the members, their community-based providers, and hospital staff. The Health Home Care Manager is also well positioned to help members remove barriers and advocate for the medical and behavioral care that they need. The Care Manager's role with Medication Reconciliation is like their role in general; they ask questions, document answers, communicate information, identify problems, and support the member on solving problems.

When do members need help with Medication Reconciliation?

Not all members need a Care Manager's help with medication reconciliation. Part of the Health Home Comprehensive Assessment process is identifying whether the member needs assistance with keeping track of their medications, understanding medication changes, and/or communicating with various providers about what medications they are taking. The Care Manager must ensure that the member has access to medication reconciliation, even if they are not actively assisting with it.

If a member does not need help with this task, document who is responsible for it. Sometimes members do these tasks for themselves, sometimes it is a family member, or they have an in-home nursing service, or they live in a supportive housing facility that provides medication monitoring and reconciliation. The procedures below apply only to those members who do not have the ability to self-manage their medications, and do not have access to someone to help them. In those situations, it could be appropriate for the Care Manager to assist with medication reconciliation through asking questions, documenting answers, communicating information, identifying problems, and supporting the member on solving problems.

Procedures for assisting with Medication Reconciliation when it is appropriate to do so:

When the member is in the community

1. Ask the member what medications they are taking, document them into FCM.
2. Ask the member's consented providers what medications they have been prescribing to the member.
3. If there are differences between what has been prescribed, and what the member is taking, surface those differences in conversation with the member and the provider.
4. Update the list of medications in FCM, if what the member is taking changes.

When the member is transitioning in/out of a hospital setting

1. Attempt to inform the hospital staff of what the member was taking before admission.
2. Compare that list to the medications listed on the Discharge Summary.
3. Through discharge planning/follow up discussions with the hospital, the members, and/or their community-based provider(s), help the member identify, understand, and implement any changes.
4. Update the list of medications in FCM, if what the member is taking changes.

Limitations and Constraints

The Health Home Care Manager operates within many constraints. They are limited by the information that the member and their providers choose to share with the Care Manager. For example, sometimes Care Managers struggle to get a hospital to give them a copy of a discharge summary or return phone calls. For this reason, Care Managers are not responsible for having a perfectly accurate medication list at all times; but rather for attempting to gather, document, and share whatever information they can get, to help the member.

Institute for Healthcare Improvement: Accuracy at Every Step: The Challenge of Medication Reconciliation
Patient Safety and Quality: An Evidence-Based Handbook for Nurses Charter 38 Medication Reconciliation
It Takes a Village: Medication Reconciliation that Transcends Setting and Professions
Perceived Impact of Care Managers' Work on Patient and Clinician Outcomes

Q. Excluded Settings Policy

First Issued: 5/14/19
Reviewed by Quality Committee: 4/14/20
Revised Effective: 6/14/24

PURPOSE

Health Home services are provided to members in Community Based Settings. DOH designates non-Community Based Settings as Excluded Settings and outlines specific billing requirements and expectations for service when members are in Excluded Settings. This policy describes what CCMP CMAs will do when a member enters, exits, or is located in an Excluded Setting.

POLICY

To support member retention and opportunities for Re-engagement, CCMP CMAs will ensure appropriate Comprehensive Transitional Care services are provided to members who enter, exit, or are located in an Excluded Setting.

DEFINITIONS

Excluded Setting: Jail, Prison, Inpatient Hospital Unit, Nursing Home, Rehabilitation Center, Inpatient or Residential Substance Abuse Treatment, State Operated Transitional Living Residence.

PROCEDURE

1. If member enters or is found to be in an Excluded Setting, the Care Manager will make attempt to contact the member and/or consented discharge planning staff of the excluded setting to provide Comprehensive Transitional Care, i.e., notification of the member's Health Home enrollment, confirm the admission/incarceration date, anticipated length of stay in the excluded setting, reason for entry into the excluded setting, and to collaborate on discharge planning procedures.

2. During the month of entry into incarceration CMAs may bill for any Core Service provided prior to the date of entry into the jail/prison. CMAs may not bill for any Core Services provided while the member is incarcerated.
   - 2.1. *Comprehensive Transitional Care* services should still be attempted to be provided to members expected to be released from incarceration in the current or following month as a non-billable service, to facilitate a return to the Community Based Setting.
   - 2.2. At minimum the CMA must attempt to determine the expected length of incarceration, to determine if the case should be pended or disenrolled. This can be done with the use of WebCrims or Inmate Look-Up.

3. For all other Excluded Settings, CMAs may bill for *Comprehensive Transitional Care* <u>either</u> during the month in which the member enters the excluded setting, <u>or</u> the month where the CMA first contacts the member and/or staff of the excluded setting.

3.1. For all other Excluded Settings, CMAs may also bill for Comprehensive Transitional Care in the thirty days prior to the member's discharge from the Excluded Setting, to facilitate discharge planning. If the member is expected to remain in the excluded setting longer than six months following entry into the setting, the Care Manager will follow procedures for disenrolling the member from the HH program.

4. If the client is expected to be released/discharged from the Excluded Setting within six months, or expected length of stay is unknown, CMAs must Pend the Enrolled Segment, effective the 1st day of the month following entry into the Excluded Setting.
   4.1. CMAs can choose to keep the case open if release/discharge is expected in in the current or next calendar month, than pend/unpend those cases, if doing so would be administratively burdensome or disrupt continuity of care. If they do not pend the case, they must still follow all billing restrictions outlined in this policy.
   4.2. While cases in excluded settings are pended, there are no explicit requirements for provision of services, and FCM will not generate any potential Billing Support Questionnaires.
   4.3. CMAs should establish relationships with discharge planners, family members, and other member supports, encouraging them to engage with the CMA when approaching discharge/release so that the CMA can facility a return to the Community Based Setting.
   4.4. Any contact made with the member or their Care Team Members, family, discharge planners, or other supports while the case is pended must be documented in the case record; even though the services are not billable.
   4.5. If, while pended, a CMA is informed that a member's anticipated length of stay has changed such that they will not be discharged/released within six months of date of entry, they should proceed to disenrollment.

5. If a potential member is referred from an excluded setting they may be enrolled into the program and billed at the enrolled rate while still in the excluded setting, if:
   5.1. A core service (usually an enrollment meeting) was provided within the 30 days prior to discharge/release from the excluded setting; only one such instance of billing is allowed.
   5.2. The core service provided should not duplicate or replace the discharge planning activities that are the responsibility of the hospital discharge staff.
   5.3. Focus should be meeting and engaging the member, assessing for Health Home and/or HCBS eligibility, signing consent and enrollment forms, understanding the discharge/release plan from the excluded setting.

6. If a potential member referred from an excluded setting does not return to the community as planned:
   6.1. If an enrolled segment was opened, and there is still a plan for discharge, pend the segment "excluded setting" until member is back in the community.
   6.2. If an enrolled segment was opened, and the discharge plan is called off, or no longer is inclusive of Health Home Care Management, disenroll the member.

6.3. If the potential member was not yet enrolled, instruct hospital staff to re-refer once there is a new discharge plan.

7. If a member or potential member has an NH code on their Medicaid case due to being in a Nursing Home, the enrolled segment must be opened directly in MAPP so that the NH code override functions can be used.

Training and Compliance

CCMP provides training on this policy in TalentLMS. Compliance with this policy is monitored with chart audits and billing restrictions built into FCM, per the Quality Management Program Policy.

Sources:

DOH Policy #HH0006 Continuity of Care and Re-engagement for Enrolled Health Home Members

DOH Policy #HH0007 Member Disenrollment from the Health Home Program

DOH Policy #HH0011 Health Home Care Management Activities and Billing Protocols for Managing Newly Referred Individuals from Excluded Settings

R. Crisis Management Services Policy

First Issued: 12/7/12
Reviewed by Quality Committee:
Revised Effective: 5/14/19

PURPOSE: To ensure that all Health Home members receive 24-hour coverage for psychiatric, medical, and after-hour crises.

DEFINITIONS:
Psychiatric emergency - a situation in which a person with a mental health diagnosis (or symptoms prior to being diagnosed) requires immediate observation, care and treatment in a hospital and the symptoms are likely to result in a serious harm to self or others. The risk is manifested by threats or attempts at suicide or serious bodily harm, or by homicidal or other violent behavior towards self or others.

Medical emergency - a situation in which a person has a physical health diagnosis (or symptoms prior to diagnosis) that requires immediate observation, care and treatment in a hospital and the symptoms are likely to result acutely in serious harm or death to the member.

POLICY:
The CMA has primary responsibility for crisis response, and it is a first contact for after-hours crisis calls. Each CMA must operate a continuous after-hours on-call system with staff who are experienced in the Health Home and skilled in crisis intervention procedures. Each CMA must have the capacity to respond rapidly to emergencies and member after-hour crises, both by telehealth and in person when needed.

PROCEDURE:
1. To ensure direct access to the CMA, members are provided an emergency hotline number which each CMA must maintain. This hotline service can be outsourced; however, each CMA is ultimately responsible for crisis intervention outcomes.
2. In the event of a crisis or emergency during working hours, members will immediately be connected to CMA staff.

S. Case Transfer of Enrolled Members Policy

First Issued: 11/11/20

Reviewed by Quality Committee: 6/11/24

Revised Effective: 6/14/24

Policy:

Member transfers may be initiated by the member or initiated by the CMA due to the CMA's inability to continue to serve the member (caseload capacity, safety concerns, program closure, etc.). When a member transfers from one CMA to another, whether within the same Health Home or between Health Homes, the process for the member should be as seamless as possible. This type of transfer is a continuation of Health Home services; while the member may need to update their Health Home Consent, or make decisions about whether to transfer or not, they should not have to re-start the enrollment/assessment/POC process.

Procedure

1. Most transfers will be voluntary, meaning the member both knows about and desires the transfer.

Transferring to another CCMP CMA.

- Must be voluntary, whether initiated by the member or the CMA.

Transferring to a new Health Home and a new CMA

- Must be voluntary, whether initiated by the member or the CMA.

Transferring to a new Health Home, staying with their current CMA.

- Should be voluntary, unless the CMA terminates their contract with one Health Home network and transfers cases to a different Health Home. This situation would be guided by DOH and the new Health Home.

TRANSFERS INITIATED BY MEMBER

1. Care Managers must be responsive to any member requests for transfer. This may include supervisory review, or problem solving around member complaints, but if a member has directly asked for a transfer that request should be honored.

2. The member may already know which CMA and/or HH they want to transfer to, or they may need to be connected to CCMP to determine which CMA/HH makes sense based on their needs and network capacity.

3. Care Managers must follow the Disenrollment Policy, issue all required letters/forms, and notify Care Team Members.

4. Care Managers should have the member consent the new CMA/HH so that a warm handoff and information sharing can occur. If the member does not consent to this, the CMA should involve CCMP to assist.

5. The transferring CMA should keep the case open until the member has completed their intake meeting with the new CMA/HH, and subsequently end the segment, unless the member or new CMA has asked for their case to be closed prior to their intake meeting with the new CMA/HH.

6. The CMAs will need to communicate as to the start date/end dates of segments and include the Health Homes as needed to problem solve. Best practice is to have some overlap of services, i.e. warm handoff, to ensure continuity, however only one CMA can bill for services each month.

7. All transfers must be managed by CCMP staff, through MAPP. Therefore, once the member has agreed to the transfer the CMA must contact CCMP to do the transfer in MAPP.

Transfers initiated by CMA (program is not closing, member is still eligible for services)[32]

1. If the CMA is unable to continue to work with the member, they must explain the situation to the member, and offer them a choice of transferring to a different CCMP CMA, a different HH/CMA, or disenrolling from Health Home Care Management.
   1.1. Common reasons for this type of transfer offer are:
   - Staff vacancies limiting capacity in general, or in specific boroughs
   - CMA unable to find a way to work with the member safely (see Code 7 Disenrollments)
   - Closure of a specific sub-program that the member is in, such as HH+

2. The CMA must notify the member of the reason they can no longer serve the member, the effective dates, the member's options, and what will happen if the member does not communicate a choice. Notification does not have to be made in writing, but if the CMA wants to do so, CCMP has a template letter that can be customized by the CMA.

3. The CMA must document the member's choice regarding transfer vs. disenrollment, and any specific preferences in FCM.
   3.1. If the member chooses to transfer, follow the steps 2-7 in the section above.

Procedure for the New CMA

1. Once a member has decided to transfer, the transferring CMA must contact CCMP to process the transfer in MAPP.
   1.1. This may be done in bulk for Program Closures.

[32] CMAs must consult with CCMP about these types of transfers. Depending on the reasons for the transfer, notification to the member may need to be in writing, and the CMA may need to provide more specific options.

2. The new CMA's enrolled segment will open automatically in MAPP and FCM, they should not create any segments – the original consent date will transfer to the new segment.
   2.1. Do not upload the prior CMAs consent or care plan under the new CMA.

3. There is no outreach or intake; the new CMA should treat the case as a continuation of the prior segment
   3.1. If the transferred member is not responsive to the new CMA, the Continuity of Care Policy should be followed.

4. In general, documents done by the prior CMA will remain in effect until the new CMA updates them. Updates should generally happen when they would have come due had the member stayed with their original CMA.
   4.1. A new/updated consent including the new CMA on page 3 is due when consented Care Team Members change, or at the time of the Annual Reassessment, whichever is sooner.
   4.2. If the transfer was from another Health Home, a new consent must be completed within 30 days of transfer.

5. If the transferring CMA was in FCM, the new CMA can email FCM and ask for portions of the chart to be copied over to the new CMA.
   5.1. FCM cannot copy the entire chart yet – As of May 2024, FCM can copy over the following:
      - Most recent Plan of Care[33] (includes signature date)
      - Native and custom assessments (not PDFs)
      - Strengths, barriers, risk factors
      - Medication widget
      - Diagnosis Widget
      - Care Team widget
   5.2. The new CMA can toggle in FCM to review the prior CMA's encounter notes, documents, assessments, POCs, HCBS-CORE/Children's Waiver tab, etc.

6. Transfers that are part of a **HH or CMA program closure may have specific timeframes** that will be communicated to the new CMA with the transfer.

7. The new CMA must coordinate with the member's care team and transfer source; they have consent to talk to everyone that was listed on the prior CMA's consent.

8. Initial Appropriateness is not required, but 60-day POC[34] and 12-month CES Tool are still required.

TRANSFERS DUE TO PROGRAM CLOSURE

[33] Unclear if this will include HCBS required fields pulled from the HCBS-CORE Tab

[34] Unclear if the prior CMA's signature date within the prior 12 months will override this requirement or not

1. If a CMA is leaving the CCMP Network, they are required to notify CCMP in accordance with their Network Provider Operating Agreement. Once they have notified CCMP, CCMP will hold a meeting the CMA to review the procedure for effectuating the program closure.

2. CCMP and the CMA will come to an agreement on timeframes and process, that is based on the below steps (may be modified to match unique circumstances):
   1.1 [CMA] notifies all enrolled members by XX/XX/XX telling them about the pending program closure and outlining their choices. All members are mailed a Notification of Program Closure Letter[35]. Request that members tell [CMA] of their choice as soon as possible; and that if they don't respond by XX/XX/XX they will be involuntarily disenrolled on XX/XX/XX.
   1.2 Anyone who has not decided by XX/XX/XX will be mailed a Disenrollment Letter and DOH-5235, per the Disenrollment Policy
      - If the CMA is in network with another Health Home, it may be that cases are passively transferred to the other Health Home rather than involuntarily disenrolled.
   1.3 Identify groups of members:

<u>If the CMA does not have another Health Home with capacity to take members</u>

Group 1: Want to stay enrolled with CCMP and transfer to a different CMA. NO FORMS, phone call from CCMP telling them the name/contact number of their new CMA. CCMP processed transfer in MAPP, with code 03 "Transferred to another CMA" – this automatically opens an enrolled segment with the new CMA.

Group 2: Want to have a new Health Home AND a new CMA. Disenrollment letter, per usual, with a referral to a new Health Home, managed by [CMA]. Once the new Health Home and transferring CMA have agreed on segment start dates, notify CCMP to process the transfer in MAPP with code 01 "Transferred to a new HH".

Group 3: Requests disenrollment from the whole program. Disenrollment letter, per usual, managed by [CMA]. End [CMA] /CCMP segment with code- 29 "Member withdrew consent to enroll".

Group 4: No Decision. Anyone who hasn't made a choice by XX/XX/XX will be mailed a DOH-5235 and Disenrollment letter, managed by [CMA]. At the time of program closure, they will be involuntarily disenrolled. End [CMA]/CCMP segment with code 32 "Program Closed".

<u>If the CMA has another Health Home with capacity to take their members</u>

Group 1: Wants to stay enrolled with their CMA and transfer to a different Health Home. Disenrollment letter, per usual, with a new DOH-5055/DOH-5201 completed for new Health Home, and a DOH-5234/welcome letter for new Health Home, managed by [CMA]. End [CMA] /CCMP segment with code 04 "HH to HH transfer", and [CMA] will open an enrolled segment with the new Health Home.

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[35] The letter will be developed by CCMP and CMA based on the unique circumstances of the closure.

Group 2: Want to stay enrolled with CCMP and transfer to a different CMA. NO FORMS, phone call from CCMP telling them the name/contact number of their new CMA. CCMP processed transfer in MAPP, with code 03 "Transferred to another CMA" – this automatically opens an enrolled segment with the new CMA.

Group 3: Want to have a new Health Home AND a new CMA. Disenrollment letter, per usual, with a referral to a new Health Home, managed by [CMA]. Once the new Health Home and transferring CMA have agreed on segment start dates, notify CCMP to process the transfer in MAPP with code 01 "Transferred to a new HH".

Group 4: Requests disenrollment from the whole program. Disenrollment letter, per usual, managed by [CMA]. End [CMA] /CCMP segment with code- 29 "Member withdrew consent to enroll".

Group 5: No Decision. Anyone who hasn't made a choice by XX/XX/XX will be passively transferred to new Health Home. DOH-5235 and disenrollment letter per usual, DOH-5234 for new Health Home, managed by [CMA]. Notify CCMP to process the transfer in MAPP with code 01 "Transferred to a new HH".

Instructions for New CMA following a Program Closure

1. Regarding members who choose to stay with CCMP, and transfer to different CMA following a Program Closure[36]:
   1.1. [CMA] members who provide verbal consent for transition to a new CMA, may be transferred to other CMAs in the CCMP network with an enrolled segment, and the Health Home Consent for CCMP that was executed by [CMA] will serve as a valid consent for the purposes of coordinating care and billing until there is a change in Care Team members requiring an update to the Health Home Consent, or the Annual Re-assessment (whichever comes sooner). This includes access to past records within FCM and disclosing PHI to entities listed on page three of the Health Home Consent within federal and state privacy law requirements, regardless of the quality of page three documentation.
   1.2. CCMP will notify such members of their newly assigned CMAs, and the need to meet with the new CMA within the 30 days after transfer. Whenever feasible this can/should be done with a warm handoff including the member, guardian, [CMA] staff, and new CMA staff.
   1.3. CCMP will inform the new CMAs that they must have an initial meeting with the member within the 30 days after transfer.
   1.4. New CMAs may initiate Diligent Search Efforts if the member does not keep their scheduled transfer meeting; they do not need to document that the member is disengaged at a level beyond typical level of engagement, or notify the MCO of disengagement, but will need to do three different types of outreach activities on three different days of the month (this can include standard searching).

[36] This is an example of what has been allowed in the past, however, "past DOH determinations do not guarantee future DOH decisions".

- If members do not meet with the new CMA within 30 days of the transfer, the member may be disenrolled as Lost to Services.

2. In general, documents done by the prior CMA will remain in effect until the new CMA updates them. Updates should generally happen when they would have come due had the member stayed with their original CMA.
   2.1. A new/updated consent including the new CMA on page 3 is due when consented Care Team Members change, or at the time of the Annual Reassessment, whichever is sooner.
   2.2. If the transfer was from another Health Home, a new consent must be completed within 30 days of transfer.

3. If the transferring CMA was in FCM, the new CMA can email FCM and ask for portions of the chart to be copied over to the new CMA.
   3.1. FCM cannot copy the entire chart yet – As of May 2024, FCM can copy over the following:
      - Most recent Plan of Care[37] (includes signature date)
      - Native and custom assessments (not PDFs)
      - Strengths, barriers, risk factors
      - Medication widget
      - Diagnosis Widget
      - Care Team widget
   3.2. The new CMA can toggle in FCM to review the prior CMA's encounter notes, documents, assessments, POCs, HCBS-CORE/Children's Waiver tab, etc.

4. The new CMA must coordinate with the member's care team and transfer source; they have consent to talk to everyone that was listed on the prior CMA's consent, if the transfer was from a CCMP CMA.

5. Initial Appropriateness is not required, but 60-day POC[38] and 12-month CES Tool are still required.

[37] Unclear if this will include HCBS required fields pulled from the HCBS-CORE Tab
[38] Unclear if the prior CMA's signature date within the prior 12 months will override this requirement or not

T. Disenrollment Policy Set

"Disenrollment" refers to the process of discharging a member from care management services in the CCMP Health Home or ending the enrollment process for a potential member. Disenrollment coincides with ending the members, or potential member's, enrolled or outreach segment in MAPP. The Disenrollment date is the last day of the segment. The Disenrollment reason is documented with a segment End Reason Code, which falls under an End Reason Category.

Categories:
Transferred: Segment is closed, but member continues to receive Health Home Care Management elsewhere within NYS

Administrative Closure: Segment is closed, but member continues to receive Health Home Care Management from their current CMA and HH

Disenrolled: Segment is closed, and member is no longer receiving Health Home Care Management in NYS

Stepped Down to a Lower Level of Care: Segment is closed, and member is receiving Care Management in NYS at a Lower Level of Intensity, or able to meet their Healthcare and SDOH needs on their own.

Stepped Up to a Higher Level of Care: Segment is closed, and member is receiving Care Management in NYS at a Higher Level of Intensity.

DOH lists all valid End Reason Codes and Categories for disenrolling a member here: MAPP Segment End Date Reason Code Crosswalk. Some apply only to outreach segments, some apply only to enrolled segments, and some apply to both. See the Disenrollment End Reason Code Definition Chart for more details.

The Continuity of Care Policy and Re-Engagement Policy describe the procedures for searching for, finding, re-engaging, or and/or disenrolling Disengaged members.

Training and Compliance
CCMP provides training on this policy set in TalentLMS. Compliance with this policy set is monitored with Chart Audits, per the Quality Management Program Policy.

This policy set contains:
Referral Closure Policy
Disenrollment Policy
Continuity of Care Policy
Re-Engagement Policy

1. Referral Closure Policy

First issued: 5/14/19
Reviewed by Quality Committee:
Revised Effective: 6/14/24

Purpose:
To describe all required actions when ending an outreach segment.

Background:
From 2012-2020 the Health Home program used the term “outreach” to apply to the activities associated with finding a potential member in the community, with the goal of enrolling them into the program. The Outreach activities were documented in an Outreach Segment in MAPP, which allowed the CMA to be paid for their Outreach activities, whether or not the potential member ended up enrolling in the program.

Effective 7/1/20, NYSDOH ended the Outreach Rate, and so these Outreach activities are no longer reimbursable. CCMP CMAs continue to use the Outreach Segment to track referrals and document pre-enrollment work with potential members. To reduce confusion, we use the terms “pre-enrollment work”, “referral response”, and “intake process” to describe what happens prior to enrollment, and we refer to “Intake” staff rather than “Outreach” staff.

Since “Outreach” is no longer a billable type of service, we are no longer referring to “Disenrollment from Outreach”. The Outreach segment that is used to track referrals still must be ended, and this process is now called a “Referral Closure”.

Policy:
If and when a CMA decides to stop trying to enroll a potential member, CMA will close the referral by ending the outreach segment. Along with ending the segment, the CMA must issue all required DOH forms, Enrollment/Denial of Enrollment Letters, and enter a Referral Closure Note. If the referral was Bottom-Up, and the CMA did not open an Outreach Segment, all other required documentation must be maintained in the CMAs records and available for DOH and Health Home review in case an enrollment decision is appealed.

Procedure:

1. If and when a CMA decides to stop trying to enroll a potential member, the CMA will:
    - Determine the appropriate End Reason Code, Category, and the appropriate DOH Forms to issue.
    - Issue required DOH Forms, with Enrollment/Denial of Enrollment Letter if applicable.
    - Notify the referral source (contingent on consent)
    - Enter a Referral Closure note
    - End Segment in FCM

- If the referral was received from NYC SPOA through Maven, the CMA must also close the case in Maven.

2. All Referral Closures, other than closure due to death, inability to locate, opt-out, interested at another time, or administrative closure reasons, require the issuance of either a DOH 5234 (Notice of Enrollment into the Health Home) or a DOH 5236 (Notice of Denial of Enrollment into the Health Home).

3. DOH-5234 is issued when the potential member enrolls into the program.
   3.1. CMA must issue the DOH-5234 with a corresponding Enrollment letter. See Notice of Determination and Fair Hearing Policy for more details.

4. DOH-5236 is issued when the member wants to enroll into the program, but the CMA has determined that the member does not meet program eligibility and/or appropriateness requirements.
   4.1. There is no requirement for a corresponding letter, though CMAs may generate one if they would like. See Notice of Determination and Fair Hearing Policy for more details.

5. All Referral Closures are documented in FCM with a Referral Closure note. Required elements of a Referral Closure note are:
   - Reason for and date of Referral Closure (reason matches the End Reason Code on the segment).
   - If initiated by or discussed with the member, the date of discussion and description of that discussion.
   - Any unsuccessful attempts to discuss Referral Closure with the member.
   - Description of how and when DOH paperwork was issued to and reviewed with the member (or attempts to do so).

Examples of Referral Closure notes:

Potential member was referred by XXXX on XXXX date. Referral is being closed because potential member said she is not interested in the service. CM notified the referral source of the potential member's decision.

DOH-5234- Potential member was referred by XXXX on XXXX date. They completed intake meeting on XXXX date and have been approved for enrollment on XXXX date. DOH-5234 was mailed home address with a Welcome Letter on XXXX date, and call was placed to member to inform her of acceptance into the program and to expect the letter in the mail. Member will be assigned to a Care Manager within XXXX business days. Referral source was notified.

DOH-5236- Potential Member was referred by XXXX on XXXX date. She completed intake meeting on XXXX date, but she was not approved for enrollment because XXXXX. DOH 5236 was mailed to home address on XXXX date, and call was placed to potential member to inform her of denial of enrollment and her fair hearing

rights. She expressed an understanding of the decision. Referral source was not notified, because member did not provide consent to do so.

7. Additional requirements related to ending an outreach segment specific to the Disenrollment End Reason Code are as follows:

Individual Opted Out (Code 2)

- Used when the potential member is located, is not interested in enrolling in the program, and does not want to be re-outreached in the future.
- No forms/letters required.
- Category: Disenrolled

Individual Deceased (Code 4)

- Used when the Intake Worker finds out that the member has died.
- No forms/letters required.
- Not allowed to bill for any services provided after learning of the death of a potential member.
- Category: Disenrolled

Transferred to another CMA (Code 3)

- Used when the potential member decides to enroll with a different CMA. Sometimes one CMA will have an active Outreach Segment, but another CMA will locate and “bottom up” the member while in the community.
- DOH-5236 is required only if the potential member had already completed an enrollment meeting/DOH-5055 with the first CMA. No corresponding letter required.
- Category: Transferred

Individual moved out of State (Code 9)

- Used when the potential member has moved out of New York State.
- DOH-5236 required only if the potential member had already completed an enrollment meeting/DOH-5055. No corresponding letter required.
- Category: Disenrolled

Individual Incarcerated (Code 11)

- Used when the potential member is incarcerated, in prison or jail.
- If potential member is to be released soon, CMA may choose to keep the referral open with a goal to complete the intake post release.
- DOH-5236 required only if the potential member had already completed an enrollment meeting/DOH-5055. No corresponding letter required.
- Category: Disenrolled

Individual is in an Inpatient Facility (Code 13)

- Used when the potential member is in an institutional setting (hospital, nursing home, rehabilitation center, etc.)
- If potential member is scheduled to be discharged soon, CMA may choose to keep the referral open with a goal to complete the intake post discharge or can conduct the intake while the potential member is still in the institution, following the Excluded Settings Policy.
- DOH-5236 required only if the potential member had already completed an enrollment meeting/DOH-5055. No corresponding letter required.
- Category: Disenrolled

Inability to contact/locate individual (Code 16)

- Used when Intake staff have been unable to contact the potential member after an appropriate length of time, as defined by the CMA.
- This includes situations where the referral was contacted and intake scheduled, but the referral did not keep the intake appointment or reschedule.
- No forms/letters required.
- Category: Disenrolled

Member interested in health Home at a future date (Code 18)

- Used when Intake staff have located a potential member who does not want to enroll at this time but wants to be contacted in the future.
- No forms/letters required.
- Category: Disenrolled

Individual doesn't meet Health Home eligibility/appropriateness criteria (Code 19)

- Used when potential member is found to not meet either diagnostic eligibility or appropriateness requirements.
- DOH-5236 required only if the potential member had already completed an enrollment meeting/DOH-5055. No corresponding letter required.
- Category: Disenrolled

Individual is not/no longer eligible for Medicaid (Code 24)

- Used when potential member does not have active Medicaid.
- DOH-5236 required only if the potential member had already completed an enrollment meeting/DOH-5055. No corresponding letter required.
- Category: Disenrolled

Individual moved from Outreach to Enrollment Status (Code 25)

- Used when potential member has signed a DOH-5055 to enroll into the Health Home and has been determined by the CMA to be eligible and appropriate for the program.

- DOH-5234 and Enrollment letter required.
- Category: Administrative Closure

Coverage not Compatible (Code 41)

- Used when potential member has active Medicaid, but it is not the correct type of Medicaid for Health Home Services.
- Refer to Guide to Coverage Codes and Health Home Services for more details.
- DOH-5236 required only if the potential member had already completed an enrollment meeting/DOH-5055. No corresponding letter required.
- Category: Disenrolled

Program Not Compatible (Code 42)

- Used when potential member is in a community-based program not compatible with Health Home Services.
- Refer to GUIDE TO RESTRICTION EXCEPTION (RE) CODES AND HEALTH HOME SERVICES for more details (not an exhaustive list).
- DOH-5236 required only if the potential member had already completed an enrollment meeting/DOH-5055. No corresponding letter required.
- Category: Disenrolled

Sources:
Member Disenrollment from the Health Home Program Policy #HH0007
Interim Guidance Addressing Outreach Modifications
DOH Guidance: Elimination of Health Home Billing for Outreach
MAPP File Specs 3.8 Appendix D

2. Disenrollment Policy

First issued: 12/7/12
Reviewed by Quality Committee:
Revised Effective: 6/1/22

Purpose:
To describe all required actions when discharging a member from Health Home Care Management services, i.e., ending an enrolled segment.

Policy:
If and when a CMA identifies that an enrolled member meets the criteria for disenrollment, or upon a member's request for disenrollment, CMA will disenroll the member. Disenrollment includes issuing all required DOH forms, Disenrollment Letter, notification to the Care Team (including MCO), engaging in Discharge Planning, closing the Health Home Plan of Care, and entering a Disenrollment Note.

Procedure:

1. For all disenrollments, whether member initiated, or CMA initiated, the following procedures are followed, with unsuccessful attempts documented in the record:
   - Review the discharge reason and plan with the CMA supervisor.
   - Discuss the discharge reason and plan with the member.
   - Discuss the discharge reason and plan with the member's Care Team, including the MCO.
   - Update/Close out Health Home Plan of Care.
   - Determine the appropriate Disenrollment End Reason Code, Category, and the appropriate DOH Forms to issue.
   - Issue required DOH Forms, with Disenrollment Letter.
   - Offer/provide copies of chart documents to the member
   - Enter a Disenrollment note
   - End Segment in FCM
   - If the referral was received from NYC SPOA through Maven, the CMA must also close the case in Maven.

2. All disenrollments, other than case closure due to death, voluntary disenrollments, or administrative closure reasons, require the issuance of a DOH 5235 (Notice of Determination of Disenrollment from the Health Home).
   - 2.1. All disenrollments that are voluntary, i.e., member knowingly and voluntarily chooses to withdraw from the program do not require the use of any DOH forms.
   - 2.2. DOH-5235 (Notice of Determination of Disenrollment from the Health Home) is issued for all disenrollments that are involuntarily, i.e., CMA decides to disenroll the member, and the member either does not know about the decision or disagrees with the decision.

2.3. All disenrollments, other than case closure due to death, or administrative closure reasons, require the issuance of a Disenrollment Letter. CCMP has developed Disenrollment Letter Templates for CMAs to use; or CMAs can write their own, if they meet the following requirements:

Disenrollment Letter (for Involuntary Disenrollments; to be used with the DOH-5235)

- Written on agency letterhead
- Indicate the reason for disenrollment
- Indicate effective date of disenrollment
- Offer the member a copy of pertinent documentation, such as most recent plan of care, contact information for Care Team members, Discharge/Safety Plan, referrals made by the CMA at time of disenrollment, plan for ongoing coordination of HCBS (if applicable)
- Instructions on how to get copies of documents
- Notify member of fair hearing rights.
- Instructions on how to contact the CMA to discuss the reasons for disenrollment

Disenrollment Letter (for Voluntary Disenrollments)

- Written on agency letterhead
- Indicate the date that member requested disenrollment
- Indicate how the member requested disenrollment
- Indicate the reason the member requested disenrollment (if known)
- Indicate effective date of disenrollment
- Indicate the date CMA will cease sharing PHI with Care Team members.
- Offer the member a copy of pertinent documentation, such as most recent plan of care, contact information for Care Team members, Discharge/Safety Plan, referrals made by the CMA at time of disenrollment, plan for ongoing coordination of HCBS (if applicable)
- Instructions on how to get copies of documents
- Instructions on how to contact the CMA to continue services or re-enroll in services
- Instructions on how to enroll in a different CMA or a different Health Home

3. All disenrollments are documented in FCM with a Disenrollment Note. This may also be called a Discharge Summary or Case Closure Note. Required elements of a Disenrollment note are:
   - Reason for and date of Disenrollment (reason matches the End Reason Code on the segment)
   - If initiated by or discussed with the member, the date of discussion and description of that discussion.
   - Any unsuccessful attempts to discuss Disenrollment with the member
   - Description of how and when Disenrollment paperwork was issued to and reviewed with the member (or attempts to do so)
   - A summary of the course of services.
   - Why and when was the member enrolled?

- What were their goals?
- What goals were met by the time of disenrollment?
- Did the member participate actively in discharge planning?
- What referrals were given to the member at discharge?
- Did you inform all care team members (including MCO) of the discharge plan?

Examples of Disenrollment notes:
VOLUNTARY DISENROLLMENT: *Member was referred by XXXX on XXXX. Initial goals at enrollment were XXXX. Care Manager assisted member with X, Y, Z. On XXXX member requested case closure because XXXX. Member did/did not participate in discharge planning activities. Care Manager notified the following Care Team Members of case closure and end of PHI sharing: X, Y, Z. Care Manager provided member with the following referrals at disenrollment: X, Y, Z. Care Manager offered member a copy of the following chart documents and member refused/accepted. Care Manager mailed Disenrollment Letter and X, Y, Z chart documents to the member on XXXX.*

INVOLUNTARY DISENROLLMENT- *Member was referred by XXXX on XXXX. Initial goals at enrollment were XXXX. Care Manager assisted member with X, Y, Z. CMA is closing member's case because of [Disenrollment Reason]. Describe attempts to inform member of the decision and/or describe member's disagreement with the decision. Care Manager notified the following Care Team Members of case closure and end of PHI sharing. Care Manager mailed 5235 with Disenrollment Letter and X, Y, Z chart documents on XXXX.*

4. Additional requirements related to ending an enrolled segment, specific to the Disenrollment End Reason Code are as follows:

Member is deceased (code 4)

- Used when the Case Manager finds out, usually from family, a Care Team member, or a hospital, that the member has died.
- No forms/letters required.
- Should attempt to find out the cause of death; may be a reportable incident.
- Not allowed to bill for any services provided after the death of an enrolled member.
- Category: Disenrolled

Closed for Health, Welfare, and Safety Concerns for Member and/or Staff (code 7)

- CMA is required to involve CCMP and the member's MCO in the process BEFORE a determination to disenroll for this reason is made.
- Used when the member's behavior is deemed unsafe for a Care Manager to continue to provide Health Home services to the member.
- Before closing this type of case, CMA must ensure they have done all appropriate emergency follow up and safety planning with/for the member.
    - Does 911 need to be called?

  - Should a police report be made?
  - Is the member in need of medical or psychiatric hospitalization?
- Encounter notes must describe the concerning behavior in detail:
  - What is the behavior?
  - What has the CMA done to try to address the behavior?
  - Why is the CMA unable to serve the member at this time?
- Ensure that all options for addressing the issue have been exhausted, including transfer to a different Care Manager who could appropriately meet the members' needs.
- If the member wants to continue to receive services, find out if they would want to transfer to a different CMA.
- If the closure is involuntary (DOH-5235), check off "Does not meet Appropriateness" on the DOH-5235, and write "Health, Welfare, and Safety Concerns" on the line for "Other".
- This closure reason is most often involuntary (DOH-5235) but can sometimes be voluntary (no forms required).
- Category: Disenrolled

Transferred to another CMA (code 3)

- Used when a member wants to transfer to another CMA (inside or outside of CCMP)
- A warm handoff should always be attempted.
  - Find out if the member would be interested in a meeting with representatives from both CMAs.
  - If not, ask the member to consent the new CMA, so that the CMAs can have a phone handoff.
  - If member will not give consent for the new CMA, contact CCMP to facilitate sharing of necessary case information.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents that they may want to share with the new CMA.
- These types of Disenrollments are always voluntary (no forms required).
- See Case Transfer of Enrolled Members Policy for more information
- Category: Transferred

Transferred to another Health Home (code 1)

- Used when a member wants to transfer to another Health Home in NYS
- If they will also be changing CMAs, a warm handoff should always be attempted.
  - Find out if the member would be interested in a meeting with representatives from both CMAs.
  - If not, ask the member to consent the new CMA and HH, so that the CMAs can have a phone handoff.

- If member will not give consent for the new CMA and HH, contact CCMP to facilitate sharing of necessary case information.

- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents that they may want to share with the new HH.
- These types of Disenrollments are always voluntary (no forms required).
- See Case Transfer of Enrolled Members Policy for more information
- Category: Transferred

Transferred to a CCO/HH (code 54)

- Used when a member with a Developmental Disability wants to transfer to a Health Home that specializes in this population; this will always involve a new CMA as well.
- A warm handoff should always be attempted.
    - Find out if the member would be interested in a meeting with representatives from both CMAs.
    - If not, ask the member to consent the new CMA and CCO/HH, so that the CMAs can have a phone handoff.
    - If member will not give consent for the new CMA and CCO/HH, contact CCMP to facilitate sharing of necessary case information.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents that they may want to share with the new CCO/HH.
- Must follow procedures for CCO/HH transfers
- These types of Disenrollments are always voluntary (no forms required).
- Category: Transferred

Individual moved between HHSC and HHSA (code 43)

- Used when a member aged 18-21 moves from a Children's CMA to an Adult CMA or vice versa.
- If there is a change in CMA, a warm handoff should always be attempted.
    - Find out if the member would be interested in a meeting with representatives from both CMAs.
    - If not, ask the member to consent the new CMA, so that the CMAs can have a phone handoff.
    - If member will not give consent for the new CMA, contact CCMP to facilitate sharing of necessary case information.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents that they may want to share with the new CMA.
- These types of Disenrollments are always voluntary (no forms required).
- Category: Transferred

Individual is in an Inpatient Facility (code 13)

- Used only when the Care Manager has been able to confirm that the member will be in an institutional setting (hospital, State psychiatric hospital, nursing home, rehab, etc.) for more than six months from date of admission.
    - If the member is expected to be discharged from the institution in the current or next month, case may remain open while Care Manager provides Comprehensive Transitional Care.
    - If the member is expected to be discharged from the institution within six months, or if the Care Manager is unable to determine an expected discharge date, the case must be pended.
    - Care Managers are expected to work with discharge planning staff at the time of discharge to coordinate a return to the community, at which point the case can be re-opened.
    - Should attempt to find out the reason for the hospitalization; it may be a reportable incident.
- If the closure is involuntary (DOH-5235), check off "Excluded Setting" on the DOH-5235.
- These types of disenrollments can be voluntary (no forms required) or involuntary (DOH-5235).
- Category: Disenrolled

Individual is Incarcerated (Code 11)

- This is only used when the Care Manager has been able to confirm that the member will be incarcerated for more than six months from date of incarceration.
    - If the member is expected to be released from jail or prison in the current or next month, case may remain open while Care Manager provides Comprehensive Transitional Care.
    - If the member is expected to be released from jail or prison before six months, or if the Care Manager is unable to determine an expected discharge date, the case must be pended.
    - Care Managers are expected to work with discharge planning staff at the time of release to coordinate a return to the community, at which point the case can be re-opened.
    - Should attempt to find out the charges and the "story" behind the charges; it may be a reportable incident.
- If the closure is involuntary (DOH-5235), check off "Excluded Setting" on the DOH-5235.
- This closure reason is most often involuntary (DOH-5235) but can sometimes be voluntary (no forms required).
- Category: Disenrolled

Individual doesn't meet Health Home Eligibility or Appropriateness Criteria (Code 19)

- Used when the member no longer has qualifying diagnoses, or continued appropriateness for services.
- In consultation with CCMP this code could also be used if an enrolled member revokes consent for any of the required entities (MCO, CMA, primary provider), or refuses to sign a Health Home Plan of Care that addresses at least one of their Qualifying Diagnoses within 60 days of enrollment.

- These disenrollments often require specific referrals, because if the member was ready for graduation you would be using that as the disenrollment reason.
  - Since the member likely still has needs, but can't be served through this program, identify where they should be referred for help with those needs.
- If the closure is involuntary (DOH-5235), check off either "Appropriateness" or "Eligibility" on the DOH-5235, as indicated.
- These types of disenrollments can be voluntary (no forms required) or involuntary (DOH-5235).
- Category: Disenrolled

Individual is not/no longer Eligible for Medicaid (Code 24)

- Used when member has inactive Medicaid and has not taken steps to re-activate it or is no longer eligible for Medicaid.
  - Case Managers are required to find out why Medicaid is inactive, what needs to be done to re-activate it, and attempt to help the member to re-activate it.
  - CMAs may set time limits on how long they will serve a case without active Medicaid.
  - NYC SPOA can facilitate a referral to non-Medicaid Care Management if that is indicated.
- If the closure is involuntary (DOH-5235), check off "Medicaid Coverage" on the DOH-5235.
- These types of disenrollments can be voluntary (no forms required) or involuntary (DOH-5235).
- Category: Disenrolled

Coverage not Compatible (Code 41)

- Used when member has active Medicaid, but it is not the correct type of Medicaid for Health Home Services.
- Refer to Guide to Coverage Codes and Health Home Services for more details.
- If the closure is involuntary (5235), check off "Medicaid Coverage" on the DOH 5235.
- These types of disenrollments can be voluntary (no forms required) or involuntary (DOH-5235).
- Category: Disenrolled

Program Not Compatible (Code 42)

- Used when member is in a community-based program not compatible with Health Home Services.
- Refer to GUIDE TO RESTRICTION EXCEPTION (RE) CODES AND HEALTH HOME SERVICES for more details (not an exhaustive list).
- If the closure is involuntary (DOH-5235), check off "Appropriateness" on the DOH-5235 and write "Program Not Compatible" on the line for "Other".
- These types of disenrollments can be voluntary (no forms required) or involuntary (DOH-5235).
- Category: Disenrolled

Individual has moved out of State (Code 9)

- Used when a member has moved out of New York State.
- It may be appropriate to provide referrals for Care Management or other services in the new state.

- If the closure is involuntary (DOH-5235), check off "Does not meet Appropriateness" on the DOH-5235, and write "Moved out of New York State" on the line for "Other".
- These types of disenrollments can be voluntary (no forms required) or involuntary (DOH-5235).
- Category: Disenrolled

Note:
There is no disenrollment code for "moved out of NYC" or "moved out of catchment area".
If a member moves out of NYC, but is still in New York State, the Care Manager is expected to transfer the member to a CMA or HH in their new area, unless the member wants to disenroll from Health Home services.

Member Withdrew Consent to Enroll (Code 29)

- Used when the member initiates a voluntary request to disenroll for any reason not covered by a different code.
- If the reason is due to dissatisfaction with services, CMA should first try to problem solve and see if the complaint can be remedied.
- Ask member if they would prefer a different Care Manager, different CMA, or different Health Home.
- Health Home is a voluntary program, members are not required to give us their reason for wanting to disenroll, but it is helpful to find out.
- This disenrollment reason is always voluntary (no forms required)
- Category: Disenrolled

Enrolled Health Home Member Disengaged from Care Management Services (Code 14)

- These disenrollments are only done AFTER the member has been deemed disengaged from care, and CMA has done at least one month but no more than three months of consecutive Diligent Search.
- See Continuity of Care Policy for more details.
- These disenrollments are always involuntary (DOH-5235).
- Category: Disenrolled

Individual has a new CIN (Code 5)

- Used to close one case and open a new one if the member has a new Medicaid CIN.
- Ensure there are transitional notes in the old and new case explaining the closure and CIN change.
- FCM may be able to copy/paste certain portions of the chart into the new chart with the new CIN.
- Ensure other databases, such as UASNY, are updated with the new CIN.
- No forms required
- Category: Administrative Closure

Segment Correction (Code 44)

- Only if directed by NYS DOH in order to correct RE codes/start/end dates.
- No forms required
- Category: Administrative Closure

Member has Graduated from the Health Home Program (code 21)

- Member met their Care Management goals, i.e., can self-manage and monitor their chronic condition(s), or can do so with natural supports.
- If the Graduation is involuntary (DOH-5235), check off “Does not meet Appropriateness” on the DOH 5235.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- Graduations are usually voluntary (no forms required), but occasionally are involuntary (DOH-5235)
- Category: Step Down

Transitioned to MCO or MLTC Care Management (code 47)

- Member’s MCO or MLTC has accepted them into their Care Management program.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- This disenrollment reason is always voluntary (no forms required)
- Category: Step Down

Transitioned to PCMH or Other Health Care Provider Care Management (code 46)

- Member’s Healthcare Provider has accepted them into their Care Management program.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- This disenrollment reason is always voluntary (no forms required)
- Category: Step Down

Transitioned to Standard HHCM (code 49)

- Member moved from the HH+ Level of Care to the Standard HHCM Level of Care
- Only used when the member must transfer CMAs in order to move from HH+ to Standard HHCM.
- A warm handoff should always be attempted.
    - Find out if the member would be interested in a meeting with representatives from both CMAs.
    - If not, ask the member to consent the new CMA, so that the CMAs can have a phone handoff.
    - If member will not give consent for the new CMA, contact CCMP to facilitate sharing of necessary case information.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- This disenrollment reason is always voluntary (no forms required)
- Category: Step Down

Transitioned to ACT Team (code 50)

- Member has been assigned to an ACT Team by the LGU (NYC SPOA).
- A warm handoff should always be attempted.
    - Find out if the member would be interested in a meeting with representatives from the CMA and the ACT Team
    - If not, ask the member to consent the ACT Team, so that the providers can have a phone handoff.
    - If member will not give consent for the ACT Team, contact CCMP to facilitate sharing of necessary case information.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- This disenrollment reason is always voluntary (no forms required)
- Category: Step Up

Transitioned to HH+ for AOT (code 51)

- Member has been assigned to a HH+ for AOT Team by the LGU (NYC SPOA), as reflected on an AOT court order.
- If there is a change in CMA, a warm handoff should always be attempted.
    - Find out if the member would be interested in a meeting with representatives from the CMA and the AOT Team
    - If not, ask the member to consent the AOT Team, so that the providers can have a phone handoff.
    - If member will not give consent for the AOT Team, contact CCMP to facilitate sharing of necessary case information.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- These types of disenrollments can be voluntary (no forms required) or involuntary (5235).
- Category: Step Up

Transitioned to HH+ for HIV (code 52)

- Member was accepted into a HH+ for HIV CMA
- Only used when the member must transfer CMAs in order to move to HH+ for HIV.
- A warm handoff should always be attempted.
    - Find out if the member would be interested in a meeting with representatives from both CMAs.
    - If not, ask the member to consent the new CMA, so that the CMAs can have a phone handoff.
    - If member will not give consent for the new CMA, contact CCMP to facilitate sharing of necessary case information.

- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- This disenrollment reason is always voluntary (no forms required)
- Category: Step Up

Transitioned to HH+ for SMI (code 53)

- Member was accepted into a HH+ for SMI CMA (MH CMA)
- Only used when the member must transfer CMAs in order to move to HH+ for SMI.
- A warm handoff should always be attempted.
    - Find out if the member would be interested in a meeting with representatives from both CMAs.
    - If not, ask the member to consent the new CMA, so that the CMAs can have a phone handoff.
    - If member will not give consent for the new CMA, contact CCMP to facilitate sharing of necessary case information.
- All other standard disenrollment processes must be followed, including notifying Care Team Members, and providing the member with copies of case documents.
- This disenrollment reason is always voluntary (no forms required)
- Category: Step Up

Source:
Member Disenrollment From the Health Home Program Policy #HH0007
MAPP File Specs 3.8 Appendix D

3. Continuity of Care Policy

First Issued: 9/18/15
Revisions Approved by Quality Committee: 7/2/19
Revised Effective: 7/1/19

Purpose:
To outline requirements for what to do when members become disengaged from Care Management services.

Background:
Continuity of Care procedures apply to those members who, after having been engaged and consented, subsequently lose their connection to the Health Home despite documented outreach and team intervention, and the CMA does not know where they are. Consequently, they have not kept scheduled appointments, met with Health Home staff, been available to home or field visits, or been able to work on their Plan of Care goals.

There are many reasons that a member may become disengaged from services, including but not limited to:

- Loss of/change in phone number
- Unexpected move
- Excluded Setting (hospitalization/incarceration)
- Lack of interest in Health Home Care Management
- Ready to graduate from Health Home Care Management

CMAs can work proactively to avoid periods of disengagement through the following strategies:

- Asking members to provide alternate contact information
- Asking homeless members for locations where they can be looked for if they change shelters (park, library, etc.)
- Discussing with members how Care Management is a voluntary service, and how the member can choose to disenroll if they do not want to continue with the services
- Giving members the CMA business card or 24/hour number, asking them to contact the CMA if they are hospitalized, or provide the CMA contact info to hospital personnel.

CMAs should work to understand their members' typical patterns of engagement to be able to identify when each member should be considered to be disengaged.

Ex. Some members never miss scheduled appointments, and always return texts within 24 hours. Others may take up to a week to return a phone call but are always at home for unplanned home visits. A CMA may consider the first member disengaged if a text is not responded to after several days, while the second member might not be considered disengaged unless they haven't returned calls for two weeks, and there is no answer at their home.

The determination of when a member is disengaged is made on a case-by-case basis, based on CMA knowledge of the member, and with supervisory oversight or guidance. CMA's must have a process for supervisory oversight when members are deemed to be disengaged, and throughout the Diligent Search months.

Policy:
If an enrolled member is unable to be reached during a month, at a level beyond their typical pattern of engagement, the member is deemed to be disengaged, and the CMA begins Diligent Search Activities for at least one but no more than three consecutive months:

Procedure:
1. Once the member is deemed to be disengaged, the CMA pends the enrolled segment in FCM, with a Pend Reason of "Diligent Search.
   1.1. The segment is pended for the first of the month in which the CMA deemed the member to be disengaged.
   1.2. The pended segment will have an automatic end date three months from the start of the pended segment, with an End Reason Code of Code 14: Enrolled Health Home Member Disengaged from Services, this automatically ends the segment in MAPP.
   1.3. The segment will close automatically without intervention from the CMA or CCMP.
   1.4. Unlike other pend reasons, when a segment is pended for Diligent Search enrollment rate claims can still be billed.
   1.5. During the pended segment, there are no DOH CES Tools due, and there are no billing blocks associated with overdue Plans of Care, DOH CES Tools, etc.

2. Diligent Search Activities start as soon as possible after the member has been deemed to be disengaged, but within no more than five business days.
   2.1. A minimum of three different Diligent Search Activities on three different days must be conducted each month to locate and re-engage the member.

3. During the first month of Diligent Search the CMA must notify the Health Home and MCO that the member is disengaged and in Diligent Search. This is considered one of the Diligent Search Activities.
   3.1. Submission of the Diligent Search Billing Support Questionnaire is sufficient notification for CCMP. CCMP recommends that Billing Support Questionnaires are submitted by the end of the first week of the following month. CMAs that submit beyond this timeframe could encounter problems with timely claims submission requirements from MCOs.
   3.2. MCOs may have their own timeframes and preferences for how they would like to be notified, see the MCTAC Matrix New York County for up-to-date MCO contact information.
   3.3. Notification to the MCO must be documented within the FCM encounter notes and can only happen if the MCO is consented on the DOH-5055 or the CMA has a BAA with the MCO; if there is no consent or BAA, contact CCMP for assistance with the notification.

4. Approved Diligent Search Activities are:
    - Notification to the HH/MCO of member Disengagement (required in Month 1)
    - Attempted face to face visit with the member
    - Phone contact with consented providers
    - Contacting consented friends, families, and other unpaid supports
    - Contacting consented government agencies (Department of Homeless Services, H+H-Correctional Health Services, Division of Probation or Parole, Administration for Children's Services, Adult Protective Services)
    - Contacting the Office of the Chief Medical Examiner *(OCME)*
    - Online research (Webcrims, Inmate Lookup)
    - Reviewing hospital alerts, RHIO, and PSYCKES
    - Others, appropriate to the member and to support search efforts

5. Formal notification to the member's Care Team (other than the MCO in Month One) is not required to bill for Diligent Search, however, engagement of available and appropriate resources, including Care Team Members, should be evident in the Diligent Search Activities.

6. To trigger billing for Diligent Search in FCM, the member's Billing Support Questionnaire is completed with the selection of: Core Service: Yes (Diligent Search)
    6.1. The segment must have been pended for Diligent Search prior to submitting the Billing Support Questionnaire.
    6.2. If a member is disengaged and pended for Diligent Search, but billable Diligent Search activities were not done, the member's Billing Support Questionnaire is completed with the selection of "Core Service: No".
    6.3. While a disengaged member's segment is pended for Diligent Search, there is no option to select "Core Service: Yes", i.e., the only service that is billable is Diligent Search.
    6.4. Members may be billed for Diligent Search for no more than three consecutive months.

7. Diligent Search ends when the member is located, or after three consecutive months of Diligent Search.
    7.1. CMAs can choose to end Diligent Search early, after only one or two months. A common reason for this is if all possible Diligent Search activities have been exhausted.
    7.2. Reason for ending Diligent Search after fewer than three consecutive months must be evident in the Disenrollment note.

8. If the member is located within the same month that the segment was pended:
    - Delete the pended segment.
    - Edit the previous enrolled segment and remove the end date and end date reason code.
    - If, upon location of the member, the member is appropriate for disenrollment, follow the Disenrollment Policy.

- If, upon location of the member, the member is re-engaged, follow the Re-Engagement Policy

9. If the member is located one or more months after the month in which the segment was pended:
   - Close the pended segment as of the last day of the previous month.
   - If, upon location of the member, the member is appropriate for disenrollment, follow the Disenrollment Policy.
   - If, upon location of the member, the member is re-engaged, use the End Reason Code of "Member Re-engaged" (Code-45), open a new enrollment segment starting on the first day of the month in which the member was re-engaged, and follow the Re-Engagement Policy.

10. Members may enter Diligent Search and be Re-engaged multiple times over the course of the enrolled segment.

11. Regardless of whether a segment is ended automatically by FCM after three consecutive months of Diligent Search, or ended by the CMA, the Care Manager must follow all other requirements for disenrolling case.

Sources:
DOH Policy #HH0006 Continuity of Care and Re-engagement for Enrolled Health Home Members
DOH Policy #HH0007 Member Disenrollment from the Health Home Program
DOH Policy #HH0009 Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents

4. Re-Engagement Policy

First Issued: 8/4/15
Revisions Approved by Quality Committee: 7/2/19
Revised Effective: 7/1/19

Purpose:
To outline requirements regarding what to do when a previously disengaged member is found, with a goal of retaining members in care and preventing future disengagements. Although this policy applies to members who were designated as "disengaged" and subsequently located, the general principles of a Re-engagement conversation may also be useful with members who are loosely engaged in services, or members who are being considered for re-enrollment in the Health Home program.

Policy:
When a Care Manager locates a disengaged member, the Care Manager has a Re-engagement conversation with the member. The goals of this conversation are:

- Determine the reason for the Disengagement
- Determine if the case is appropriate for Disenrollment, or if Care Management services should resume.

Procedure:

1. Upon locating a previously disengaged member, Diligent Search Activities cease, and Disenrollment or Re-engagement occurs as appropriate.

2. The Care Manager determines the reason for Disengagement. The Care Manager may determine this from a variety of sources, including the member, the Care Team, or other outside resources.

3. If the case is appropriate for Disenrollment, follow the Disenrollment Policy. Common reasons a member is appropriate for Disenrollment after being Disengaged from care are:
   - Member is deceased
   - Member is located in an excluded setting and will not return to the community within six months
   - Member is not interested in receiving Health Home Care Management services (this must be confirmed by the member).
   - Member is no longer eligible for Health Home Care Management

4. If the case is not appropriate for Disenrollment, Care Manager continues the Re-engagement conversation with the member, and if applicable, members of their Care Team.

5. Re-engagement conversations, may also be referred to as "Level Setting" or "Re-Contracting", and should include the following elements:

- Confirm the reason for disengagement.
- If disengagement was due to a complaint about Health Home Care Management services, address the complaint per the Member Rights and Complaint Management Policy.
- Confirm that the member understands the purpose and framework of Health Home Care Management, and wants to continue with the services, either with the current CMA or a different CMA/HH.
- Discuss ways to prevent disengagement in the future
- Assess for Appropriateness[39], any new risk factors, new needs, new Care Team members, and/or updates to the Plan of Care.
- Update demographic information, consents, assessments, and Plan of Care in FCM[40], if indicated.
- Notify Care Team members of Re-engagement, including any updates to the Plan of Care.
- Resume Health Home Care Management services, ideally with the same Care Manager.

6. Re-engagement conversations are documented in FCM Encounter notes. CMAs may also choose to use a Re-engagement Form to structure the conversation for their staff. CCMP has a Re-Engagement Form that CMAs can use or customize if they would like to include this in their workflow.

7. If the member is located within the same month that the segment was pended:
   - Delete the pended segment.
   - Edit the previous enrolled segment and remove the end date and end date reason code.

8. If the member is located one or more months after the month in which the segment was pended:
   - Close the pended segment as of the last day of the previous month, using the End Reason Code of "Member Re-engaged" (Code-45)
   - Open a new enrollment segment starting on the first day of the month in which the member was re-engaged.

9. For the month wherein the member is located and re-engaged into care, the member's Billing Support Questionnaire is completed with the selection of: Core Service: Yes.

Sources:
DOH Policy #HH0006 Continuity of Care and Re-engagement for Enrolled Health Home Members
DOH Policy #HH0007 Member Disenrollment from the Health Home Program

[39] Initial Appropriateness must be documented on the segment screen in FCM within 30 days of the new Enrolled segment. The next DOH Continued Appropriateness for Services Tool is due 12 months from the new Enrolled segment.
[40] Plan of Care must be signed by the member within 60 days of the new Enrolled segment

vi.SUPPORTING MATERIALS

A. Supplemental Resource Links

DOH Health Home Basics

DOH Health Home Policies

DOH Authorization for Release and Complaint Forms

First Episode Psychosis

First Episode Psychosis Program Directory

On Track NY- Resources for First Episode Psychosis

Advanced Directives and End of Life Planning

Children's Palliative Hub-Resources

Five Wishes- Advanced Directive Document

Hello Game (Home Edition) - Common Practice End of Life Conversation Game

Specific Advance Directives – End of Life Choices New York

Psychiatric Advance Directives – NYC Well

Smoking Cessation

Get Help Quitting - New York State Department of Health

Center for Practice Innovations Tobacco Cessation Curriculum for Practitioners

Self-Help Recovery Resources

CRAFT-SMART Recovery- How to Help a Loved One Find Addiction Recovery

WRAP is - Wellness Recovery Action Plan

Chronic Conditions

Hypertension- Michigan Care Management Resource Center

Diabetes- Michigan Care Management Resource Center

Asthma- Michigan Care Management Resource Center

Complaints and Reporting

NYS Justice Center/Vulnerable Persons Central Registry

NYS Adult Care Facilities/Assisted Living Complaints

NYS Nursing Home Complaint Hotline

The Statewide Central Register of Child Abuse and Maltreatment

CCMP Resources

CCMP COVID-19 Resource Guide

CCMP Support Page-FCM

CCMP Health Home Website

B. CCMP Quality Committee Charter

Updated: 10/10/23

Reviewed by Quality Committee: 10/10/23

I. Authority:

The Committee will be called the CCMP Quality Committee. It is authorized by the Community Care Management Partners (CCMP) Board of Governors.

II. Purpose:

The committee is responsible for advising the CCMP Health Home regarding the development and implementation of policies and best practices that guide the provision of service by CCMP Care Management Agencies (CMA). The committee recommends policies and best practices that establish the required and expected standards for care management intervention built upon the regulatory frameworks established and enforced by the New York State Department of Health, the New York State Office of Mental Health, the New York State AIDS Institute, and the Managed Care Organizations which reimburse for Care Management services. The guiding principles driving the committee's recommendations are person-centered care, mitigation of barriers to wellbeing related to the social determinants of health, and increased adherence to recommendations for primary, behavioral, and pharmacy health services. The Quality Committee is also a venue for CCMP staff to communicate about changes in state policy and network performance.

III. Relationship of Quality Committee to the CCMP Staff, Board of Governors, and other Committees:

The Quality Committee is a venue to which representatives of CCMP CMAs are invited to provide advice, counsel and technical support to the staff of CCMP regarding the development of policies which define the quality and performance requirements of CMAs. In turn, CCMP staff integrates CMA feedback into its work-product(s). The committee provides ongoing feedback on the successes and challenges of the implementation of CCMP policies as they impact the procedures and workflows of CMAs. Iterative feedback between CCMP administration, CCMP CMAs, CCMP's IT vendor, the Children's Committee, and the Operations Committee are integral to the development of CCMP policies.

IV. Membership

The Quality Committee is chaired by the CCMP Chief Policy and Compliance Officer or designee. Additional composition includes:

CCMP staff including but not limited to the Chief Executive Officer and Operations staff

Representatives of all active CCMP Care Management Agencies.

V. Logistics:

The committee will meet at least 10 times per year. CMA members subscribe to the "Quality Committee" group in Mailchimp and are then included on the monthly meeting invitation. The meeting slide deck, materials, and previous meeting's minutes are shared via email prior to each meeting. Minutes of each meeting will be taken by CCMP staff and maintained in CCMP files.

C. CCMP Grievance Form

Community Care Management Partners
HEALTH HOME

CCMP Grievance Form

Grievance Information

Please Describe the Grievance:

How would you like this Grievance to be resolved?

Member information

Name ____ CIN ____

CMA ____ FCM Case-link (if applicable) ____

Signature ____ Date ____

Information of anyone who helped member complete the form (if applicable)

Name ____ Relationship to member ____

Signature ____ Date ____

This is a screenshot of the first page of the form, the full document is available to CMAs here.

D. CCMP Member Rights and Responsibilities Form

CCMP Network Member Rights and Responsibilities

1. Receipt of information, if requested, from any CMA about ownership and control.
2. Receipt of information, if requested, from any CMA, about the organization's grievance procedures which include contact names, phone numbers, hours of operation and how to communicate problems.
3. Information about services/products and equipment available directly or by contract.
4. Information about names and responsibilities of the staff that will provide care and the proposed frequency of visits/service.
5. Participate in the plan for care and/or any change in the plan before it is made.
6. Receive information about the scope of services that will be provided and specific limitations on those services.
7. Receive services without regard to race, creed, gender, age, handicap, national origin, sexual orientation, veteran status, or lifestyle.
8. Refuse care or treatment and explore alternative health care options after learning the potential results and/or risks.
9. Be free from mistreatment, neglect or verbal, mental, sexual, and physical abuse, including injuries of unknown source.
10. Be free from misappropriation of property.
11. Be treated with consideration, respect and full recognition of individuality and dignity.
12. Receive service without regard to whether any advance directive has been executed.
13. Make independent informed decisions about care and treatment plans and to receive information in a way that is understandable.
14. Be notified in advance of treatment options, transfers of care to other programs, when and why care would be discontinued.
15. Receive adequate, appropriate, and timely services.
16. Education, instruction, and recommendations for continuing care if the services of the Health Home program are discontinued.
17. Participate in the selection of options for alternative levels of care or referral to other organizations, as indicated by the need for continuing care.
18. Receive disclosure information regarding any beneficial relationships the organization has that may result in profit for the referring organization.
19. Be referred to another agency if the CMA is unable to meet member needs or if there is dissatisfaction with the care received.
20. Be advised of the availability, purpose and appropriate use of State and Medicaid hotline numbers.
21. Express complaints free from interference, coercion, discrimination or reprisal to staff at any organization within the Health Home network, the New York State Department of Health, or any outside representative of the member's choice.
22. Receive a written response from the agency regarding investigation and resolution of a complaint about the care and services provided including notification that if not satisfied by the response, a complaint to the Department of Health's Office of Health Systems Management may be made.
23. Appeal a grievance. A grievance appeal is a continuation of the complaint process that offers a second level of recourse to the member. It begins when a member expresses dissatisfaction with the disposition of a complaint or if the complaint is not resolved within the specified period.
24. Not to participate in or receive any experimental research or treatment without specific agreement and full understanding.
25. Have a confidential clinical record.
26. Information regarding the organization's liability insurance upon request.

If a member has a complaint about the Health Home services they receive from their CMA, or feels their rights have been violated, they should first file a complaint with their CMA.

How to file a complaint with my CMA:

1

This is a screenshot of the first page of the form, the full document is available to CMAs here.

A. Attestation of SCR, SEL, and CHRC Clearances

Community
Care Management
Partners
HEALTH HOME

CCMP CMA Attestation of SCR, SEL, and CHRC Clearances

To be used instead of submitting copies of clearance results directly to CCMP

Clear

Form fields fo

This document

Don't show a

Employee Name	Date of Hire	SCR Date	SEL Date	CHRC Date

New York State Department of Health requires Health Home Care Managers working with individuals under age 21 to receive a Criminal History Record Check (CHRC), Staff Exclusion List (SEL) check, and a Statewide Central Register (SCR) Database check prior to hire.

By signing this form I am attesting that all of the information contained herein is accurate. My signature verifies that all of the Health Home Care Managers working with members under age 21 employed by our organization (listed above) meet the clearance requirements as determined by the New York State Department of Health.

HR Representative Name/Signature/Date

CMA Representative Name/Signature/Date

This is a screenshot of the form, the full document is available to CMAs here.

B. Attestation of Qualifications for HARP and HH+ for SMI

Community Care Management Partners
HEALTH HOME

CCMP CMA Attestation of Qualifications for HARP and HH+ for SMI

To be used instead of submitting copies of resumes/waivers directly to CCMP

Name of Employee	Is staff doing HARP, HH+ for SMI, or both?	Harp Assessor/HH+ for SMI Qualified	HARP/HH+ Supervisor Qualified	Qualifies with resume or OMH waiver?

New York State Department of Health and the Office of Mental Health require Health Home Care Managers working with HH+ for SMI members, conducting HCBS Eligibility Assessments, and their supervisors to meet separate qualification standards, evidenced by experience and education on a resume or an OMH Waiver.

By signing this form I am attesting that all of the information contained herein is accurate. My signature verifies that all of the case management staff providing/supervising HARP/HH+ for SMI services meet the qualifications requirements as determined by the New York State Department of Health and OMH.

HR Representative Name/Signature/Date

CMA Representative Name/Signature/Date

This is a screenshot of the form, the full document is available to CMAs here.

C. Attestation of Qualifications for HH+ for HIV

Community Care Management Partners
HEALTH HOME

CCMP CMA Attestation of Qualifications for HH+ for HIV

To be used instead of submitting copies of resumes/waivers directly to CCMP

Name of Employee	Current Role	Navigator/Community Health Worker/Peer Qualified?	Care Manager/Coordinator Qualified?	Care Management Supervisor Qualified?

New York State Department of Health and the AIDS Institute require Health Home Care Managers, Supervisors, and Paraprofessional staff working with HH+ for HIV members, to meet separate qualification standards, evidenced by experience and education on a resume.

By signing this form I am attesting that all of the information contained herein is accurate. My signature verifies that all of the staff providing/supervising HH+ for HIV services meet the qualifications requirements as determined by the New York State Department of Health and the AIDS Institute.

HR Representative Name/Signature/Date

CMA Representative Name/Signature/Date

This is a screenshot of the form, the full document is available to CMAs here

D. CCMP Adult Health Home Referral Form

COMMUNITY CARE MANAGEMENT PARTNERS HEALTH HOME

Health Home Referral Form

Send via Encrypted Email: Referrals@ccmphealthhome.org

Section A: Member Demographics

Last Name: ____ First Name: ____

DOB: ____ HARP: Yes ◯ No ◯ CIN# ____

Gender: ◯ Male ◯ Female ◯ Other Preferred Language: ____

Primary Phone Number: ____ ☐Home ☐Cell ☐ Other: ____

Address: ____

Type of Residence:

☐ Private Residence (alone or with spouse/partner, parent, child, or other family)

☐ Homeless (street, park, drop-in center, or other undomiciled) ☐ Supportive Housing

☐ Homeless Shelter or Emergency Housing ☐ Other: ____

Section B: Referral Information

Referral Source:

◯ Family ◯ Self ◯ MCO ◯ Hospital: ______________ ◯ Other: ____

Referring Agency/Program/Facility: ____

Referring Worker's Name: ____

Referrer's Phone Number/Email: ____

Section C: Eligibility

Medicaid Eligibility: ◯ Medicaid FFS ◯ Medicaid Managed Care:

Referrals must have EITHER two or more chronic conditions OR one single qualifying condition.
If member has SMI or HIV, indicate whether the member is Health Home Plus eligible.

◉ Two or more chronic conditions:

☐ Mental Health Condition (non-SMI)

☐ Substance Use Disorder

☐ Asthma ☐ Diabetes

☐ Heart Disease ☐ BMI >25

☐ Other Chronic Conditions: ____

◯ Single qualifying condition

HIV / AIDS

Not HH+ for HIV Eligible to my knowledge

Serious Mental Illness

Not HH+ for SMI Eligible to my knowledge

Additional Comments/Notes:

____

This is a screenshot of the first page of the form, the full document is available to CMAs here.

E. CCMP JOINT HH+ Screening and Documentation of Eligibility (SMI/HIV)

Members Name	CIN #	Date of Eligibility Determination	If the member is placed on a HH+ caseload, enter the date eligibility will Expire	Staff Approving Determination

By marking, "Yes" to any question below, you are indicating that the corroborating documentation required by NYS DOH Health Home policies, is in the member's record in FCM at the time of this review.

Diagnosis	Yes	No
HIV+ (human immunodeficiency virus)	◯	◯

Diagnosis	Yes	No
Serious Mental Illness	◯	◯

- If the answer is "No" to both HIV+ and SMI diagnoses, this member is NOT HH+ eligible. **Stop here**.
- If the answer is "Yes" to either, continue to the corresponding diagnosis below.

DO THEY ALSO HAVE CURRENT?	Yes	No
Viral load greater than 200 copies/mL	◯	◯

- If the answer is "Yes" to the above section, the member is eligible for HH+ HIV. **Stop here.**
- If the answer is "No" to the above section, continue below.

DO THEY ALSO HAVE CURRENT?	Yes	No
SMI diagnosis	◯	◯
IV Drug Use (IVDU)	◯	◯

If both answers are "No" to the above section, the member is not HH+ HIV Eligible.
Stop here.
If either answer is "Yes" to the above section, continue below.

Within the last 12 months…	Yes	No
3+ inpatient hospitalizations NOTE: Substance use inpatient only qualifies under IVDU not SMI	◯	◯
4+ ER visits NOTE: Substance use ED visits only qualify under IVDU not SMI	◯	◯

DO THEY ALSO HAVE CURRENT?	Yes	No
HUD Category 1 Homelessness	◯	◯
HH+ High Need Population in PSYCKES (also visible in FCM Patient Overview) **Enter Flag description:**	◯	◯

- If either answer is "Yes" to the above section, the member is eligible for HH+ SMI. **Stop here.**
- If both answers are "No" to the above section, continue below.

Within the last 12 months…	Yes	No
Discharged from ACT	◯	◯
AOT Court order expired	◯	◯
Discharged from State or Forensic Psychiatric Center	◯	◯
2+ mental health inpatient hospitalization AND No outpatient mental health	◯	◯
3+ mental health inpatient hospitalization	◯	◯
3+ mental health ER visits AND No outpatient mental health services	◯	◯
3+ medical inpatient hospitalizations AND diagnosis of schizophrenia or bipolar disorder	◯	◯
4+ mental health ER visits	◯	◯

- If any answer is "Yes" to the above section, the member is eligible for HH+ eligible. **Stop here.**
- If the answers are all "No" to the above section, and the CMA feels there is a compelling need for the HH+ level of care, you may request Clinical Discretion approval for HH+ and document any approvals below:

Clinical Discretion Approval Obtained?	Yes	No
MCO Discretion for HH+ HIV	◯	◯
Medical (HIV) Provider for HH+ HIV	◯	◯

Clinical Discretion Approval Obtained?	Yes	No
MCO Clinical Discretion for HH+ SMI	◯	◯
SPOA Clinical Discretion for HH+ SMI	◯	◯

This is a screenshot of the form, the full document is available to CMAs here.

F. Additional Guidance on Clinical Discretion

Issued: 9/14/21

As described in the HH+ for SMI and HH+ for HIV policies, one eligibility category for both populations is "MCO Clinical Discretion". HH+ for SMI also allows for "SPOA Clinical Discretion", and HH+ for HIV allows for "Medical Provider Clinical Discretion".

This means that if a CMA has a member that has SMI and they feel the member needs the HH+ level of care, but doesn't qualify under the other eligibility categories, the CMA can ask the MCO or the local SPOA to designate the member as HH+ for SMI eligible, at the MCO/SPOA's discretion.

Similarly, if a CMA has a member that has HIV and they feel the member needs the HH+ level of care, but doesn't qualify under the other eligibility categories, the CMA can the MCO or medical provider to designate the member as HH+ for HIV eligible, at the MCO/provider's discretion.

OMH and the AIDS Institute did not grant CMAs the ability to use clinical discretion when determining HH+ eligibility, nor did they grant it to Health Homes. They granted clinical discretion powers solely to MCOs (SMI/HIV), SPOA (SMI), and Medical Providers (HIV).

What types of members should we try to get Clinical Discretion for?

Because it is at the "discretion" of the MCOs/SPOA/PCP, there is no set list, but CCMP's general recommendation would be those members that have HIV or SMI, you think **NEED** the HH+ level of care, and:

- are "close" to the standard eligibility categories, or
- are on an ACT Waitlist, or
- are requesting a higher frequency of contact (or their care team is), or
- to whom you have already been providing a higher frequency of contact, or
- are significantly overusing/misusing the healthcare system.

MCO Clinical Discretion

For various reasons, some MCOs have not yet fully engaged in the Clinical Discretion process. Each MCO has provided different answers to CCMP and our network CMAs when asked about granting Clinical Discretion for HH+. Some example responses from MCOs are:

We don't need to give a clinical discretion for a client to be enrolled in HH+. Health Home lead and CMA should make the determination and that should be enough. [We] will just support the decision.

If [a] member is assessed, and the CMA feels that HH+ is the correct level of care to meet their needs then they should submit HH+ claims and we will pay them. We have no formal approval process in place, so we have no way to provide anything in writing.

We are waiting for DOH and OMH to provide more explicit guidance on how to operationalize "Clinical Discretion".

You need to talk to the Health Home to get Clinical Discretion.

To help our CMAs navigate this world where some MCO's are not necessarily implementing the HH+ policies as designed by OMH and the AIDS Institute, these are CCMPs recommendations:

- Use the CCMP JOINT HH+ Screening and Documentation of Eligibility Form (HIV/SMI) to find out if a member that needs a higher level of care might qualify for HH+ under a standard eligibility category.
- Do not rely solely on PSYCKES flags; there are other eligibility categories not captured in PSYCKES, such as recent incarceration, homelessness, IV drug use, etc.
- Make a clear tally of all psych INP, med INP, psych ED, and med ED visits in the last 12 months. Use PSYCKES, clinical event notifications, and keyword searching in the encounter notes to get a full list.

If the member still does not meet any of the standard eligibility categories, identify if they are *close* to meeting eligibility.

Examples:

A member with SMI who has had 2+ psych INP visits in the last 12 months and has been disconnected from outpatient mental health care for the last 10 months. This person will be eligible for HH+ for SMI two months from now, assuming they don't go to a mental health clinic between now and then. This person is very close to being eligible for HH+, and you could make a strong argument that they should get HH+.

A member with HIV who does not have SMI or IV drug use, but is homeless, and whose viral load is unknown because they will not engage in medical care, and who you suspect has a high viral load due to mouth ulcer, fatigue, night sweats, etc. This member would be eligible for HH+ for HIV if they had an SMI or used IV drugs, but they don't. They would be eligible for HH+ for HIV if you could get them to take a blood test, but you can't. You could make a strong argument that providing the HH+ level of care is the best way to get this person into medical care to get their viral load checked. You can't request Clinical Discretion from a medical provider because the member won't see a medical provider. The MCO is the best route to Clinical Discretion.

A member with SMI who has had 3 psych ED and 2 psych inpatient visits in the last year. The member also has had 7 medical ED visits in the last two months. If they have just one more psych ED, or 1 more psych inpatient visit, they will be eligible for HH+ for SMI, but you have noticed that the member has stopped telling hospital staff about their mental health symptoms and is presenting repeatedly to the ER complaining only of somatic problems. Medical ED visits don't "count" towards HH+ for SMI eligibility, but you believe they are fundamentally due to the SMI condition, and that the member needs a higher level of care now, rather than try to wait for an ED visit to get classified as psych.

Consult the CCMP "MCO Survey on Clinical Discretion" spreadsheet, to see if the member's MCO has a process in place for Clinical Discretion Requests already. If they do, follow their process.

If the MCO doesn't have a process for Clinical Discretion Requests yet, contact the member's MCO and - discuss the members current needs and level of care.

You should already have a direct number to the assigned MCO Care Manager, but if you don't, use the MCTAC Matrix to find the best person to speak with. If the member is HARP Enrolled, look for the HARP or Behavioral Health contact number on the Matrix, if they are not HARP look for the Case Management contact. Do not call a random 1-800 number, unless that is the explicit direction on the MCTAC Matrix.

Document your request(s) to discuss HH+ Clinical Discretion, and the result of the discussion clearly in FCM. The full name, title, and contact information of the MCO staff should be in the note.

Explain to the MCO representative why you think the member needs to be seen at the HH+ level of care, why they do not meet one of the standard eligibility categories, and (if it is a timeframe issue), when you expect them to meet a standard eligibility category (e.g., at the next psych admission, or if they don't go to a mental health clinic in the next month, etc.).

If you have already been serving the member at the HH+ level of care, in response to their high level of need, say that. If the member (or their care team) has been asking for a higher frequency of contact that you cannot give because they are not in HH+, say that.

Remind the MCO representative that per the OMH (SMI) or AIDS Institute (HIV) HH+ policy the MCO can provide Clinical Discretion for HH+, and you are formally requesting MCO Clinical Discretion. Offer to put the request in writing if they would like.

Document very clearly what their response is. Do not use passive voice in your notes. It is no help to read, "HH+ was discussed" or "HH+ was recommended", or "HH+ was not advised at this time". Who said what to whom?

If the MCO denies the specific request, or tells you that they are not able to provide Clinical Discretion in general, or they are waiting for guidance from the state, or you should talk to the Health Home, or to do whatever you think is best, or anything that is not a clear "yes" or "no", and you would like CCMP to assist you with the matter, email us the link to the note, and we will review the case.

There is no formal "appeal" process; CCMP cannot override an MCO's decision if they deny a specific request, but we can often help you to make a stronger case, or to find other resources to help the member. If the MCO gives a "non-decision", we can also flag these cases to OMH and the AIDS Institute and encourage them to enforce their policies with the MCOs.

SPOA Clinical Discretion
For HH+ for SMI cases, CMAs must follow the process designed by their local SPOA. The majority of CCMP CMAs are based in NYC and will need to work with NYC SPOA.
For NYC SPOA, there is a Clinical Discretion Request form you must use.

This form, and all communication about these requests, should go to Daria Rosa at NYC SPOA (encrypted email to drosa1@health.nyc.gov with a cc to spoa@health.nyc.gov)

The form asks for the member's "SPOA Maven ID", you can put "n/a" in this field.

Document this email request and any response you get clearly in the chart.

There is no formal "appeal" process; CCMP cannot override SPOA's decision if they deny a specific request, but we can often help you to make a stronger case, or to find other resources to help the member.

Medical Provider Clinical Discretion
For HH+ for HIV cases, CMAs can request Clinical Discretion from a member's Medical Provider. This was designed for the Infectious Disease specialist, or HIV PCPs treating the population, but technically it can come from any of the member's medical providers.

Medical Providers are unlikely to know anything about HH+ for HIV, or their role in providing clinical discretion. If you have a provider you work with on a lot of cases, it may make sense to explain the program in detail and help them implement their role formally.

Example: Your CMA has 50 members who all go to the same Infectious Disease Clinic for HIV treatment. You have developed strong relationships with the RNs, SWs, and MDs at the clinic. You share the HH+ for HIV policy with them and help them design a form they will use (on their letterhead) to request/approve Clinical Discretion for HH+ for HIV.

For other providers who are less involved with you, you could take a much more informal approach.
Example: You have a member who sees a PCP for their HIV treatment, it is a small and busy medical practice, and the doctor rarely has time to talk with you over the phone. You could accompany the member to an appointment and say to the doctor, "I'm not sure if you know, but I normally see John Doe one time a month. We have a more intensive program model for people with HIV who are high risk, where we see them 4 times a month. John doesn't quite qualify right now but I heard you telling him that you are worried about his drug use and unstable housing leading to trouble staying on his medications. If you would like him to be moved into the more intensive program, he can qualify based on his PCP's request. What do you think?

Reach out to the medical provider in the way that makes the most sense for this provider and your member. This could be email, phone, letter, or in person. It may make sense to talk with the clinic's social worker or RN rather than the MD, if the MD is not available.

Explain the program and the reason you think the member needs a higher level of services (ideally using things that the provider has recognized too….).

Ask if the provider would be willing to recommend HH+ level of care for this member.

The recommendation does not have to be in writing, although that is always ideal.

Document clearly in your Encounter notes all requests and responses for clinical discretion. If the provider makes the request during a phone call, and you document it in an Encounter note, you can upload that note as proof of Clinical Discretion Eligibility.

G. CCMP HARP Brochure

Health and Recovery Plan (HARP)

You Are Already Enrolled in a HARP Plan!

HARPs have the same benefits that are in regular Medicaid health plans. Plus HARPs cover extra benefits and specialized support so you can get the best possible results from your care.

You do not have to change any of your healthcare providers!

You have access to more services (HCBS and CORE)!

HARP Plan:

MCO HARP Care Manager:

Health Home: CCMP Health Home

Care Management Agency:

Health Home Care Manager:

Home and Community Based Services (HCBS)

Let your Health Home Care Manager know if you are interested in a referral to any of the HCBS services below:

HCBS Services (7 services)

- Habilitation/residential support services
- Non-medical transportation for needed community services
- Education support services
- Pre-vocational services
- Transitional employment
- Intensive support employment (ISE)
- Ongoing supported employment

IF MEMBER IS INTERESTED IN ANY HCBS SERVICES ABOVE:

-HCBS Eligibility Assessment
-Update POC with HCBS Requirements - LOSD
-Refer to HCBS
-Update POC with F/S/D

Community Oriented Empowerment Services (CORE)

Let your Health Home Care Manager know if you are interested in a referral to any of the CORE services below:

CORE Services (4 services)

- Psychosocial rehabilitation
- Peer support
- Family Support and Training
- Community Psychiatric Support and Treatment

IF MEMBER IS INTERESTED IN ANY CORE SERVICES ABOVE:

- CORE Referral Form (as required by CORE Provider)

Community Care Management Partners HEALTH HOME

This is a screenshot of the brochure, the full document is available to CMAs here.

H. Template Welcome/Enrollment Letter

Community Care Management Partners HEALTH HOME

Insert CMA Logo here

Click here to enter a date.

Dear Click here to enter member name,

You have been enrolled into the CCMP Health Home effective Click here to enter a date..

Click here to enter text. is the Care Management Agency (CMA) within CCMP's provider network, that will be providing you with Health Home Care Management services.

A Care Manager from Click here to enter text. will call you soon to schedule your first visit, and complete a Comprehensive Assessment and Care Plan.

If you have any questions or concerns you may contact Click here to enter text. at Click here to enter text.

You can also contact CCMP Health Home at (212) 609-1785.

For 24/7 crisis support you contact Click here to enter text. at Click here to enter text.

In an emergency, please contact 911.

Sincerely,

Click here to enter text.

This is a screenshot of the letter, the full document is available to CMAs here.

I. Comprehensive Assessment Crosswalk with FCM

DOH Comprehensive Assessment Policy Data Requirements

• Identification Information	• Self-management skills and functional ability (thinking and planning, social ability/coping skills, activity/interests)
• Verification of Eligibility and Appropriateness for Health Home Services	• Strengths, support systems, and resources
• Screening tool for high-risk behavior	• Service needs being met already
• Description of Medical Health	• Service needs needing referral
• Description of Mental Health	• Gaps in Care (*on FCM Gaps in Care tab*)
• Description of Substance Use	• Barriers to service access
• Description of Psychosocial Conditions and needs	• Risk factors relating to HIV/AIDS, harm to self/others, use of substances, food instabilities, and housing instabilities.
• Assessment of Social Determinants of Health (lifestyle behaviors, social environment, health literacy, communication skills, care coordination needs such as entitlement and benefit eligibility/recertification)	• HCBS Assessment/Referral status for HARP/SNP members

FCM Category	DOH Assessment Requirement Met	FCM Category	DOH Assessment Requirement Met
Demographics	Identification Information	**Family**	Description of Psychosocial Conditions and needs Assessment of Social Determinants of Health Support systems Service needs being met already Service needs needing referral
Medical	Description of medical health Service needs being met already Service needs needing referral	**Legal**	Description of Psychosocial Conditions and needs Assessment of Social Determinants of Health Service needs being met already Service needs needing referral
Mental Health	Description of mental health Screening tool for high-risk behavior (PHQ-2 and PHQ-9) Service needs being met already Service needs needing referral	**Activities of Daily Living**	Description of Psychosocial Conditions and needs Assessment of Social Determinants of Health Self-management skills and functional ability Service needs being met already Service needs needing referral
Substance Use	Description of substance use Screening tool for high-risk behavior (AUDIT and DAST) Service needs being met already Service needs needing referral Risk factors relating to use of substances.	**Education & Employment**	Description of Psychosocial Conditions and needs Assessment of Social Determinants of Health Resources Service needs being met already Service needs needing referral
Housing	Description of Psychosocial Conditions and needs Assessment of Social Determinants of Health Service needs being met already Service needs needing referral Risk Factors relating to housing instabilities.	**Risk Assessment**	Description of Psychosocial Conditions and needs Risk factors relating to HIV/AIDS, harm to self/others
Income & Entitlements	Description of Psychosocial Conditions and needs Assessment of Social Determinants of Health Service needs being met already Service needs needing referral Risk factor relating to food instabilities.	**HCBS** **HCBS-CORE Tab**	Status of HCBS Assessment Use of HCBS Plan for HCBS Engagement/Assessment
Initial Appropriateness (segment screen),	Verification of appropriateness	**Background Tab/POC/Overview**	Verification of eligibility
Continued Eligibility for Services Tool	Verification appropriateness	**Background Tab/POC**	Strengths, support systems, and resources Barriers to service access
Intake/Enrollment Note/Form	Verification of eligibility and appropriateness	**Summary**	Service needs being met already Service needs needing referral

J. Examples of Core Health Home Services & Activities

CORE HEALTH HOME SERVICES	EXAMPLES OF CORE HEALTH HOME SERVICES INTERVENTIONS/ACTIVITIES
Comprehensive Care Management	Complete a comprehensive health assessment/reassessment inclusive of medical/behavioral /rehabilitative and long-term care and social service need
	Complete/revise an individualized member centered plan of care with the member to identify member's needs/ goals and include family members and other social supports as appropriate.
	Consult with Care Team on member's care plan/needs/goals.
	Consult with primary care physician and/or any specialists involved in the treatment plan.
	Conduct member outreach and engagement activities to assess on-going emerging needs and to promote continuity of care & improved health outcomes. *(only billable during Enrolled Segment-Pended for **Diligent Search**)*
	Prepare member crisis intervention plan.
Care Coordination & Health Promotion	Coordinate with Care Team and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.
	Link/refer member to needed services to support care plan/treatment goals, including medical/ behavioral health care; member education, and self-help/recovery and self-management.
	Conduct Care Team Meetings with the Care Team to monitor/evaluate member status/service needs.
	Advocate for services and assist with scheduling of needed services.
	Coordinate with Care Team to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
	Monitor/support/accompany the member to scheduled medical appointments.
	Crisis intervention, revise care plan/goals as required.
Comprehensive Transitional Care	Follow up with hospitals/ER upon notification of a member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
	Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to ensure a safe transition/discharge that ensures care needs are in place.
	Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.
	Link member with community supports to ensure that needed services are provided.
	Follow-up post discharge with member/family to ensure member care plan needs/goals are met.
Patient & Family Support	Develop/review/revise the individual's plan of care with the member/family to ensure that the plan reflects individual's preferences, education, and support for self-management.
	Consult with member/family/caretaker on advance directives and educate on member rights and health care issues, as needed.
	Meet with member and family, inviting any other providers to facilitate needed interpretation services.
	Refer member/family to peer supports, support groups, social services, entitlement programs as needed.
Referral to Community & Social Support Services	Collaborate/coordinate with community-based providers to support effective utilization of services based on member/family need.

K. Core Service Definitions Guidance

First Issued: 11/8/19

Reviewed by Quality Committee: 1/10/23

Revised Effective: 1/10/23

PURPOSE

The purpose of this document is to guide staff in how to choose the appropriate Core Service type when documenting their work in FCM.

CORE SERVICE DEFINITIONS

There are 5 DOH Approved Core Services:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Member and Family Support
- Referral and Community and Social Support Services

"Diligent Search" operates as an unofficial sixth core service and is outlined as such below.

The approval of **Comprehensive Care Management (CCM)** as a core service can be achieved by fulfilling one or more of the following criteria:

1. **Comprehensive Assessment**: Includes the completion of any State mandated assessment tools.

Current tools in use:

AUDIT, DAST, and PHQ Screenings

Comprehensive Assessment (Initial and Annual)

HCBS Eligibility Assessment (Initial and Annual)

2. **Complete/revise care plan**: Activities that result in the development or update of a member's Plan of Care (POC).
   - 2.1. This can either be a full annual review, with member signing the revised the POC, or it can be an individual update to a Need, Goal, or Task that is instigated by a conversation with the member or the member's Care Team, or by the Care Manager addressing a Task on the POC. These types of updates occur ongoing, as the POC is considered a "living document". Best practice is to update monthly at the time of the Billing Support Questionnaire.
   - 2.2. A POC update that only extends the target dates of Needs, Goals, or Tasks is not sufficient for this Core Service.
   - 2.3. Use of the FCM feature to "link" an encounter with a POC Task does not constitute a POC update.

2.4. Changes are reflected in the Care Plan tab in FCM.

3. **Consult with Care Team on care plan/needs/goals**: Conversations including the Care Manager and at least one Care Team member (e.g., primary care physician, psychiatrist, social worker, counselor, etc.) resulting in the completion or revision of a member's POC.
   3.1. The conversation can occur in person, via phone, or via secure email/text, but must be with the actual treatment provider.
   3.2. Conversations with clinic staff who are not directly providing care to the member (receptionist, RN who answers the front desk phone, etc.) are not sufficient for this Core Service.
   3.3. A conversation with a provider where the provider only discusses appointment adherence is not sufficient for this Core Service (unless appointment adherence a documented need in the Assessment and is on the POC); the conversation must be directly related to creating or revising POC Needs, Goals, or Tasks.
   3.4. The POC updates are evident on the FCM Care Plan tab.

4. **Consult with primary care physician and/or any specialists involved in the care plan**: Communication between the CM and at least one Care Team member (e.g. primary care physician, psychiatrist, social worker, counselor, etc.) about the member's clinical stability or treatment needs.
   4.1. This conversation can occur in person, via phone, or via secure email/text, but must be with the actual treatment provider.
   4.2. Conversations with clinic staff who are not directly providing care to the member (receptionist, RN who answers the front desk phone, etc.) are not sufficient for this Core Service.
   4.3. A conversation with a provider where the provider only discusses appointment adherence is not sufficient for this Core Service (unless there has been an acute change in appointment adherence, or appointment adherence is directly related to member's needs and stability).

5. **Conduct outreach and engagement activities**: Activities initiated by the Care Manager to locate an enrolled member and re-establish a connection to the member.
   5.1. Standard outreach and engagement activities (such as leaving voicemails for a member) are not billable as a core service; they are an expected part of care management.
   5.2. Outreach and engagement activities are billable only during an Enrolled (Pended for Diligent Search) segment when member is disengaged, and they are being done as part of a Diligent Search.

6. **Prepare member crisis intervention plan**: Engaging in conversation and activities that result in the creation or revision of a plan to help the member find safety and stability in times of crisis. "Crisis" is defined as any situation that directly threatens the safety of the member and/or community (e.g., suicidality, homicidality, domestic violence, or natural disaster, etc.).
   6.1. CMAs may use their own versions of these plans (e.g., Safety Plan, Suicide Prevention Plan, Emergency Plan, Crisis Plan).
   6.2. The Plan is uploaded to the FCM Document Tab

6.3. The Plan should be incorporated into the Health Home Plan of Care when appropriate.
6.4. A copy of Plan is offered to the member unless the member refuses.

The approval of **Care Coordination and Health Promotion (CCHP)** as a core service can be achieved by fulfilling one or more of the following criteria:

1. **Coordinate with providers (secure necessary care, share case information)**: Sharing case related information via direct (e.g., phone conversation) or indirect (e.g. faxing written status update) communication with involved treatment partners in efforts to ensure that all involved parties are in receipt of the most current case synopsis to accurately identify the appropriate levels of care (*e.g. ongoing substance use that may result in a needed increase in recovery group schedule*). May include reviewing and establishing needed appointments and coordination with providers that results in the securing of needed services (*e.g., obtaining physician's authorization for needed transportation services*).
   1.1. Speaking with a receptionist solely to confirm past appointment attendance and/or upcoming appointments is not sufficient for this Core Service.
   1.2. The CM must share information about the member's care and needs with the providers, and vice versa, for this Core Service to be billed. An example of coordination might be speaking to the member's therapist to tell them that the member just received a serious medical diagnosis and may benefit from more support, and the therapist agrees to move up the date of their next appointment and offers to research support groups for the member; you had already referred the member to some medical support groups, so you share that information with her so that you and she do not duplicate services.
   1.3. There may be instances where a conversation with a receptionist about a member's care is billable under this Core Service, e.g., if the receptionist opens the member's chart and shares clinical information from the last visit, or is able to document clinical information that you share into the member chart, etc.
   1.4. If the information was shared indirectly via fax, the fax must be uploaded to FCM.

2. **Link/refer member to needed services**: Identification and securing referrals designed to meet the goals of a member's Health Home Plan of Care. This action includes active steps that result in the receipt of an actual appointment date/time/location, or submission of an application/referral to get an appointment in the future.
   2.1. Submitting housing applications or other applications (i.e., Food Stamps or Access-A-Ride) are sufficient for this core service if the application is completed for or with the member and is submitted to the appropriate entity. A copy of the application and proof of submission must be uploaded to the member's chart.
   2.2. Giving a member blank application forms, or a resource list, or a phone number to call, is not sufficient for this core service.

3. **Conduct Care Team Meetings to monitor/evaluate member status**: Participating in/facilitating discussions via direct contact with Care Team members to provide basic member status updates and review current case disposition for accuracy. May be one to one conversations or full Care Team Meetings.
   3.1. Discussing cases internally with CMA coworkers or supervisors, or with CCMP staff, is not sufficient for this core service.

4. **Advocate for/assist with scheduling of needed services**: Providing advocacy that results in the removal of barriers preventing the member from securing needed services (*e.g., working with an MCO to obtain authorization for a cardiology appointment and securing needed appointment*).
   4.1. Scheduling recurrent appointments for members is not sufficient for this Core Service unless it is clear from the Assessment and the POC why this level of service is needed.

5. **Coordinate with treating professionals to ensure appropriate levels of care are provided**: Conducting case reviews with licensed medical and/or behavioral health staff to ensure that the member is receiving the services needed to improve his/her health outcomes.

6. **Monitor/support/accompany to scheduled medical appointments**: Providing physical accompaniment to a scheduled healthcare appointment (traveling with or meeting the member at the appointment).
   6.1. Accompanying the member to an appointment should be purposeful; Care Manager should use the opportunity to attempt to coordinate care with the provider, or the accompaniment itself should be a needed service (i.e., member rarely goes unless escorted, or member needs help communicating with the doctor during their session, or member gets impatient waiting to be seen and will walk out if Care Manager is not there).
   6.2. Accompaniment should not be incidental to the member's care, i.e., if a member has no actual need for accompaniment and Care Manager meets the member at the appointment, the Care Manager should be providing a different needed core service that just happens to be provided at the doctor's office.

7. **Crisis intervention, revise care plan/goals as required**: Activities taken to intervene in an active crisis situation that result in the receipt of additional services and activities which are incorporated into the POC (*e.g., providing a member experiencing breathing troubles with an immediate referral to urgent care and then incorporating the new diagnosis of "asthma" to the care plan with appropriate Goals and Tasks*).

8. **Coordinate/provide access to medical services**: Activities that result in the receipt of needed medical services (e.g., assistance in locating a needed provider, assisting with scheduling an appointment, securing transportation assistance).

9. **Coordinate/provide access to mental health services**: Activities that result in the receipt of needed mental health services (e.g., assistance in locating a needed provider, assisting with scheduling an appointment, securing transportation assistance).

10. **Coordinate/provide access to substance abuse services**: Activities that result in the receipt of needed substance use services (e.g., assistance in locating a needed provider, assisting with scheduling an appointment, securing transportation assistance).

The approval of **Comprehensive Transitional Care** as a core service can be achieved by fulfilling one or more of the following criteria:

1. **Follow up with hospital/ER upon notification of a member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting**: Directly communicating with (consented) hospital staff upon or soon after a member's admission to receive admission and treatment information, share Health Home enrollment status, and participate in the member's treatment episode.
   1.1. Getting member admit/discharge info from patient information is not enough to bill under this core service. There should be specific reciprocal communication with hospital treatment providers about the member's hospital event and treatment needs.

2. **Facilitate discharge planning to ensure a safe transition/discharge that ensures care needs are in place**: Actively engage in the discharge planning process with appropriate staff of the treating agency; ensure that POC needs are reflected.
   2.1. Finding out the date of anticipated discharge or finding out after the fact the date the member was discharged is not sufficient to bill under this Core Service. This service requires active reciprocal engagement with hospital treatment providers or discharge planning staff that ensures member needs are addressed for the transition.

3. **Notify/consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation**: Contacting outpatient treatment providers (e.g., primary care physician, psychiatrist, counseling staff) to provide notification of the admission, treatment, and discharge plans surrounding a hospitalization event; securing follow up visits with needed specialists and care providers; ensuring that medication supplies are intact and accounted for across providers.
   3.1. The Health Home requirement of scheduling post discharge follow up appointments within 7 days of discharge would be covered by this core service and could be done with a receptionist.

4. **Link member with community supports to ensure needed services are provided**: Includes referrals to social support entities such as housing agents, community support groups, and/or any other community-based support program that will provide value to the member's recovery process.

5. **Follow-up post discharge with member/family to ensure member care plan needs/goals are met**: Conduct POC review involving the member with or without his/her (consented) family members to review changes to the POC resulting from the hospital event, and discuss modifications needed to promote ongoing health and wellness.

The approval of **Patient and Family Support** as a core service can be achieved by fulfilling one or more of the following criteria:

1. **Develop/review/revise the individual's care plan with member/family to ensure that the plan reflects individual's preferences**: Engaging in active conversation with (consented) family members to include them in care planning activities and/or updates.

2. **Consult with member/family on advance directives; educate on member rights and health care issues**: Sharing/receiving information with/from (consented) family members about a member's rights and options surrounding medical/behavioral health care and advance directives.

3. **Meet with member/family, inviting any other providers to facilitate needed interpretation services**: Delivering or coordinating access to services that provide needed interpretation services for a member and/or his/her family to remove barriers to care.

4. **Refer member/family to peer supports, support groups, social services, entitlement programs**: Providing direct referral for services designed to provide social and or financial support to the member's family.

5. **Coordinate/provide access to chronic disease management, self-management support to individuals and their families**: Providing the member and/or his/her family members with referrals to services and programs in the community designed to provide information and support for people living with chronic diseases/conditions (e.g., NAMI, Nar-Anon).

The approval of **Referral to Community and Social Supports (RCSS)** as a core service can be achieved by fulfilling one or more of the following criteria:

1. **Identify resources and link member with community supports**: Activities that result in the linkage to services designed to support and/or enhance the member's social/community support and engagement (e.g., referral to AA meetings; assistance in identifying a religious organization and schedule; providing referral to NAMI).
   1.1. These are typically non-paid, informal supports that are available to any member of the community, i.e., no requirement to have Medicaid, or proof of a specific diagnosis.
   1.2. Providing the member with a resource list, or phone number to call, is not sufficient to bill for this core service. Linkage to these types of resources/community supports requires identifying,

planning, troubleshooting, and/or identifying and mitigating barriers. For example, although giving a member a list of local AA meetings is not sufficient, giving a member a list of local AA meetings, helping the member to identify which meeting time and location would be the best fit for her, calling the meeting number to confirm the schedule, making sure the member has the meeting added to her personal calendar for the following week, and calling the member either to remind her to go or to find out if she went to the meeting, would be sufficient to bill for this core service.

2. **Collaborate/coordinate with community-based supports to support effective utilization of services based on member/family need**: Sharing case related information with involved and consented community-based supports (non-paid, such as an AA sponsor, neighbor, pastor, or senior center director) in efforts to ensure that all involved parties are in receipt of the most current case synopsis to provide appropriate levels of care, secure needed services, and support the member.
   2.1. The Care Manager must share information about the member's care and needs with the community-based support, and vice versa, for this core service to be billed.

The approval of **Diligent Search**[41] as a core service can be achieved by fulfilling all the following criteria*:

- Member has become Disengaged from Care Management, and this is evident in the chart.
- Member has been Pended for Diligent Search.
- Care Manager has provided at least three Diligent Search Activities in the month, including Notification to the MCO/HH in Month 1.

[41] See the Continuity of Care Policy, Re-Engagement Policy, Diligent Search Activities Table, and Disenrollment Policy for more details on using the Diligent Search Core Service.

L. Guide to Formal Care Conferences with MCOs

If an MCO requests a Formal Care Conference with the CMA, it is usually because they are seeing a pattern in the member's claims that they are trying to understand. Your role is to help them understand what is going on. Their role is to show you information about the member's service use that you may not have been aware of and provide general clinical recommendations that may improve your ability to coordinate the member's care.

The MCO brings value to the Care Conference in the following ways:

- They can see all Medicaid claims submitted for the member, so they have a broad picture of all the healthcare services being provided.
- They have clinical staff who can provide guidance as to standard practice of care and various treatment options.
- They know the general cost of care for their full member panel, so they can identify outliers in cost and use patterns quickly.
- They may know of other resources and programs available to the member through their network.

The MCO is limited in their understanding of the member in the following ways:

- They may have never spoken to the member, their family, or their doctors.
- They don't know the community the member lives in.
- They have never seen the member's apartment, house, or shelter.
- They don't know if the member has basic skills and resources to access transportation, technology, language, etc.
- They don't know why the member is making decisions they are making, and why providers are making decisions they are making.

If an MCO asks to have a Care Conference about a member, you should ideally be able to explain:

- What the member's diagnoses are, and whether they are treated or untreated.
- Why they are getting various treatments.
- Why you are referring them for various services.
- What the member's level of adherence to various treatments has been, and why it is at that level.
- Whether they member is still benefitting from Care Management.
- Whether the member is appropriate for disenrollment from Care Management (graduation, step up, or step down) now or in the near future.
- If member has been hospitalized or visiting the ER, what were the reasons for those visits/admits, and were they preventable.

It may be appropriate to ask a supervisor, clinical consultant, or another member of the Care Team to join the conference.

<u>You may not know everything described above, and that is okay</u>. Be prepared to tell the MCO if there are things about the member's care and services that you do not understand. They may be able to help you.

M. Hospitalization Checklist

This is a screen shot of the checklist, the full checklist is available within TalentLMS.

HOSPITALIZATION CHECKLIST

Regardless of when or how a CCMP network CMA learns of a hospitalization, the Case Manager is required to provide follow up to improve member health and prevent re-admission as follows:

IF YOU FIND OUT ABOUT THE HOSPITALIZATION BEFORE DISCHARGE

Within two business days of learning a member is in the hospital

- ☐ Make contact with the hospital, member, or appropriate Care Team Members to:
  - Notify the hospital of the member's Health Home enrollment
  - Determine the admission date
  - Determine the anticipated length of stay
  - Determine the reason for admission
  - Collaborate on discharge planning
- ☐ For detox: attempt an in -person visit during the admission and within 24 hours of discharge

IF YOU FIND OUT ABOUT THE HOSPITALIZATION AFTER DISCHARGE

Within two business days of learning a member was in the hospital

- ☐ Make contact with the hospital, member, or appropriate Care Team Members to:
  - Determine the admission and discharge date
  - Determine the reason for admission
  - Understand the discharge instructions

AFTER THE MEMBER HAS BEEN DISCHARGED

- ☐ Review discharge instructions with member
- ☐ Ensure member is scheduled for a follow up appointment with the appropriate outpatient provider within seven days of discharge (unless the treatment team recommended an earlier/later timeframe)
- ☐ For psychiatric admissions: Ensure member is scheduled for a second follow up appointment with their psychiatric provider within 30 days of discharge (unless the treatment team recommended an earlier/later timeframe)
- ☐ Provide supports to the member to keep the follow-up appointments
- ☐ Assist member with obtaining new or changed medications
- ☐ Add/update hospitalization follow up tasks on the Plan of Care as applicable, to prevent future admissions.

LONG TERM HOSPITALIZATION

- ☐ If there is no immediate plan for discharge to the community, consult the Excluded Settings Policy.

COMMUNITY CARE MANAGEMENT PARTNERS HEALTH HOME

N. Template Transfer Choice Letter

Community
Care Management
Partners
HEALTH HOME

Dear Member,

You are currently a member of the CCMP Health Home (CCMP). CCMP has a network of Care Management Agencies (CMAs) who provide Health Home Care Management to our members.

As a member of CCMP, you have been receiving health home care management services from the ________ CMA, one of CCMP's network participants.

We are writing to notify you that the ________ CMA is no longer able to provide you with Health Home Care Management services because ________ .

Please note there will be no changes to your Medicaid coverage, health insurance or health care providers. Only your Care Management services will be affected by this change.

You have three choices:

- ☐ Option 1: Stay in CCMP; transfer to a different CMA
- ☐ Option 2: Transfer to a new Health Home and a new CMA
- ☐ Option 3: Disenroll from Health Home Care Management

Please contact either ________ ________ or CCMP (212-465-2741) as soon as possible to tell us your choice.

If we do not hear back from you by ________ you will be disenrolled from Health Home Care Management effective ________ .

If you decide to disenroll or are automatically disenrolled due to not making a choice by ________, and you later want Health Home Care Management services again, you can contact CCMP at 212-465-2741 to re-enroll.

Sincerely,

CCMP Health Home
212-465-2741

Community Care Management Partners Health Home • (212) 465-2741
ccmphealthhome.org

This is a screenshot of the letter, the full document is available to CMAs here.

O. Template Disenrollment Letters

Disenrollment Letter Template (Involuntary-for use with DOH-5235)

Community Care Management Partners
HEALTH HOME

Insert CMA Logo here

Click here to enter a date.

Dear Click here to enter member name,

We are writing to inform you that Click here to enter text. intends to disenroll you from the Health Home program within the CCMP Health Home effective Click here to enter a date. On this date we will also stop sharing of Protected Health Information with your Care Team members.

Please review the attached Notice of Determination of Disenrollment form (DOH-5235), which indicates that you are being disenrolled because: Choose an item.

The attached Notice also includes instructions on how to request an Informal Agency Conference and/or a Fair Hearing, if you disagree with our decision.

You have the option to receiving a copy of the following documentation as part of the disenrollment process:

- Most recent Care Plan, including contact information for your Care Team members.
- Discharge/safety plan
- Any referrals made by Click here to enter text. for new providers/services
- A plan for ongoing coordination if you are receiving HCBS services.
- Other documents as appropriate

If you would like a copy of any of the above documents, or if you have questions about the Notice, please contact Click here to enter text. at Click here to enter text..

Sincerely,

Click here to enter text. /

This is a screenshot of the letter, the full document is available to CMAs here.

Disenrollment Letter Template (Voluntary)

Insert CMA Logo here

Click here to enter a date.

Dear Click here to enter member name,

We are writing to inform you that, per your request, Click here to enter text. intends to disenroll you from the Health Home program within the CCMP Health Home effective Click here to enter a date. On this date we will also stop sharing of Protected Health Information with your Care Team members.

You requested to be disenrolled from the program on Click here to enter a date.

- You made your request via Choose an item.
- You said that you wanted to disenroll because: Click here to enter text.

If you did not intend to disenroll from the program or if you change your mind and want to resume Health Home Care Management services in the future, you can contact Click here to enter text. at Click here to enter text..

If you would like to receive Health Home Care Management services from a different Care Management Agency within the CCMP network, or with a different Health Home, you can contact CCMP at 212-609-1785.

You have the option to receive a copy of the following documentation as part of the disenrollment process:

- Most recent Care Plan, including contact information for your Care Team members.
- Discharge/safety plan
- Any referrals made by Click here to enter text. for new providers/services
- A plan for ongoing coordination if you are receiving HCBS services.
- Other documents as appropriate

If you would like a copy of any of the above documents, please contact Click here to enter text. at Click here to enter text..

Sincerely,

Click here to enter text.

This is a screenshot of the letter, the full document is available to CMAs here.

P. Disenrollment End Reason Codes Definitions Chart

Disenrollment End Reason Codes Definitions Chart

END REASON CATEGORY	DEFINITION	END REASON CODE #	END REASON CODE	Applicable Segment	How/When to Use?	Required Forms?
Transferred	Segment is closed, but member continues to receive Health Home Care Management in NYS	1	Transfer to another HH	Outreach/Enrolled	Member wants to enroll with another Health Home.	Not applicable
		3	Transferred to another CMA	Outreach/Enrolled	Member wants to enroll with another Care Management Agency, within the same HH.	Not applicable
		54	Transferred to a CCO/HH	Outreach/Enrolled	Member with a Developmental Disability wants to enroll with a CCO/HH	Not applicable
		43	Individual moved between HHSC and HHSA	Outreach/Enrolled	Member 18-21 moves from a children's HH to adult HH (or vice versa).	Not applicable
Administrative Closure	Segment is closed, but member continues to receive Health Home Care Management from their current CMA and HH	25	Individual moved from Outreach to Enrollment Status	Outreach	Can be system generated or user selected. Ends the segment due to enrollment in HH services.	5234
		5	Individual has a new CIN	Outreach/Enrolled	Used to close case and open a new one if member's CIN changes. Ensure there are transitional notes in the old and new case explaining the closure and CIN change.	Not applicable
		44	Segment Correction	Outreach/Enrolled	Only if directed by NYS DOH in order to correct RE codes	Not applicable
Disenrolled	Segment is closed, and member is no longer receiving Care Management in NYS	4	Individual Deceased	Outreach/Enrolled	Member has died.	Not applicable
		7	Closed for health, welfare, and safety concerns for member and/or staff	Outreach/Enrolled	Administrative decision- CMA should assess if hospitalization/arrest is indicated, should provide any appropriate referrals. Must consult with HH first.	5235 or 5236
		9	Individual moved out of state	Outreach/Enrolled	Member/other informs CMA that they no longer reside in New York state.	If Enrolled, no forms if conversation is with the member, 5235 if it is not.
		11	Individual incarcerated	Outreach/Enrolled	Member arrested and detained in prison or jail (excluded setting). Confirm with WebCrims/Inmate Look-Up. For Enrolled, can only use if member will not be released within six months from the 1st day of incarceration.	5235 or 5236
		13	Individual is in an inpatient facility	Outreach/Enrolled	Member is residing in a long term care facility (excluded setting) such as nursing home, long-term rehab facility, state Psychiatric hospital. For Enrolled, can only use if member will not be released within six months.	5235 or 5236
		14	Enrolled Health Home member disengaged from care management services	Enrolled	Member not found after 1-3 months of Diligent Search.	5235
		24	Individual is not/no longer eligible for Medicaid	Outreach/Enrolled	Member has inactive Medicaid and has not taken steps to re-activate it, or is ineligible for Medicaid.	5235 or 5236
			Coverage Not Compatible	Outreach/Enrolled	Member does not have the right kind of Medicaid coverage for the HHCM program	5235 or 5236
		29	Member withdrew consent to enroll	Enrolled	Member voluntarily disenrolls from the HH program. CMA should first attempt to resolve any dissatisfaction with services.	Not applicable
		42	Program not compatible	Outreach/Enrolled	Member enrolls in a community based program not compatible with Health Home	5235 or 5236
		2	Individual opted-out (pre-consent only)	Outreach	Member does not want to enroll, and does not want to be re-outreached in the future.	Not applicable
		16	Inability to contact/locate individual	Outreach	Member cannot be located after a period of time as determined by the CMA	Not applicable
		18	Member interested in Health Home at a future date.	Outreach	Member states "not at this time".	Not applicable
		19	Does not meet eligibility requirements	Outreach/Enrolled	Member does not have Qualifying Conditions or a Significant Risk Factor supporting a need for services.	5235 or 5236
Step Down to Lower Level of Care	Segment is closed, and member is receiving Care Management in NYS at a Lower Level of Intensity, or able to meet their Healthcare and SDOH needs on their own.	47	Transitioned to MCO or MLTC Care Management	Enrolled	Member's MCO or MLTC has accepted them into their Care Management program.	Not applicable
		46	Transitioned to PCMH or other Healthcare Provider Care Management	Enrolled	Member's PCMH or other healthcare provider has accepted them into their Care Management program.	Not applicable
		49	Transitioned to Standard HHCM	Enrolled	Member moved from the HH+ Level of Care to the Standard HHCM Level of Care **	Not applicable
		21	Member has Graduated from Health Home Program	Enrolled	Member met their Care Management goals, i.e. can self-manage and monitor their chronic condition(s), or can do so with natural supports.	5235 if involuntary, 5058 if voluntary
Step Up to Higher Level of Care	Segment is closed, and member is receiving Medicaid funded Care Management in NYS at a Higher Level of Intensity.	50	Transitioned to ACT Team	Enrolled	Member has been accepted by an ACT Team.	Not applicable
		51	Transitioned to HH+ for AOT	Enrolled	Member has been accepted by a HH+ for AOT CMA.**	No forms if it is a voluntary change, 5235 if it is not.
		52	Transitioned to HH+ for HIV	Enrolled	Member has been accepted by a HH+ for HIV CMA.**	Not applicable
		53	Transitioned to HH+ for SMI	Enrolled	Member has been accepted by a HH+ for SMI CMA.**	Not applicable

**At this time the Step Up/Step Down codes related to HH+ are only used if the member is moving into (or out of) a HH+ program with a different CMA. HH+ Level of Care changes within the same CMA do not require a segment ending. If the member is transferring to a new CMA due to move into or out of HH+, CMAs should use the HH+ Step Up/Down codes, NOT the CMA Transfer code.

This is a screenshot of the chart, the full document is available to CMAs here.

Q. Diligent Search Activities Table

Diligent Search Activities Table

First Issued: 5/14/19
Reviewed by Quality Committee: 4/9/19
Revised: 6/28/19

Diligent Search Activities
Notify consented MCO and HH of the member's disengagement (required in Month 1)
Attempted in person visit with client
Search of External Clinical Databases (*Healthix, PSYCKES, etc.*)
Online database search (*WebCrims, DOC Inmate Look Up, National Missing and Unidentified Persons Database, etc.*)
Contact with the Office the Chief Medical Examiner (OCME)
Contact with consented family or emergency contact
Contact with consented government agencies (*Department of Homeless Services, H+H-Correctional Health Services, Division of Probation or Parole, Administration for Children's Services, Adult Protective Services, etc.*)
Contact with consented treatment providers

REMEMBER:
You should continue attempting to contact the member via phone/letter/text*/email* as needed to re-engage them, but these are not billable Diligent Search activities, these are part of Standard Outreach and Engagement.

Before you can bill for diligent search (DS) efforts, the client's "Disengaged" status must be clearly documented, and the segment must be Pended for Diligent Search.

Once a client's status has been document as "Disengaged", the CM **must provide a minimum of three Diligent Search Activities** in that calendar month. They should be varied, progressive, and appropriate to the client's needs.

Notification to the HH/MCO must be done in M1, and documented in an Encounter Note (MCO), and in the Diligent Search HML (HH)

Diligent Search Activities may be done on the same day, or on different days...however, in order to bill for a Diligent Search month, there must be Diligent Search Activities done on at least three different days.

Diligent Search Activities do not have to be successful to be billable. For example, leaving a voicemail for an emergency contact that is not returned considered a billable Diligent Search Activity, whereas that would not be billable for any other Core Service type.

*Text/email communications are used only when in compliance with CMA Privacy Policies, and relevant State/Federal laws and regulations.

This is a screenshot of the document, the full document is available to CMAs here.

R. Re-Engagement Form

Community Care Management Partners HEALTH HOME

Re- Engagement Information		
Previous Care Manager:	Re-Engagement Date:	Re-Engagement Location:
Member Located via: ☐ Hospital Alert ☐ Member contacted CMA ☐ Care Team member contacted CMA ☐ Other ________________________	Reason for Disengagement:	

Verify Member Demographic Information		
First Name:	Last Name:	DOB:
Address:	City:	Zip Code:
Email:	Phone Number(s):	

Verify Medicaid Status		
Medicaid #:	MCO Provider/ Fee For Service (FFS):	Medicaid Status: ☐ Active ☐ Pending ☐ Inactive

Continued Appropriateness for Health Home Service (must have at least one of the below risk factors)

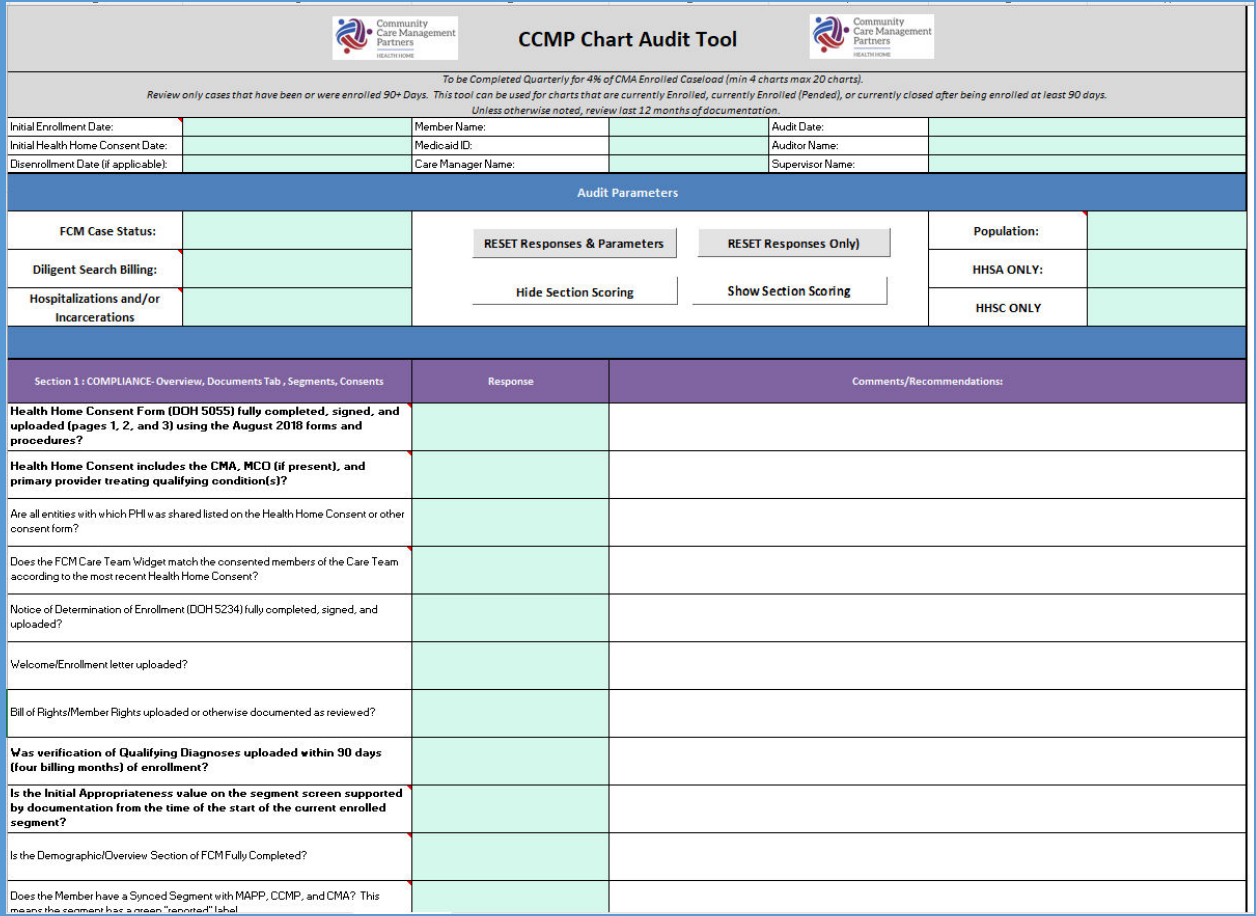
- ☐ *At risk for negative events (e.g., death, disability, inpatient hospitalization or nursing home admission)*
- ☐ *Recent release from psychiatric hospitalization ____________________(date)*
- ☐ *Lack of or poor connectivity with healthcare system*
- ☐ *Difficulty managing treatments or medication(s)*
- ☐ *Not able to perform activities of daily living such as dressing, eating, toileting and/or bathing*
- ☐ *Difficulties with reading, writing or comprehension*
- ☐ *Lack of or poor social/family/housing support*
- ☐ *Recent release from incarceration ____________________(date)*

Decision to Resume Care Management or Disenroll?		
1. Is member still appropriate for Health Home Care Management services?	☐ Yes	☐ No
2. Does member identify active care management goals? Goals:____	☐ Yes	☐ No
3. Does member want to participate with active Care Management, which include monthly contact, in person meetings (home, community, and office) as needed but at least every six months to accomplish goals?	☐ Yes	☐ No
If any of the above three questions are answered, "**NO**", proceed to Disenrollment: Does member need any referrals to other services as part of their disenrollment?	☐ Yes	☐ No

If member is still appropriate for and is interested in resuming Care Management, assess for any changes to demographic information, consents, risk factors/assessment, and Care Plan, and update in RMA as appropriate.

This is a screenshot of the form, the full document is available to CMAs here.

S. Chart Audit Tool



CCMP Chart Audit Tool

To be Completed Quarterly for 4% of CMA Enrolled Caseload (min 4 charts max 20 charts).
Review only cases that have been or were enrolled 90+ Days. This tool can be used for charts that are currently Enrolled, currently Enrolled (Pended), or currently closed after being enrolled at least 90 days.
Unless otherwise noted, review last 12 months of documentation.

Initial Enrollment Date:		Member Name:		Audit Date:	
Initial Health Home Consent Date:		Medicaid ID:		Auditor Name:	
Disenrollment Date (if applicable):		Care Manager Name:		Supervisor Name:	

Audit Parameters

FCM Case Status:		RESET Responses & Parameters	RESET Responses Only)	**Population:**	
Diligent Search Billing:				**HHSA ONLY:**	
Hospitalizations and/or Incarcerations		Hide Section Scoring	Show Section Scoring	**HHSC ONLY**	

Section 1 : COMPLIANCE- Overview, Documents Tab , Segments, Consents	Response	Comments/Recommendations:
Health Home Consent Form (DOH 5055) fully completed, signed, and uploaded (pages 1, 2, and 3) using the August 2018 forms and procedures?		
Health Home Consent includes the CMA, MCO (if present), and primary provider treating qualifying condition(s)?		
Are all entities with which PHI was shared listed on the Health Home Consent or other consent form?		
Does the FCM Care Team Widget match the consented members of the Care Team according to the most recent Health Home Consent?		
Notice of Determination of Enrollment (DOH 5234) fully completed, signed, and uploaded?		
Welcome/Enrollment letter uploaded?		
Bill of Rights/Member Rights uploaded or otherwise documented as reviewed?		
Was verification of Qualifying Diagnoses uploaded within 90 days (four billing months) of enrollment?		
Is the Initial Appropriateness value on the segment screen supported by documentation from the time of the start of the current enrolled segment?		
Is the Demographic/Overview Section of FCM Fully Completed?		
Does the Member have a Synced Segment with MAPP, CCMP, and CMA? This means the segment has a green "reported" label		

This is a screen shot of the first section of the interactive, self-scoring, audit tool. Full tool is available to CMAs here.

Tool may be updated periodically; check TalentLMS for the most recent version.

T. Billing Audit Tool

CCMP BILLING AUDIT TOOL					
Member Name:		[SELECT CMA FROM DROPDOWN]		Auditor:	
Medicaid ID:		Care Manager Name:		Audit Period:	
Adult/Child:		Supervisor Name:		Audit Date:	

OUTREACH/ENGAGEMENT (for Outreach claims pre-10/1/17, consult prior versions of CCMP policies)

☑ Outreach Claims Paid	YES/NO	If "No" list the erroneous claims identified.
Was an Outreach and Engagement Core Service provided in month one?		
If there is a second month of billed Outreach, was there a successful in person contact with member that month?		
If there was more than two months of Outreach billed in the last 12 months, was it triggered by documented receipt of new "Actionable Information" (e.g. alert, MCO assignment, etc.)?		
Are there no more than four months of Outreach billed within the last 12 months?		

ENROLLMENT

☑ Enrolled Claims Paid	YES/NO	If "Yes", list the erroneous claims identified.
Are there any months paid at the Enrolled rate PRIOR to the month that the CCMP consent form was signed (DOH-5055/DOH-5200/5201)?		
Are there any months paid at the Enrolled rate PRIOR to the month in which Health Home diagnostic and appropriateness criteria are documented in the chart?		
Are there more than four months billed at the Enrolled rate PRIOR to Verification of Diagnosis being uploaded to the chart?		
Are there more than three months billed at the Enrolled rate PRIOR to the signed Person Centered Plan of Care? EFFECTIVE DATE [illegible]		

DILIGENT SEARCH

☐ Diligent Search Claims Paid	YES/NO	If "No" list the erroneous claims identified.

HEALTH HOME PLUS (refer to HH+ Policies for AOT/SMI/HIV specific requirements)

☐ Health Home Plus Claims Paid	YES/NO	If "No", list the erroneous claims identified.

EXCLUDED SETTING (for Excluded Settings claims pre-3/1/19, consult prior versions of CCMP policies)

☐ Member was in an excluded setting during the review period	YES/NO	If "Yes", list the erroneous claims identified.

DISENROLLMENT

☐ Member was disenrolled from Health Home Care Management	YES/NO	If "Yes", list the erroneous claims identified.

CORE SERVICE/BILLING QUESTIONNAIRE

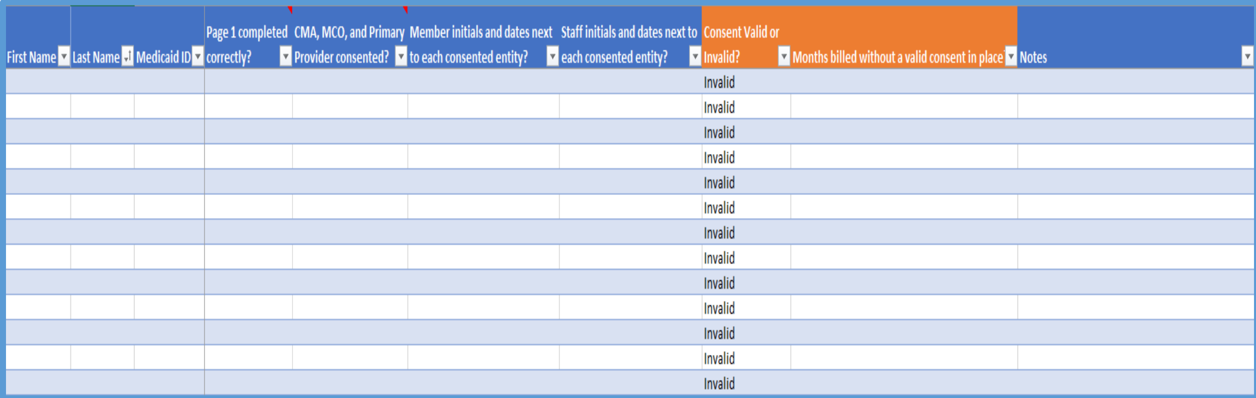
	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
Enter month/year of the claim----->						
Intervention described in the note matches a core service definition, i.e. a core service was provided.						
Notes no core services (if above answer is "No")						
Back up documentation uploaded in RHH justifies level of billing (Proof of incarceration, homelessness, IMP discharge, HIV, etc.)						
Notes on Billing Questionnaire's (if above answer is "No")						

SUMMARY	UNBILLABLE RATE	
	Total Paid Months Reviewed:	
	Total Paid Months Unbillable:	
	Unbillable Rate:	#DIV/0!
	Determining an unbillable rate is *optional*, if you are looking to compare performance across CMs,	

This is a screen shot of part of the interactive, self-scoring, billing audit tool. Full tool is available to CMAs here.

Tool may be updated periodically; all updated versions are distributed to the Quality Committee.

U. Consent Audit Tool



First Name	Last Name	Medicaid ID	Page 1 completed correctly?	CMA, MCO, and Primary Provider consented?	Member initials and dates next to each consented entity?	Staff initials and dates next to each consented entity?	Consent Valid or Invalid?	Months billed without a valid consent in place	Notes
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		
							Invalid		

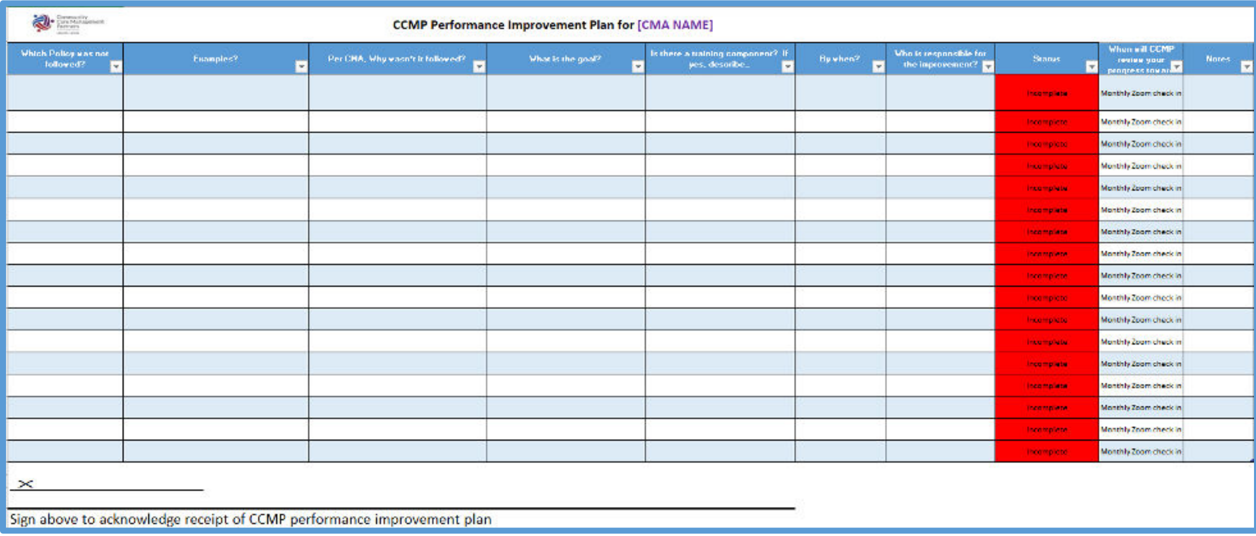
This is a screen shot of part of the interactive, self-scoring, consent audit tool. Full tool is available to CMAs here.

Tool may be updated periodically; all updated versions are distributed to the Quality Committee.

V. Guidance on Step Up/Step Down Options

In development

W. CCMP Performance Improvement Plan Template



CCMP Performance Improvement Plan for [CMA NAME]

Which Policy was not followed?	Examples?	Per CMA, Why wasn't it followed?	What is the goal?	Is there a training component? If yes, describe...	By when?	Who is responsible for the improvement?	Status	When will CCMP review your progress toward	Notes
							Incomplete	Monthly Zoom check in	
							Incomplete	Monthly Zoom check in	
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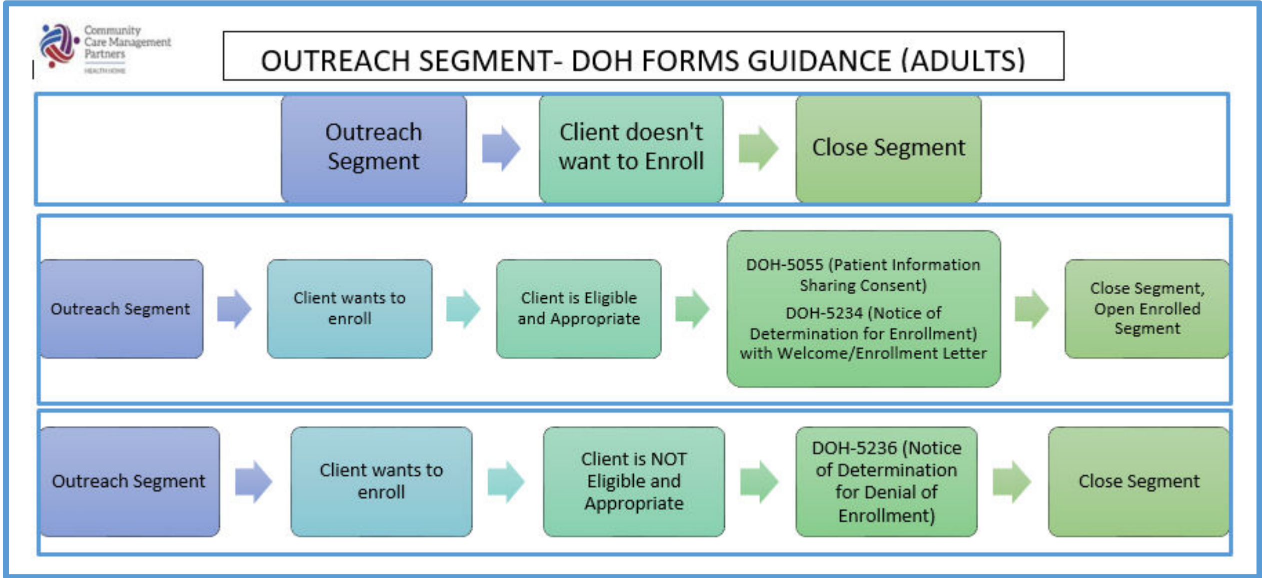
X ____________________

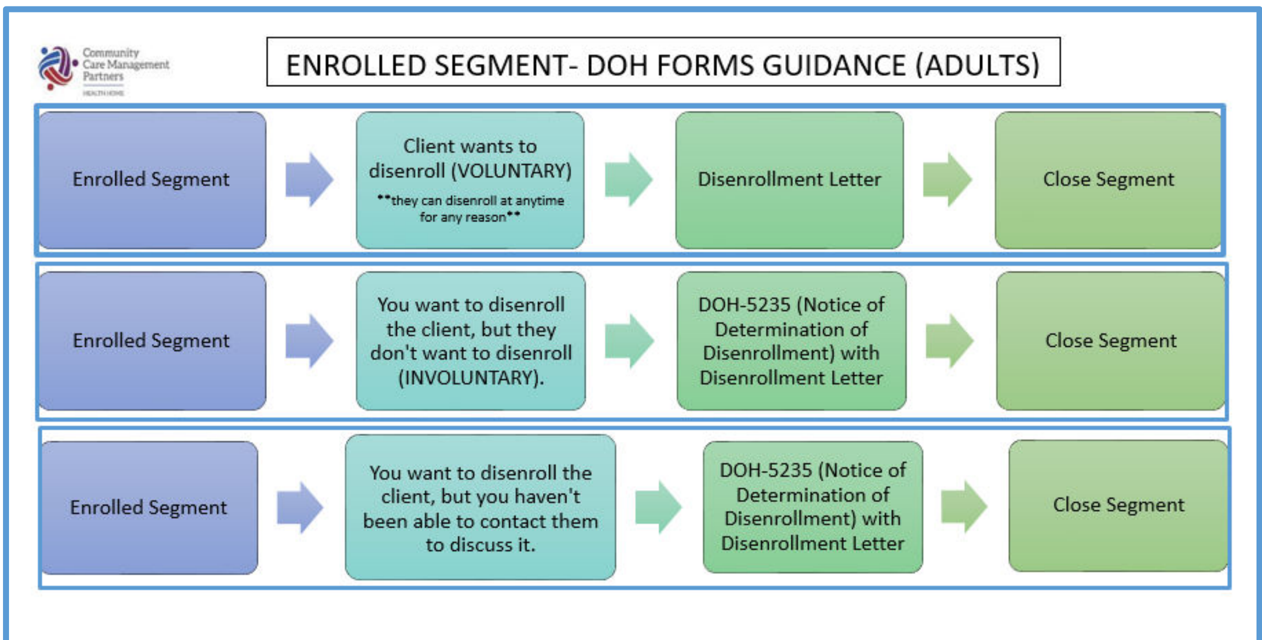
Sign above to acknowledge receipt of CCMP performance improvement plan

This is a screenshot of the PIP; the full document is available to CMAs here.

X. DOH Forms Workflow



This is a screenshot of the workflow; the full document is available to CMAs here.

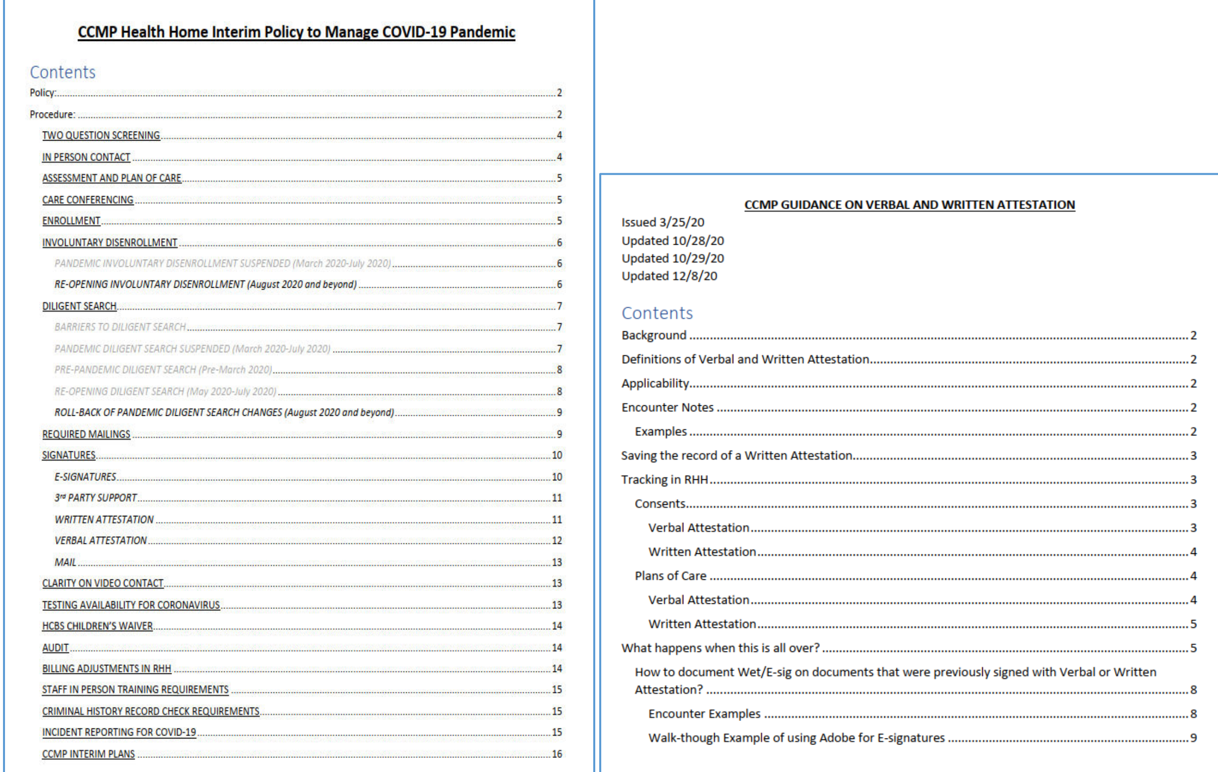


This is a screenshot of the workflow; the full document is available to CMAs here.

Y. COVID-19 Pandemic Policy Changes and Guidance

During the COVID-19 Pandemic, starting in March 2020, there were a series of policy changes prompted by State and Federal States of Emergency that supported temporary changes to some of the policies described in this manual.

CCMP issued two documents to help CMAs understand the changes; these documents were updated frequently as policies changed.



CCMP Health Home Interim Policy to Manage COVID-19 Pandemic

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CCMP GUIDANCE ON VERBAL AND WRITTEN ATTESTATION

Issued 3/25/20
Updated 10/28/20
Updated 10/29/20
Updated 12/8/20

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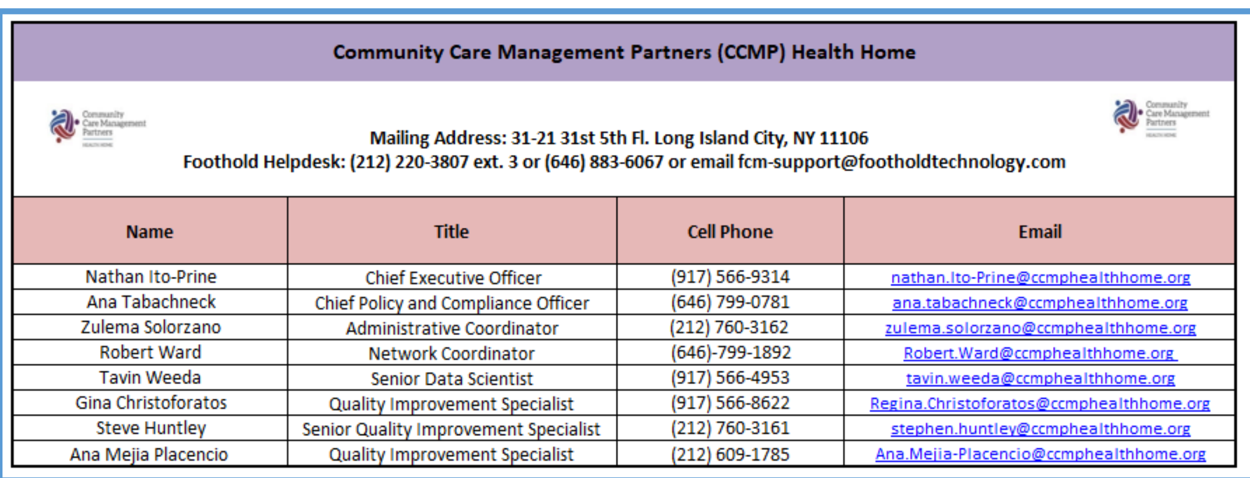
[CCMP Health Home Interim Policy on Managing the COVID-19 Pandemic](#)
[CCMP Guidance on Verbal and Written Attestation](#)

CCMP also held regular COVID focused Office Hours to review policy changes, discuss field/office safety protocols, etc., and further discussed the gradual return to pre-COVID activities in monthly Quality Committee meetings.

Z. CCMP Staff Contact Information



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