CCMP

Children's 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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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.

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Section 1: INTRODUCTION

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

CCMP Partners and 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

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.

This Policy Manual applies to Children's CMAs, operating within the Health Home Serving Children (HHSC) program model.

The Health Home Serving Adults (HHSA) Model is not covered in the Policy Manual. Please see the Adult 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.

Notes on Language

Members:
CCMP strives to use Person-Centered language in its documents whenever possible. Previous version 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.

The term “member” is used in this throughout this manual to refer either to the child (if Self-Consenting), or the child along with their parent, guardian, or legal representative (if Non-Self-Consenting).

If a policy or procedure is intended to only refer to the child, or to only refer to the parent, guardian, or legal representative, that will be stated explicitly.

Although the communication and work for Non-Self Consenting Children may be done with the child’s parent, guardian, or personal representative, it is always done to meet the child’s identified needs. For example, when discussing “follow up on a *member’s* hospitalization”, we are always referring to the child’s hospitalization, never the parents. Within that same context, we may write, “ask the *member* about changes to medication”, in this case the CMA could be asking the parent or the child about changes to the child’s medication, depending on the age and level of functioning of the child.

Personal Representatives:
Personal representative for sharing health information is defined as “a person or agency authorized by state, tribal, military or other applicable law, court order or consent to act on behalf of a person for the release of medical information”. This is further explained in the Personal Representative Policy.

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.

Section 2: ADMINISTRATIVE REQUIREMENTS

Contracting Policy

First issued: 12/17/12
Reviewed by Quality Committee: 6/11/24
Revised Effective: 6/14/24

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.

Minimum Billing Standards Policy

First Issued: 8/4/15

Reviewed by Quality Committee: 7/23/24

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 High Fidelity Wrap (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 member acuity level.
   2.1. See the Level of Service document for these requirements.
   2.2. A note describing the provision of the Core Service(s) is documented in the record.

3. A Billing Questionnaire is completed for the month, documenting the provision of the Core Service(s), and the most recent CANS-NY Acuity Level.
   3.1. Documentation to substantiate acuity level must be present in the case record.

4. If the member has been enrolled more than 60 days, an Initial CANS-NY Assessment has been data entered into UASNY.

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

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

7. 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

CANS 2.0 Algorithm[1]

DOH Guidance: Elimination of Health Home Billing for Outreach

[1] Technically, DOH has not published the CANS 2.0 Algorithms as they had with the original CANS. This was shared in a training, and when asked about the algorithm, DOH referred Health Homes to review these training slides.

Quality Management Program Policy

First Issued: 12/7/12
Reviewed by Quality Committee: 6/11/24
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

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.

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.

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.

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. The 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.

Training

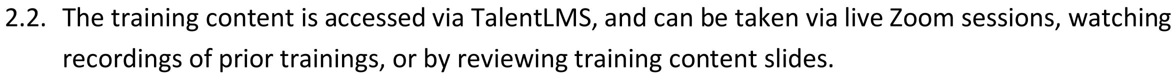
1. General training requirements for CMAs are described in the Staff Training Policy. In addition to the general required trainings, the Quality Management Program uses information gleaned from audit results, Metric Reports, and Quality Committee discussions to identify new training needs, and CMAs in 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 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 Children's HCBS Trainings
   - 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



2.2. 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

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Documentation Requirements

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

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 (not an exhaustive list):

- Consents
  - DOH-5055
  - DOH-5201
  - DOH-5203
  - DOH-5204
- Notices of Determination
  - DOH-5234
  - DOH-5235
  - DOH-5236
  - DOH-5287
- Letters
  - Disenrollment Letter
  - Enrollment Letter
- Assessments
  - Comprehensive Assessment
  - Billing Questionnaire
  - CANS-NY
  - HCBS Level of Care
- Care Plans
  - 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*

Personal Representative Policy[2][3]

First issued: 6/14/24

Reviewed by Children's Committee: 7/25/24

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.

This is why, in the HHSC program, the assessment process includes an assessment of the capabilities of the caregiver (guardian). If the caregiver was fully capable of managing the child's health and social determinants of health needs, they would be unlikely to need or benefit from Health Home Care Management, or the enrollment would be relatively short.

Types of Personal Representatives in New York State:

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[2] This policy does not apply to HHSC members who are Self-Consenting.

[3] 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 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.

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:

1.1. Request a copy of the paperwork authorizing the personal representative to make certain decisions for the member[4].

1.2. 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[5].

1.3. 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. Some children, due to age or cognitive/physical limitations, will not have the capacity to actively participate in program.

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 children in the foster care system

[4] This does not apply to cases where the Personal Representative is a child's custodial parent. We do not need to obtain proof of custody or birth certificates.

[5] In the case of a custodial parent, documenting the parent's contact information in the Legal Guardian section of the FCM Demographics is sufficient.

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.
   6.4. 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[6]	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

[6] Some children, due to age or cognitive/physical limitations, will not have the capacity to actively participate in program.

Language Accessibility Policy

First issued: 5/14/19

Reviewed by Quality Committee: 7/23/24

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[7] may be used when materials are not produced in multiple languages.

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

Member Rights and Complaint Management Policy

First Issued: 12/7/12
Reviewed by Quality Committee: 6/11/24
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.

Definitions:
Complaint: Dissatisfaction expressed verbally or in writing by or on behalf of a member, other than an appeal or Fair Hearing Rights. Such expressions may include dissatisfaction with the provision of services or other services identified in the member’s plan of care. For example: a customer service issue; lack of/dissatisfaction with coordination of care; a long wait in doctor’s office; Health Home Care Manager (HHCM) not returning phone calls; HHCMs lack of response to member request for changing HHCM or Care Management Agency (CMA); etc.

Complainant: the person reporting the issue or filing the complaint; this could be either the member themselves (if they are self-reporting) or a person acting on their behalf (such as a family member).

Grievance: A wrong or hardship suffered (real or perceived), which is the grounds of a complaint.

1. Types of Complaints/Grievances
2. Any violation of rights: for example, a participant’s plan of care being shared with a provider that is not listed on their consent form
3. Availability of service or ability to receive service: for example, a participant being placed on a waitlist to receive a service for more than 1 month
4. Quality of care received and/or whether services are meeting the member’s needs: for example, services provider are not addressing the needs/goals identified on the participant’s plan of care
5. Afforded choice of providers: for example, a participant being told they must receive care management and services from the same agency
6. Whether back up plans are effective: for example, participant is not able to reach provider during a crisis
7. Program eligibility and/or qualifications: for example, participant believes their eligibility assessment was conducted incorrectly
8. Whether health and welfare are being maintained: for example, participant does not receive required care management visits to ensure health and welfare
9. Dissatisfaction with services or providers of services: for example, provider cancelling meetings/sessions or a long wait in a doctor’s office

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.

1. 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.
    1.1. This information must be written at a reading level no higher than 7th grade.
    1.2. An agency Member Rights Document can be used if the above Member Rights are included.
    1.3. 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.
    1.4. The CCMP Member Rights and Responsibilities Form may be used and customized by the CMA.

2. 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.

3. Any children's 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.

4. 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.

5. The complainant must be updated within 72 hours of receiving the grievance/complaint as to the status of the of the complaint/grievance.

6. The CMA must try to resolve the members complaint/grievance to the member's satisfaction, otherwise, if the member is not satisfied with the resolution, the member can escalate the complaint/grievance to CCMP, the Department of Health, the Medicaid Managed Care Plan Complaint line (if applicable), or to the Medicaid Help Line.

7. The entire process from original compliant/grievance report to resolution/escalation must be completed within 45 days.

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.

10. All complaints/grievances for members in a HHSC CMA must be reported to CCMP via IRAMS within 24 hours of receipt of the complaint.
    10.1. Submission in IRAMS triggers an auto-email to CCMP, CMAs do not have to directly notify CCMP.

11. CMAs must ensure that all notes relevant to the incident are available in FCM for CCMP to review.

12. CCMP may contact the CMA to clarify information about the complaint/grievance or response and may make recommendations regarding appropriate preventative/corrective actions.

13. CCMP will notify DOH of the complaint/grievance via IRAMS within 24 hours (or next business day) of receipt of the report from CMA.
    13.1. CCMP will submit the full report to DOH via IRAMS within 30 days of the initial submission by the CMA.
    13.2. The full IRAMS report must include all follow-up actions taken by the CMA and CCMP to address the complaint/grievance. If the CMA does additional actions after their initial submission, they can update the issue in IRAMS prior to the final submission to DOH.

Sources:
IRAMS User Guide
IRAMS FAQ
Complaint and Grievance Policy for Health Homes Serving Children #HH0013

Confidentiality Policy

First issued: 12/7/12
Reviewed by Quality Committee: 10/30/19
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 or DOH-5201) 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.

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 CFTSS or HCBS services, is only referred to the internal agency CFTSS/HCBS programs.

Incident Management and Reporting Policy

First Issued: 12/7/12

Reviewed by Quality Committee: 6/8/21

Revised Effective: 4/1/21

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.

The use of restrictive interventions, including restraints and seclusion: Only applicable to Children receiving HCBS

Exploitation: Only applicable to Children receiving HCBS

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 DOH of the incident via IRAMS within 24 hours (or next business day) of receipt of the report from CMA.
   3.1. CCMP will submit the full incident report to DOH via IRAMS within 30 days of the initial submission by the CMA.
   3.2. The full incident report must include all follow-up actions taken by the CMA and the Health Home to address the incident. If the CMA does additional actions after their initial submission, they can update the issue in IRAMS prior to the final submission to DOH.

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.

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

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

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

Compliance Policy

CCMP's Compliance Policy is a separate document.

Notice of Determination and Fair Hearing Policy

First Issued: 1/25/18
Reviewed by Quality Committee: 7/23/24
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[8].

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.

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

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.

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

Section 3: SERVICE MODELS

Standard Care Management Model Policy Set

First issued: 10/3/16
Reviewed by Children's Committee: 7/25/24
Revised Effective: 6/14/24

Policies in this set apply to staff serving members within the Standard Care Management Model. Staff serving members within the High-Fidelity Wrap model must meet these AND additional requirements outlined in the High Fidelity Wrap 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

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.

Health Home Care Managers that serve children with an acuity level of **"Complex"** as determined by the CANS–NY must have a combination of education and experience[9]:

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[9] Experience must consist of:

1. Providing direct services to high need** children or adults

OR

2. Linking high need** children or adults to a broad range of services essential to successful living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing and/or financial services)

- A Bachelor of Arts or Science with two years of relevant experience, OR
- A License as a Registered Nurse with two years of relevant experience, OR
- A master's with one year of relevant experience.

**CMAs may seek a waiver from the Health Home for Care Managers do not meet the required criteria for service high acuity children by submitting a HHSC High Acuity CM Qualifications: Waiver Request Form to CCMP.

This is an online form submission; after submitting the form CMAs must email the applicant's updated resume to ana.tabachneck@ccmphealthhome.org. CCMP will endeavor to respond to the request within seven business days. **

For children enrolled in the Early Intervention Program and receiving Health Home services through a provider approved under the Early Intervention Program, the minimum qualifications for EIP service coordinators set forth in Section 69–4.4 of 10 NYCRR will apply.

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.

**High Need: SMI/SED, developmental disabilities, alcoholism or substance abuse disorders, complex trauma, or complex medical conditions

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 Qualifications for High Acuity Children
   - Attestation of SCR, SEL, and CHRC Clearances

4. The CMA’s HR department must have access to The Staff Compliance Tracker in HCS-IRAMs and log all staff qualifications (inclusive of clearances and trainings). The Compliance Tracker is reviewed by the state auditors annually but should be updated as close to real time as practicable.

5. 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
Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations
Health Home Serving Children (HHSC) Care Manager Qualifications
Children's Waiver Qualification and Training Tracker Webinar (Now called Staff Compliance Tracker)
Children's Services Capacity and Staff Compliance Trackers User Guide

Staff Training Policy

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

Prior to the delivery of services

- CANS-NY training (see CANS-NY Assessment Policy)
- Consent – HIPAA/CFR 42/sharing of information
- Mandated Reporter training- New York State Mandated Reporter Resource Center- Training Course

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 (currently HHSA only)
- Chart Audit Tool Training (Auditors Only)
- Incident Reporting Training (IRAMS reporters only)

CCMP HHSC Specific Trainings

- Children's HCBS Trainings (4 parts)

Medicaid Compliance Trainings – Required ANNUALLY

- Compliance Policy Training

DOH HHSC Required Trainings

- Crisis Management Basics
- Person-Centered Planning in Behavioral Health
- Advanced Directives
- Engagement and Outreach (e.g., Motivational Interviewing)
- Safety in the Community or Partnering for Safety
- Trauma Informed Care
- Cultural Competency/Awareness
- LGBTQ Issues – serving transgender children/adolescents and working with Lesbian/Gay/Bisexual/Transgender/Questioning Families
- Meeting Facilitation

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)

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

The CMA's HR department must have access to The Staff Compliance Tracker in HCS-IRAMs and log all **DOH HHSC Required Trainings.** The Compliance Tracker is reviewed by the state auditors annually but should be updated as close to real time as practicable.

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

Supervision Policy

Supervision is an important aspect of care management service provision and oversight. The following are minimum requirements for care management supervision:

1. Supervisor to care manager ratio is expected to be 1:5 and must never exceed 1:8

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

3. 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).

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

5. 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

Level of Service Policy

CMAs may provide multiple Core Services per month to accomplish Tasks and help members meet their Goals as outlined on their Health Home Plan of Care. The mode of contact with the member and their Care Team may include but is not limited to: In person meeting(s), mailings, secure emails/texts, telephone/video calls that are reciprocal in nature, and Care Team Meetings.

There are different core service minimums to bill for different groups of members, based on their most recent CANS 2.0 Acuity. These core services must be provided on different days of the month.

Core Service Minimum Billing Requirements:

CMAs serving members Low/Standard Acuity members must provide at least one Core Service (or Diligent Search) per month.

CMAs serving Early Development/Intense or Complex Acuity members must provide at least two Core Services (or Diligent Search) per month, and one of the two Core Services must be in person with the member.

Effective 11/1/24 there are new core service Minimum Billing Requirements for Children:

CMAs serving members Low/Standard Acuity members must provide at least one Core Service (or Diligent Search) per month to meet minimum billing requirements. At least one per quarter must be with the member.

CMAs serving Early Development/Intense members must provide at least two Core Services (or Diligent Search) per month, and one of the two Core Services must be in person with the member. After the first three months of enrollment, the Core Services with the member may be provided via telehealth up to six times per year at the request of the member/caregiver.

CMAs serving Complex Acuity members must provide at least three Core Services (or Diligent Search) per month, and two of the three Core Services must be with in person the member. At the request of the member/caregiver, one of the member contacts may be provided via telehealth.

Sources:

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

Telehealth Policy

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 High Fidelity Wrap program.

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

In person requirements for Core Service provision are outlined in the Level of Service Policy.

Other in person requirements in the HHSC Standard Care Management model are for the initial Comprehensive Assessment to be completed at least partially in person and for all CANS-NY Assessments to be completed at least partially in person.

Caseload Requirements Policy

Policy:
To manage the needs of each member NYSDOH recommends a case load size of 12 for Complex Acuity members, 20 for Early Development/Intense Acuity members and 40 for Low/Standard Acuity members.

CCMP care manager’s case load must never exceed 18 for Complex Acuity, 30 for Early Development/Intense Acuity or 60 for Low/Standard Acuity members.

Procedure:
1. CCMP reviews Care Manager’s caseloads monthly to ensure that no caseload exceeds 150% of the state recommendation.

2. CCMP alerts CMAs if they find their caseload is over capacity.

3. Caseload size and structure are reviewed at Annual Site Visits.

4. CMAs may use the CCMP HHSC Caseload Maximums Tool for assistance managing a HHSC caseload.

Source:

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

High Fidelity Wrap Model Policy Set

First issued:
Reviewed by Quality Committee:
Revised Effective:

Policies in this set apply to staff serving members within the High-Fidelity Wrap Model.

This policy set includes six Policies that apply to the High-Fidelity Wrap Model.

High Fidelity Wrap Model
Quality Management for High Fidelity Wrap
Billing and Tracking for High Fidelity Wrap
Referrals for High Fidelity Wrap
CMA Eligibility for High Fidelity Wrap
Designation of High-Fidelity Wrap CMAs
Eligibility Requirements for High Fidelity Wrap
Staff Qualifications for High Fidelity Wrap
Staff Training for High Fidelity Wrap
Supervision for High Fidelity Wrap
Level of Service for High Fidelity Wrap
Caseload Requirements for High Fidelity Wrap

Quality Management for High Fidelity Wrap
TBD

Billing and Tracking for High Fidelity Wrap
TBD

Referrals for High Fidelity Wrap
TBD

CMA Eligibility for High Fidelity Wrap
TBD

Designation of High-Fidelity Wrap CMAs
TBD

Eligibility Requirements for High Fidelity Wrap
TBD

Staff Qualifications for High Fidelity Wrap
TBD

Staff Training for High Fidelity Wrap
TBD

Supervision for High Fidelity Wrap
TBD

Level of Service for High Fidelity Wrap
TBD

Caseload Requirements for High Fidelity Wrap
TBD

Section 4: SERVICE PROVISION

Referrals Policy Set

HHSC 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

Lead Health Home Referrals Policy

First Issued: 7/18/18
Reviewed by Quality Committee:
Revised Effective: 6/1/22

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 Children's 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.
   9.1. Considerations are:
   - CMA self-identified ability to accept Lead Health Home referrals, and any volume caps
   - CMA ability to serve High Risk members (Complex, Early Intervention, High Fidelity Wrap, Medically Fragile)
   - CMA Performance Improvement Plan status, including Children's HCBS Metrics
   - CMA catchment area
   - CMA population served (*ex. age, language*)

- Potential member provider affiliation (*ex. someone already using Brightpoint clinics may be most appropriate for the Brightpoint CMA)*

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[10] in FCM, and attempt contact with the potential member within two business days from date of acceptance of the referral.

11. CMAs must enter Lead Health Home Referrals into MAPP using the Children's Referral Wizard.
    11.1. This must happen the same day that the Enrolled Segment is opened in MAPP.

12. 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-5201 or DOH-5055 consenting.
    - Advises the referral source to be prepared to provide proof of diagnoses (if available) to the CMA.

13. 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).
    13.1. 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.

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

14.1. 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.

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

15. If a potential member is interested in and eligible for enrollment, they must be enrolled into the CCMP Health Home.

15.1. If a CMA completes an intake/enrollment meeting (including a signed DOH-5055 or DOH-5201 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.

16. If a CMA enrolls a member from an excluded setting, they must follow the Excluded Settings Policy.

16.1. It is recommended that CMAs enroll from excluded settings only when there is a plan for discharge/release to the community.

16.2. CMAs will need to work closely with the discharge/release planning staff and Medicaid to ensure that any institutional Medicaid Restriction Codes are removed.

17. 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.

18. 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.

Bottom-Up Referrals Policy

First issued: 7/18/18
Reviewed by Quality Committee:
Revised Effective:

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. 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".
   3.1. 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.

4. 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.

5. CMAs may open Outreach segments[11] 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.

6. 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

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

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.

7. 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).
    7.1. 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.

8. 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.

9. 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.

10. 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.

11. 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.
    11.1. 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.

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

13. CMAs must enter Bottom-Up Referrals into MAPP using the Children's Referral Wizard.
    13.1. This must happen the same day that the Enrolled Segment is opened in MAPP

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.

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.

5. 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.

6. 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.

7. 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.

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 to 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.

Procedures:

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.

Intake and Enrollment Policy

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

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 an Outreach Worker, 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. The meeting should take place with the potential member and their identified parent, guardian, legal representative, or other involved family members, per the member's wishes.

If the potential member is a Non-Self-Consenting Child, then the meeting must occur with the child and their parent, guardian, or legal representative, as the child does not have the legal authority to consent to health care services such as Health Home on their own.

If the potential member is a Self-Consenting Child it is preferable to have the meeting with the child's identified parent, guardian, legal representative, or other involved family members, but since the child can consent to health care services such as Health Home on their own, it is not required.

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 Health Home Enrollment and Consent form(s) with the potential member.

4. If 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.

5. Provides the potential member with a Notice of Privacy Practices (DOH-5055, Children's FAQs, or agency NPP), reviews the Member Rights, and explains the process to file a grievance or complaint.

6. 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.

7. 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.
   7.1. 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, the ability to voluntarily disenroll 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.

8. 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 Welcome/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?

9. Once the decision to enroll is made, the CMA opens an Enrolled Segment in FCM.
   9.1. 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.
   9.2. Per DOH email communications, the date of the consent is the date of enrollment.
   9.3. 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.
   9.4. 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.

Eligibility Requirements Policy

First Issued: 7/18/18
Reviewed by Quality Committee: 6/11/24
Revised Effective: 9/1/24

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[12]. 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 on the Annual Comprehensive Re-Assessment.

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

[12] 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.

Medicaid

1. Members must have active Medicaid, either Fee for Service (FFS) or through a Managed Care Organization.

2. There are certain Medicaid restriction codes that are incompatible with Health Home Care Management.
   Health Homes Restriction Exemption Codes
   Medicaid Coverage Codes [13]
   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.

[13] 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.

Eligible Diagnoses

1. HHSC members must have either:

   Two chronic conditions (see list of DOH Qualifying Diagnoses (Chronic Conditions) List for Both Adult and Children's CMAs)

   OR

   HIV/AIDS

   OR

   One Serious Emotional Disturbance[14] (see Definition of SED for Children's Health Homes Eligibility, and HH Eligibility Process for SED/SMI/HIV/IDD)

   OR

   Complex Trauma (see Complex Trauma Referral Cover Sheet, Complex Trauma Exposure Screen, Complex Trauma Exposure Assessment, Complex Trauma Eligibility Determination Form, and Complex Trauma Health Home Referral Workflow)

   OR

   Sickle Cell Disease (effective 4/4/22)

   OR

   Already determined to be eligible for Children's HCBS at the time of referral to Health Homes

1. 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.
   1.1. 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.

2. 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.
   2.1. In this case, qualifying diagnoses would be visible on the monthly BSQ and the FCM Diagnosis Widget.

3. 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.
   3.1. There are certain cases where the HHCM's understanding of the member's diagnosis changes over time.

[14] Must be supported by the CCMP SED Verification Form and an annual evaluation by the member's mental health provider.

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.

4. 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

5. 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.

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 – Appropriateness Criteria:

Significant Risk Factor/Appropriateness Criteria
ADVERSE EVENTS RISK: Direct referral from Managed Care Organization (MCO), Local Government Units (LGU), Single Point of Access (SPOA), or county Local Department of Social Services.
ADVERSE EVENTS RISK: Member currently involved with mandated preventive services and/or direct referral from Child Protective Services/Preventive Services Program, County Local Departments of Social Services, Administration for Children's Services (for New York City), Special Education Program, Schools (e.g., children suspension, truancy, grade failure/repeat grade or summer school). Must specify provider of service and date of referral.
ADVERSE EVENTS RISK: Member received an initial Disability Determination (SSI or DOH Disability Certificate/letter) within the last 6 months
ADVERSE EVENTS RISK: Member recent inpatient/Emergency Department/psychiatric hospital/Detox/Skilled Nursing/Crisis Stabilization within the last 6 months. Must specify name of institution and date of release
ADVERSE EVENTS RISK: Member recent out of home placement (foster care, relative, Residential Treatment Facility (RTF), Residential Treatment Center (RTC), Qualified Residential Treatment Program (QRTP), Community Residence, Residential Crisis, etc.) within the last 6 months. Must specify name of institution and date of release
ADVERSE EVENTS RISK: Member recently diagnosed with a terminal illness/condition within the last 6 months. Must specify condition and date diagnosed
ADVERSE EVENTS RISK: Released from Jail/Prison/Juvenile detention, involved with Probation, PINS, Family Court within the last 6 months. Must specify name program and date of release/court/probation
HEALTHCARE RISK: During the last 3 months, the member has been unable to schedule and keep their healthcare appointments (medical, psychiatric, etc.) and they do not know who their provider(s) is and how to contact their provider(s). Must describe the issue.
HEALTHCARE RISK: Member does not have at least one (1) of the following: Primary Care Provider, mental health provider, substance use provider, or provider to treat their Single Qualifying Condition (Complex Trauma, Sickle Cell Disease, Serious Emotional Disturbance/Serious Mental Illness, or HIV) or physical disability related to a neurologic, muscular, or neuromuscular condition.
HEALTHCARE RISK: Member has not seen their provider (e.g., PCP, BH, etc.) in the last year
SOCIAL DETERMINANTS RISK: Current Intimate Partner Violence/Current Family Violence in the home of the member
SOCIAL DETERMINANTS RISK: Member is experiencing food insecurity (due to financial limitations, ability to shop, access food site, dietary restrictions, etc.) and needs one of the following: • Emergency Food Assistance: Supplemental Nutrition Assistance Program (SNAP), Food Pantries, and Meals on Wheels • Women Infants and Children (WIC) for children under age 6 and pregnant/postpartum individuals.
SOCIAL DETERMINANTS RISK: Currently homeless (HUD 1, 2, or 4) & for Transitional Age Youth, has no stable living arrangement (living with different friends/family)
SOCIAL DETERMINANTS RISK: Member (or caregiver, if Member is a child) needs and does not have one (1) of the following needed entitlements: • Medicaid Transportation/Access-a-Ride • Housing Supports (Section 8, Empire State Supportive Housing Initiative (ESSHI), New York Health Equity Reform (NYHER) Housing Supports) • Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Temporary Assistance for Needy Families (TANF) • Home Energy Assistance Program (HEAP) • Medical Entitlements (Medicare/Medicaid support) • Child Care Supports (for caregiver of enrolled children) • Early Intervention (Head Start or Special Education)
SOCIAL DETERMINANTS RISK: Member has had a change in guardianship/caregiver within the last 6 months
SOCIAL DETERMINANTS RISK: Member is concurrently Health Home appropriate due to caregiver/guardian enrolled in Health Home. Must specify the Health Home/Care Management Agency enrolled with.
SOCIAL DETERMINANTS RISK: Recent institutionalization or nursing home placement of member's primary support person within the last six (6) months and there is no other person to provide the same level of support.
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

3. 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.
   3.1. 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.

4. 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.

Consent

Background

Given the age of the Children's Health Home members, there are privacy and consent requirements that are more nuanced than those of the Adult Health Home model.

All relevant laws and regulations must be adhered to including but not limited to:

- Family Education Rights and Privacy Act of 1974 (FERPA) – 34 CFR Part 99
- NYS Personal Privacy Protection Law (PPPL) – Public Officer's Law §§91-99
- Individuals with Disabilities Education Act (IDEA) – 20 USC §1417, et seq. and its implementing regulations at 34 CFR §300.610-300.627
- HIPAA
- The Affordable Care Act
- The New York State Department of Health
  - Public Health Law (PHL) 2504 • Article 27-f
  - Social Services Law (SSL) 365-l
- The Office of Mental Health
  - Mental Hygiene Law (MHL) 33.21, 33.16, 9.13
- The Office of Alcoholism and Substance Abuse Services
  - Mental Hygiene Law (MHL) 22.11
- 42 Code of Federal Regulations (CFR) 2.14
- The Office of Children and Family Services
  - SSL 383-b and 398(6); FCA 355.4
- 18 New York Codes, Rules and Regulations 441.22

Policy

Children and adolescents who are parents, pregnant, married, or are over the age of 18, are legally able to consent for their own enrollment into a Children's Health Home, and are referred to as "*Self-Consenting Children*".

Any child who does not fall into one of the above four categories is referred to as a "*Non-Self-Consenting Child*", and only their personal representative (usually parent) can consent to enroll them into the Health Home and authorize health information sharing among their providers.

Both Self-Consenting and Non-Self-Consenting Children can refuse services.

The term "Health Home Consent" is used to refer to either the DOH-5055 (used for Self-Consenting Children) or the DOH-5201 and FAQs (used for Non-Self Consenting Children).

Procedure

1. Health Homes is a voluntary program; therefore, members must consent 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.

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 dated and initialed 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. 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.
    10.1. Sharing PHI with an entity not listed on the Health Home Consent, or a valid 2-way authorization form, may constitute a PHI Breach.

11. Revoking consent for an entity previously listed on the Health Home Consent (DOH-5201) is done by checking the “remove” checkbox next to the entity, the member adding the date of the change, and the member and worker adding their own respective initials.

12. Revoking consent for an entity previously listed on the Health Home Consent (DOH-5055) is done by ~~striking through~~ the listed entity, and the member/staff initialing and dating the change.

13. 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.

14. 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.

15. CMAs may have many other consent forms that they use for various reasons.
    15.1. With any consent form, the instructions for that form must be followed.
    15.2. With any consent form, all required fields on the form must be filled out.
    15.3. 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.

16. Some children are not able to participate in the consenting process due to age or other significant functional limitations. Barring such an explicit functional limitation, children should be actively included in the consenting process, regardless of whether they have the legal right to sign various consent forms.

Self-Consenting Children

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[15][16].

[15] *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.*

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.

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.

Non-Self Consenting Children

1. Consent to enroll and consent to share PHI is documented on the DOH-5201.

2. The Health Home FAQs is a separate document, and functions as the Notice of Privacy Practices for the Health Home.

3. Without completion of a DOH-5201 and the Health Home FAQs, a potential member cannot enroll into the program.
   3.1. If a potential member has been determined to be otherwise eligible and appropriate, and wants to enroll into the program, but their personal representative refuses to complete the DOH-5201 and review the FAQs, the CMA must document this in the case record.
   3.2. Care Management Core Services cannot be billed without an appropriately completed and signed DOH-5201 and FAQs.

4. An updated DOH-5201 must be done within 30 days if:
   - A Non-Self Consenting Child enters or exits foster care (new DOH-5201)
   - The personal representative who signed the consent is no longer the personal representative for the Non-Self Consenting Child (new DOH-5201)
   - A Non-Self Consenting Child becomes a Self-Consenting Child, i.e., turns 18-years-old, gets married, becomes pregnant, or becomes a parent (new DOH-5055)

5. The CMA must review the FAQs with the family, complete page 3 of the FAQs (may be pre-filled by the CMA) and provide them with a copy of the FAQs.

6. The DOH-5201 is the equivalent of the DOH-5055; it is where the family consents to enroll into the program and lists the providers who can share PHI about the member (Care Team). The first page contains instructions to the guardian, HHCM and consenting entity who may be completing or reviewing the form. The rest of the DOH-5201 is divided into two sections.

7. Section 1 of the DOH-5201 is completed by the Non-Self Consenting Child's personal representative (usually the parent).

8. Section 2 of the DOH-5201 is only completed for Non-Self Consenting Children aged 10 or older. Section 2 is completed privately by the child with the Care Manager. When applicable, Section 2 is completed

separately because children over the age of 10 may consent (without their guardian's knowledge) to information sharing about the following Health Care services:

- Family Planning
- Emergency Contraception
- Abortion
- Sexually Transmitted Infection Testing and Treatment
- HIV Testing
- Prenatal Care, Labor/Delivery
- Chemical Dependency
- Drug and Alcohol Treatment
- Sexual Assault Services
- Mental Health Services and Developmental Disabilities services- *For children over the age of twelve*

9. When completing the DOH-5201 Section 1, the enrolling worker reviews all material on the first page of Section 1, including that the member may disenroll or withdraw consent at any time and that all PHI can be shared with all Care Team Members in Section 1.

10. The potential member's personal representative signs and dates the first page of Section 1 to indicate their consent to enroll the child into the program, and authorization for the entities on the section page of Section 1(Care Team Members) to receive and share the potential member's PHI.

11. The potential member's personal representative and the enrolling worker list all members of the Care Team on the second page of Section 1[17].

12. CCMP and Child's Name must be indicated at the top of each page.

13. All entities that the personal representative wants to consent must be added by hand.
    13.1. Commonly consented entities have designated rows, such as CMA, MCO, PCP, Hospital, Etc.
    13.2. Additional entities can be consented on the rows labeled "Name of Participating Provider".

14. Subsequent updates to the consented entities are made by checking the add/remove checkboxes, the guardian dating the change, and both the personal representative and HHCM initialing the change.

15. The "Health Home Care Management Tracker for Section 2" is completed for all DOH-5201's, regardless of the age of the child, or what happened with Section2.

[17] *The procedures for completing the DOH-5201 were updated effective 6/1/22 with the use of the revised DOH-5201 form; all members enrolled prior to that date are required to be re-consented with the new form and procedure by the time of the next CANS Assessment, or no later than 12/1/22.*

16. When completing Section 2, the enrolling worker reviews all material on the first page of Section 2, including that children over age 10 can consent to certain healthcare services on their own, and therefore can consent to share information about those services on their own.

17. Should it not be possible for the child to complete section 2 of the DOH-5201, the reason must be documented in the case record in a note, and on the "Health Home Care Management Tracker for Section 2".
    17.1. In this case the HHCM would revisit Section 2 with the family when appropriate, but at least annually in conjunction with the Annual Comprehensive Assessment.

Refer to the CCMP Enrollment Training for extensive instructions, including examples of how to complete and update Section 2 with a child over age 10.

Continued Eligibility for Services Policy

First Issued: 12/8/20
Reviewed by Quality Committee: 12/8/20
Revised Effective: 6/14/24

Effective 11/2/23 DOH has implemented routine Continued Eligibility for Services screening for the HHSA program with a standardized DOH CES Tool. HHSC members are exempt from these requirements. Therefore, CCMP is no longer having HHSC CMAs complete CCMP’s CES Review Tool.

This policy will be updated if DOH expands CES Screening to HHSC.

Sources:

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

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
- OPWDD/TBI Waiver
- Nursing Home Diversion Waiver

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.

Assignment to Care Managers Policy

First issued: 11/29/16
Reviewed by Children's Committee: 7/25/24
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.

Comprehensive Assessment Policy

First issued: 12/7/12

Reviewed by Quality Committee: 6/11/24

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[18].
   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.

[18] 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. 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.
   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 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 IEP your teachers are giving you extra time for tests, is that correct?"*
    11.4. Information gathered from the CANS-NY should be reflected in and not contradicted by the Comprehensive Assessment. Both the CANS-NY and Comprehensive Assessment are required; neither substitutes for the other.

12. All providers and family members identified in the Comprehensive Assessment should be reflected on the Health Home Consent (DOH-5055 or DOH-5201), 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 translated into goals on the Health Home Plan of Care.
    13.3. Care Managers should attempt to get copies of all Advanced Directives and upload them to the FCM Documents Tab.
    13.4. Resources for talking with families about Advanced Directives and End of Life Planning are available in the Supplemental Resource Links.

14. The Comprehensive Assessment document may be shared with the member's Care Team since they are listed on the Health Home Consent (DOH-5055 or DOH-5201). If the member wants this document shared with anyone not already on the Health Home Consent (and that they do not want to add to the Health Home Consent), this must be documented on a HIPAA compliant authorization for release of information form.

15. Children's CMAs may choose to use an alternate Assessment tool in place of the Comprehensive Assessment in FCM, if pre-approved by CCMP. An example of this would be the Mount Sinai Health Home Children's Comprehensive Assessment Tool.
    15.1. If an alternate tool is used it must be uploaded (all pages) to the FCM Assessment Tab.
    15.2. If the alternate tool was completed by hand, it must be fully legible.
    15.3. If the alternate tool used does not include the areas that are traditionally Plan of Care Requirements described in item seven above, then the CMA will be required to include those items on the Plan of Care.

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

CANS-NY Assessment Policy

First issued: 10/3/16

Reviewed by Children's Committee: 7/25/24

Revised Effective: 6/14/24

Purpose:

To describe all required components and timeframes around the CANS-NY Assessment.

Policy:

CCMP Children's CMAs are required to complete a CANS-NY Assessment on all enrolled members, to determine the member's strengths and needs. This process determines the acuity level of the member, which sets the billing rate and guides the ongoing Care Management services. The CANS-NY does not determine eligibility for the Health Home program.

Procedure:

1. The Care Manager assigned to the member completes the Initial CANS-NY within 30 days of enrollment.
   1.1. Members are billed at the Low/Standard Acuity rate until the completion of the CANS-NY.
   1.2. If the CANS-NY is not completed by the end of the second month of enrollment, the CMA will no longer be able to bill until the month the CANS-NY is completed.

2. Once the CANs-NY is finalized, it will generate either a Low/Standard, Early Development/Intense, or Complex Acuity[19] rate code based on the functional needs of the member.
   2.1. Each Acuity level has its own number/type of core service requirements needed to bill at that rate.
   2.2. In any given month, if the core service requirements for the CANS-NY determined acuity level were not met, but the requirements for a lower acuity level were met, the case can be billed at the lower rate.
   2.3. The billing rate can never exceed the rate set by the CANS-NY determined acuity level, even if the core service requirements for a higher acuity level were met.

3. The Care Manager assigned to the member completes the CANS-NY annually.
   3.1. The CANS-NY is due annually from the 1st date of the month in which the prior CANS-NY was completed.
   3.2. In the High-Fidelity Wrap model, the CANS-NY is due every 6 months from the 1st date of the month in which the prior CANS-NY was completed.

4. The Care Manager assigned to the member completes an early CANS-NY within 30 days of the following events; regardless of when the formal annual update is due:

[19] Prior to CANS 2.0 implementation on 11.15.23, the Acuities were Low, Medium, and High.

- Significant change in member's functioning (including increase or decrease of symptoms or a new diagnosis)
- All service plan and treatment goals are achieved.
- Member admitted, discharged, or transferred from hospital/detox, residential placement, or foster care
- Member has been seriously injured or in a serious accident
- Member's (primary or identified) caregiver is different than on the previous CANS-NY
- Significant change in caregiver's capacity/situation
- Court request

5. Anytime a new CANS-NY is completed, the timeline for completing the next annual CANS-NY is reset.

6. The CANS-NY can be completed over any number of days, but at least partially in person with the member[20].
   6.1. The CANS-NY is data entered into the UAS-NY within one business day of completion.
   6.2. The process of completing or updating the CANS-NY is reflected in corresponding Encounter notes.

7. A one-time assessment fee ($185) per enrollment into a designated children's health home may be billed upon completion of the first CANs-NY assessment.
   7.1. There is no assessment fee for CMA to CMA, or HH to HH enrolled transfers, as the transfer is considered a continuation of care.

8. Information gathered from the CANS-NY is reflected in and not contradicted by the Health home Comprehensive Assessment. Both the CANS-NY and the Comprehensive Assessment are required and inform the development and revision of the Plan of Care.

9. Supporting Documentation for the CANS-NY must be present in FCM for any item on the CANS-NY that was scored as a "2" or a "3", and those needs must be reflected on the Plan of Care.

10. Care Managers and Supervisors must complete training(s) and certification in the CANS-NY prior to providing care management services to children and families and must recertify annually.
    10.1. Both Care Managers and Supervisors must complete the Into CANS-NY Training.
    10.2. After completing the Into CANS-NY Training, Supervisors must also complete the Supervisor CANS-NY Training.
    10.3. CANS-NY certification is done in UASNY and can only be accessed after trainings are completed..

[20] [20] The CANS-NY 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*

15. Additional optional trainings are available through the CANS-NY Institute on Building Engagement with Youth and Families and Plan of Care Training.

Training and Compliance
CCMP does not provide training on the CANS-NY, all training is provided through UASNY and the CANS-NY Technical Assistance Institute. Documentation of training completion is kept in the CCMP Learning Management System, Talent LMS.

11. Compliance with this policy is monitored with chart audits and site visit review of training records, per the Quality Management Program Policy.

Sources:
CANS 2.0 Algorithm[21]
Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations
A Guide to Edits Included in Policies Relating to the CANS-NY

[21] Technically, DOH has not published the CANS 2.0 Algorithms as they had with the original CANS. This was shared in a training, and when asked about the algorithm, DOH referred Health Homes to review these training slides.

Plan of Care Policy

First Issued: 12/7/12
Reviewed by Children's Committee: 7/25/24
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 and CANS-NY 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.

2. The member should play a central and active role in the development and execution of their POC.
   2.1. Some children are not able to participate in the development and execution of their POC due to age or other significant functional limitations. Barring such an explicit functional limitation, children should be actively included in the POC process.

3. 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.

4. 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.

Required Elements of the POC

5. The POC must contain goals and tasks that address the member's qualifying diagnoses for Health Home, as the member deems necessary.
   5.1. 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.
   5.2. 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.
   5.3. Any **health and safety risks** identified on the CANS-NY or Assessment, that require active Care Management interventions, must be incorporated into the Plan of Care.

6. The POC must identify all active **Needs** that the member chooses to work on. These needs are elicited through the comprehensive assessment and CANS-NY process and member choice.

Possible types of needs are[22]:

- Primary Care
- Home Care
- Advanced Directives
- Substance Use Disorder
- 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

7. For each active need area, identify one or more **Goals** that the member will attempt to meet, that would contribute towards addressing the need.
   7.1. Goals must be: Specific, measurable, time framed, and obtainable.

8. 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.
   8.1. Tasks must be: Specific, measurable, time framed, and realistic.
   8.2. Tasks must clearly identify who is responsible for the Action (i.e., the member, the Care Manager, or a specific Care Team member)

9. Needs, Goals, and Tasks are all built from a foundation of the member's identified **strengths**, **barriers**, **strategies to overcome barriers**, and **preferences**.
   9.1. Member strengths and barriers are documented in the Background Tab, which auto-populates onto the POC.
   9.2. Strategies to Overcome Barriers, and Preferences, are documented in the Comprehensive Assessment.

10. 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 the High-Fidelity Wrap Model?

[22] This list is taken from the NYS DOH Health Home Re-Designation Scoring Tool

10.1. This may be documented on the Comprehensive Assessment, the Plan of Care, or elsewhere in the case record.

11. There must be an **Emergency Contact** for the member.
    11.1. In FCM, this is documented in the demographics which auto-populates onto the POC.

12. There must be documentation of the child's **History and Risk Factors** related to services, treatment, wellbeing, and recovery.
    12.1. In FCM this is documented in the Background Tab, which auto-populates onto the POC.

13. **Medicaid State Plan and Non-Medicaid services identified to meet child's needs**, including Physical, Behavioral, Community and Social Supports must be evident on the POC. Plan must also document the indication of choice of (a) Service Provider, (B) Reason for the Service and (C) Intended Goals.
    13.1. Entering all Care Team members into the Care Team widget in FCM will identify the Service Provider and Reason for the Service, and data on Care Team members will auto-populate onto the POC.
    13.2. If any of the Medicaid State Plan or Non-Medicaid service providers were consented by a child over the age of 10 by using Section 2 of the DOH-5201, they cannot be listed on the Health Home POC as usual. These providers and services would be on a separate page of the Health Home POC so that the child's privacy preferences as outlined on Section 2 of the DOH-5201 can be honored.

14. **Key Informal Community Supports** must be evident on the POC. This would include any supports in place for the child/family that address identified needs
    14.1. Informal Community Supports that are consented are considered Care Team members; if they are entered into the Care Team widget in FCM these supports will auto-populate onto the POC.

15. There must be clear documentation of **Care Team Member participation or non-participation** (inclusive of family members, community members, natural supports, healthcare providers, social service providers, and/or MCO) in POC development and updates.
    15.1. Participation/Non-Participation is documented in the encounter note describing the development/revision/signing of the POC, and/or the Care Team Meeting note.
    15.2. Care Team Members are documented in the Care Team Widget, which auto-populates onto the POC.

16. 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?
    16.1. In FCM, these are documented in the Comprehensive Assessment. If a CMA uses an alternate pre-approved assessment tool, then these must be documented on the POC.

17. **Other Service Plans** as appropriate, such as Individualized Education Plans, Family Assessment Service Plans or Individualized Family Service Plans should be reviewed by the Care Team and appropriate items incorporated into the POC.

18. For children over age 14, the POC must reflect goals related to the child's **Capacity to Live Independently**, and the identification of available resources.

19. For children who will be transitioning into the adult service system, the POC must reflect goals related to that **Transition**.
    19.1. As physically disabled participants reach their 17th birthday, the CMA will begin to assist the enrollees in planning for transition to other services and/or programs
    19.2. For Foster Care enrollees, eighteen months prior to reaching the enrolled child's 21st birthday, the CMA generates a Transition Plan that identifies the action steps needed to connect with services each child needs in adulthood and the party responsible for conducting the action steps.
    19.3. For any member of a Children's CMA who is 20 years old, the Health Home POC should include a plan for transition into an Adult CMA.

20. 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.
    20.1. If a child is Non-Self-Consenting, their Personal Representative must sign the POC. The member should co-sign the POC if they are able to do so, but only the Personal Representative can sign official documents for the member. 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.
    20.2. 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.

21. 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.
    21.1. 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:

- HCBS providers (children)

3. Medicaid MCOs 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.

3. If the CANS-NY is completed earlier than the annual schedule, the POC should be updated as well.

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.

HCBS Plan of Care

1. For children eligible for HCBS (completed HCBS LOC in UASNY with a capacity slot and K-code), the POC is used to meet the requirements of an HCBS POC.

2. The POC must be shared with the MCO paying for the HCBS; this is done through syncing the POC to MAPP.

3. All children with a capacity slot and K-code must have an HCBS Need or Goal documented on their Health Home POC; irrespective of whether they are currently receiving HCBS or not.
   3.1. The HCBS Need or Goal can be used to document Goals and Tasks related to:
   - Finding an HCBS Provider and referring to an HCBS Provider
   - Attending an intake appointment for HCBS
   - The member's HCBS goals
   - Ongoing provision of HCBS, including conversations with the provider, and Scope, Frequency, and Duration[23] of the HCBS 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 Plan of Care Policy #HH0008
Comprehensive Assessment Policy #HH0002
Member Disenrollment from the Health Home Program Policy #HH0007
Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016

[23] Effective August 2024 Scope, Frequency, and Duration should be determined by the HCBS Provider, entered into the HCBS Referral Portal (HCS/IRAMS), and synced directly to the MAPP POC. It no longer has to be entered by the HHCM.

Children's Home and Community Based Services (HCBS) Plan of Care (POC) Workflow
Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations

Safety Plan Policy

First Issued: 6/14/24
Reviewed by Children's Committee: 7/25/24

Policy:
Any health and safety risks identified on the CANS-NY or Assessment will have a corresponding Safety Plan in the member's chart.

Procedures:

1. At the time of completion of the Comprehensive Assessment and/or CANS-NY, the Care Manager will ensure that any health and safety risks are mitigated with a Safety Plan.

2. Depending on the nature of the risk, the plan may have a specific focus, for example (not an exhaustive list):
   - Fire
   - Health
   - Electricity Outage
   - Self-Harm
   - Suicide Prevention
   - Disaster
   - Other emergency

   2.1. A Safety Plan can be written to address multiple risks, or the member can have multiple plans, i.e. a Disaster Plan and a separate Suicide Prevention Plan.
   2.2. It is not the case that all members have to have a plan for a fire, or a disaster, or self-harm, etc. It is specific to the risks identified for that member through the assessment process.
   2.3. There may be some members whose assessments do not identify any risks. In those cases, no Safety Plan would be needed.
   2.4. Children in the HCBS Waiver or High-Fidelity Wrap by definition will have risks that need to be mitigated and should all have a Safety Plan.

3. The Safety Plan consists of the following:
   - What is the risk?
   - What needs to happen to mitigate the risk and keep the member safe?
   - When will the plan be completed? (May be an ongoing plan, or not)
   - Who will help carry out the plan?
   - How will the Care Manager, Member, and Care Team know if the plan is working?

4. The Care Manager coordinates with the Care Team regarding the identified risks and ensures that there is only one Safety Plan for that risk. For example, members in foster care are required to have an Emergency Plan, so if the foster care agency has already made an Emergency Plan, CM should obtain a

copy of it, rather than write a second emergency plan.

5. The Care Manager coordinates with the Care Team to determine who is in the best position to develop the plan with the member. For example, a Care Manager should not be developing a Suicide Prevention Plan unless the member does not yet have a Mental Health Provider who could do so.
   5.1. Even if the Care Manager does not develop the Safety Plan, they should get a copy and upload it to FCM. Likewise, any Safety Plans the Care Manager develops with the members should be shared with the Care Team, so that all are aware of the plans in place to mitigate risk.

6. Elements of the Safety Plan may end up as Needs, Goals, or Tasks on the Plan of Care, if they require active work.

7. CCMP has created a custom assessment, "Safety Plan" in FCM that CMAs may use if they don't have their own template.

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
High Fidelity Wrap 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[24]:

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.
- 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.

[24] CCMP has developed the Core Services Definitions Guidance to help CMAs understand the difference between the different Core Service Types.

- 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 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 support, 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.

Source:

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

Care Team and Care Team Meetings Policy

First issued: 11/8/19
Reviewed by Children’s Committee: 7/25/24
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[25]: 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[26]: 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.

[25] In various state policies this may also be referred to as a Multidisciplinary Team, Interdisciplinary Team, etc.
[26] 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 CM.
   3.1. The Care Team Meeting must be scheduled at a time/place that is convenient and accessible for the member/caregiver.
   3.2. Effective 11/1/24, a Care Team Meeting must have the member and their caregiver present, at minimum. This is because no decisions about the member's care can be made without member/caregiver participation.
   3.3. The CMA may use technology conferencing tools, such as Zoom/Webex/GoToMeeting when security protocols and precautions are in place to protect PHI.
   3.4. 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.
   3.5. 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[27].
   - Upon member or Care Team Member request.
   - Effective 11/1/24, at the time of any CANS-NY or HCBS Eligibility Assessments

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.

[27] Effective 11/1/24, the frequency of Care Team Meetings is dependent on the member's Acuity. Low/Standard: Annually, Early Development/Intense: Every 6 months, Complex: Every 3 months, High-Fidelity Wrap: Within the first 45 days of enrollment, and monthly thereafter.

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
Health Home Serving Children Care Management Core Service Requirements and Billing Policy #0017 – effective 11/1/24

Managed Care Organization Policy

First issued: 11/22/16

Reviewed by Quality Committee: 7/23/24

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 their Health Home Consent, 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

Source:

Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents #HH0009

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.

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 or DOH-5201 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.

Hospital Follow-Up Policy

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[30].
   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 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.

[30] 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*

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.

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

Excluded Settings Policy

First Issued: 5/14/19
Reviewed by Quality Committee: 4/14/20
Revised 4/13/20

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. The CANS-NY and/or HCBS LOC could be completed during this time.

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

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.

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)[31]

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 High-Fidelity Wrap

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.

[31] 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.

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.

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[32] (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.

[32] Unclear if this will include HCBS required fields pulled from the HCBS-CORE Tab

8. Initial Appropriateness is not required, but 60-day POC[33] and 12-month CES Tool are still required.

TRANSFERS DUE TO PROGRAM CLOSURE

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):
   - 2.1. [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[34]. 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.
   - 2.2. 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.
   - 2.3. Identify groups of members:

If the CMA does not have another Health Home with capacity to take members

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”.

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[33] Unclear if the prior CMA’s signature date within the prior 12 months will override this requirement or not

[34] The letter will be developed by CCMP and CMA based on the unique circumstances of the closure.

<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.

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[35]:
   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

[35] This is an example of what has been allowed in the past, however, "past DOH determinations do not guarantee future DOH decisions".

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).

- 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 Health Home Consent including the new CMA 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[36] (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.

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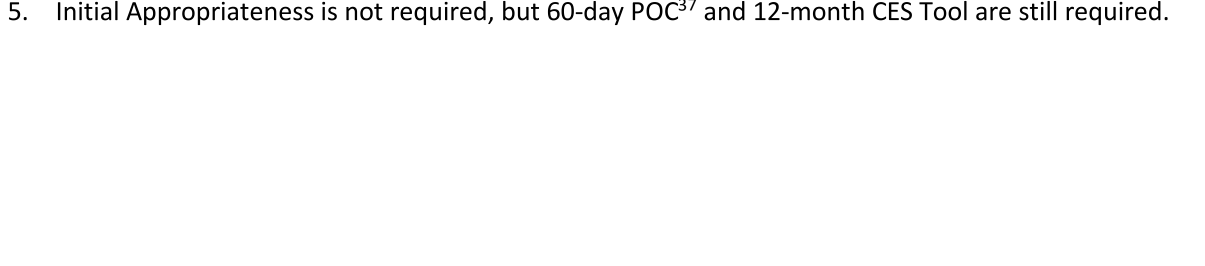
[36] Unclear if this will include HCBS required fields pulled from the HCBS-CORE/Children's Waiver Tab

5. Initial Appropriateness is not required, but 60-day POC[37] and 12-month CES Tool are still required.



[37] Unclear if the prior CMA’s signature date within the prior 12 months will override this requirement or not

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 member's, or potential member's, enrolled or outreach segment in MAPP. **T**he Disenrollment date is the last day of the segment. The Disenrollment reason is documented with a segment End Reason Code.

DOH lists all valid End Reason Codes 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 CCMP Disenrollment End Reason Code Definition Chart for more details.

Disenrollments are documented with Disenrollment Notes, Disenrollment Forms, and Disenrollment Letters.

Disenrollments for specific reasons may have additional requirements, described in the Disenrollment Policy, and the Referral Closure Policy.

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

Referral Closure Policy

First issued: 5/14/19
Reviewed by Quality Committee: 6/11/24
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.
   - CMA must issue the DOH-5234 with a corresponding Enrollment letter.
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 required only if the potential member had already completed an enrollment meeting/ Health Home Consent 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/ Health Home Consent. 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/Health Home Consent. 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/ Health Home Consent. 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/ Health Home Consent. 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/ Health Home Consent. No corresponding letter required.
- Category: Disenrolled

Individual moved from Outreach to Enrollment Status (Code 25)

- Used when potential member has signed a Health Home Consent intending 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/ Health Home Consent. 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/ Health Home Consent. 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

Disenrollment Policy

First issued: 12/7/12
Reviewed by Quality Committee: 5/11/22
Revised Effective: 6/1/22

Purpose:
To describe all required actions when disenrolling a member from Health Home Care Management services, i.e., ending an enrolled segment.

Policy:
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 disenrollment reason and plan with the CMA supervisor.
   - Discuss the disenrollment reason and plan with the member.
   - Discuss the disenrollment 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

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, as long as they meet the following requirements:

3. Disenrollments for members enrolled in the Children's Waiver (K-code on Medicaid case), must follow additional steps:
   3.1. Confirm whether the member is actively receiving HCBS services or not.
   3.2. Find out whether the member wants to continue in the Children's Waiver, regardless of whether or not they are currently receiving HCBS services.
   3.3. If yes, transfer case to C-YES
   3.4. If not, disenroll from the waiver simultaneously with disenrollment from Health Home Care Management.

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

4. 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?

<u>Examples of Disenrollment notes:</u>
VOLUNTARY DISCHARGE: *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 DISCHARGE- *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.*

5. 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 member's 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).

- 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).
- 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

Disenrolled from Health Home and HCBS (code 56)

- Used when a member in the Children's Waiver wants to disenroll from both their Health Home services and the Children's Waiver.
    - They may or may not be actively receiving HCBS
    - All disenrollment from HCBS procedures must be followed

- The member is disenrolling from Health Home for a specific reason (deceased, lost to care, withdrawal of consent, moved out of state, excluded setting, etc.) but rather than using the usual End Reason code, Code 56 is used instead.
- The use of this code triggers the DOH and Medicaid to remove the K code from the member's Medicaid case.
- These types of disenrollments can be voluntary (no forms required) or involuntary (DOH-5235).
- Category: Disenrolled

Disenrolled from Health Home only, Continue HCBS (code 57)

- Used when a member in the Children's Waiver wants to disenroll from Health Home services but wants to remain in the Children's Waiver.
    - They may or may not be actively receiving HCBS
    - All CYES Transfer procedures must be followed
- The member is disenrolling from Health Home for a specific reason (deceased, lost to care, withdrawal of consent, moved out of state, excluded setting, etc.) but rather than using the usual End Reason code, Code 57 is used instead.
- The use of this code triggers the DOH and Medicaid to keep the K code on the member's Medicaid case, so that C-YES can take over management of the HCBS services.
- These types of disenrollments are most often voluntary (no forms required). Members can not be involuntarily transferred to C-YES, but it is possible for the member to be disenrolled from Health Home as lost to care to the HHCM (involuntary-DOH 5235), while at the same time their HCBS provider confirms that they are still seeing the member, and that services should continue, requiring a transfer to C-YES.
- Category: Disenrolled

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 Plan of Care that addresses at least one of their Qualifying Diagnoses within 60 days of enrollment, and annually thereafter.

- 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 when they are no longer eligible for Medicaid.
  - Case Managers are required to find out why the 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.
- 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 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

Source:
Member Disenrollment from the Health Home Program Policy #HH0007
NYS DOH Children's Waiver Website

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. 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.
    3.1. 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.

3.2. 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. Additional requirements for Non-Self-Consenting Children:
   - In Month 1 of Diligent Search a successful in person contact[38] with the parent, guardian, or legal representative is required, and will count as one Diligent Search Activity.
   - In Months 2 and 3 of Diligent Search successful in person contact[39] with a different Care Team member than the prior month is required and will count as one Diligent Search Activity.
   - In all of these contacts the Care Manager must ascertain the other party's knowledge of the member's whereabouts and ask them to notify the Care Manager if the member is found.

7. Additional requirements for Self-Consenting Children:
   - For all Diligent Search months, successful in person contact[40] with a different member of the care team than the prior month is required and will count as one Diligent Search Activity.
   - In all these contacts the Care Manager must ascertain the other party's knowledge of the member's whereabouts and ask them to notify the Care Manager if the member is found.

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[38] This requirement may be 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*
[39] See above
[40] See above

8. 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)
   8.1. The segment must have been pended for Diligent Search prior to submitting the Billing Support Questionnaire.
   8.2. 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".
   8.3. 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.
   8.4. Members may be billed for Diligent Search for no more than three consecutive months.

9. Diligent Search ends when the member is located, or after three consecutive months of Diligent Search.
   9.1. 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.
   9.2. Reason for ending Diligent Search after fewer than three consecutive months must be evident in the Disenrollment note.

10. 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

11. 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.

12. Members may enter Diligent Search and be Re-engaged multiple times over the course of the enrolled segment.

13. 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 cases.

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

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[41], 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[42], 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

[41] 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.

[42] Plan of Care must be signed by the member within 60 days of the new Enrolled segment

Children's HCBS Policy

First Issued: 12/31/20

Reviewed by Children's Committee: 7/25/24

Last Revised: 6/14/24

Background

The Children's Consolidated Waiver was established in 2019. It combined six separate Medicaid waiver programs for children in NYS into one waiver. The waiver services are called Children's Home and Community Based Services, and are designed to help children with mental illness, medical fragility, and/or developmental disabilities live in community-based settings, when they would otherwise require the supports of an institution.

Children who are enrolled in the Children's Waiver are required to receive care management. They can get care management from a Health Home Care Manager or a C-YES Care Manager.

Policy:

CCMP CMAs will provide care management for all children enrolled in the Children's Waiver and will identify and refer eligible Children for the Children's waiver in accordance with all NYS DOH requirements. CCMP CMAs will follow the DOH Conflict Free Care Management Policy #HH0012.

Procedures:

Care Management for children interested in the waiver consists of the following procedural components:

- Explaining HCBS Services
- Guidance for E-Mod, V-Mod, and AT Request
- Guidance for Non-Medical Transportation
- Determining Eligibility for HCBS
- Including HCBS on the HH POC
- Referring to HCBS Provider(s)
- Ongoing Management of HCBS
- C-YES and Family of One
- Discontinuing HCBS

Resources:

The HCBS Quick Reference Guide

NYS DOH Children's Waiver Website

CTAC- Medicaid Children's Transformation Website

Explaining HCBS Services

CCMP Children's CMs will be familiar with the suite of services offered under the Children's Waiver, so that they can make professional recommendations for referrals as appropriate. The available services are:

- Community Habilitation
- Day Habilitation
- Caregiver/Family Advocacy and Support Services
- Respite
- Prevocational Services
- Supported Employment
- Palliative Care

- Adaptive and Assistive Equipment (AT)
- Vehicle Modifications (V-Mod)
- Environmental Modifications (E-Mod)
- Non-medical Transportation

1. Whenever a HHCM identifies that a child is at risk of institutionalization, they will review the service offerings with the child/family and if they are interested in a referral, initiate the eligibility determination process.

Guidance for E-Mod, V-Mod, and AT Request

1. E-Mod, V-Mod, and AT Requests are unique kinds of HCBS in that they are not a service per se, but a reimbursement from Medicaid for the costs of modifications to a home or vehicle that would allow a member to remain living in a community-based setting.

2. The HHCM will secure a Physicians order or statement that supports the members need and justification for the requested service. This can be done on the DOH-4359 or on Physician's Letter Head.

3. The HHCM will work with the family to secure clinical justification (Physical therapist, Behavioral health Specialist, licensed profession, etc.). The justification should define the scope and appropriateness and ensure that the request would not be covered under private insurance, community programs or other local/state/federal programs.

4. Bids will need to be collected from three qualified Vendors/Contractors.

5. The HHCM, family, and LDSS/MOC will work collaboratively on this process. The HHCM will then send the Request for Service Packet to the LDSS/MCO:

Request for Service Packet must include:

- The Member's Plan of Care that identifies the assessed need.
- Physicians' order supporting medical necessity (signed and dated).

- Professional assessment/clinical justifiable identifying the scope of the project and documentation detailing the project/product specification including scope, estimated material, and labor costs, and other requires expenditures.
- Bids: if the AT, E-Mod or V-mod costs $1,000 or more, 3 bids or justification for why 3 bids could not be secured, is required.
- Any required documentation that is needed for the modification/service/adaption/device such as landlord's permission if the home is leased, or proof that the vehicle being used is less than 5 years old/less than 50,000 miles for a V-Mod.
- Completed Clinical Justification with the description/scope of work and Cost Projection Form.

REFRESHER Environmental Modifications, Vehicle Modifications, and Adaptive and Assistive Technology (Children's HCBS Waiver) –Webinar Recording
Children's Waiver EMOD, VMOD, AT and LDSS Contact List
AT Service Authorization Guidelines
EMOD Service Authorization Guidelines
VMOD Service Authorization Guidelines
Description and Cost Projection Form
Final Cost Form
Authorization & Payment; Adaptive and Assistive Equipment, Vehicle Modifications, Environmental Modifications, & Non–Medical Transportation

Guidance for Non-Medical Transportation

1. Non-Medical Transportation is another unique HCBS, where there is not a specific HCBS service provider, but rather the members is given access to the Medicaid Transportation Management system for non-medical reasons.
2. Examples where this service may be requested include transportation to: HCBS that a child/youth was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc.
3. Health Home Care Managers are responsible for conducting and developing the Person-Centered POC. If the care manager determines there is a need for transportation to support an individual's identified goals, the Health Home Care Manager will include justification for this service within the Person-Centered POC.
4. The Health Home Care Manager will complete the **Non-Medical Transportation (NMT) Plan of Care Grid for Children's HCBS** with all known information. It is possible that the complete trip destination details may not be known (e.g., exact appointment time and date). This information can be provided by the enrollee to the Transportation Manager upon request of transportation.
   Non-Medical Transportation (NMT) Workflow Process for Children's HCBS
   Non-Medical Transportation (NMT) Children's HCBS Manual
   Transportation Contact List

Determining Eligibility for HCBS

1. The HHCM will determine whether the child is eligible for HCBS by completing an assessment in the UASNY database, called the HCBS Level of Care (LOC). The HHCM does not decide who is eligible, but rather gathers documents from other professionals, and completes data entry based on those documents. The UASNY system will then calculate whether the child is eligible.
   1.1. If the member was referred to Health Home with the explicit request for both Health Home and HCBS services, the CMA must contact the referral source within 48 hours of receipt of the referral and complete the LOC within 30 days of receiving the referral.

2. Children are found eligible for HCBS when they meet requirements in three separate areas: Target Population, Risk Factors, and Functional Criteria.
   2.1. Details on Target Populations, Risk Factors, and Functional Criteria are available in the DOH Children's HCBS LOC Eligibility Determination Training, and in the CCMP Children's HCBS Training.

3. Once the HHCM signs and finalizes the HCBS LOC, the UASNY will generate a signed/finalized Assessment Outcome of either HCBS/LOC eligible or HCBS/LOC ineligible, and, if eligible, Capacity Management will notify the HHCM that the member has received a slot in the waiver.

4. The HHCM issues a Notice of Decision Form (DOH-5287), documenting the outcome of the HCBS/LOC Eligibility Determination and provides information on State Fair Hearing Rights, regardless of the outcome of the HCBS/LOC (Eligible or Ineligible).
   4.1. If the outcome of the HCBS/LOC is Eligible, a DOH-5276 will also need to be issued.

5. Once the HCBS/LOC Eligibility Determination Assessment Outcomes is finalized within the UAS, it remains active for one year from the date of signature and finalized date, as long as HCBS services are started within six months of the finalization date.
   5.1. The CMA is paid a $200 fee for each HCBS LOC, up to one per year. The fee is not paid for HCBS LOCs that are completed late.

6. If a child is receiving HCBS, the LOC must be re-done annually for services to continue.
   6.1. Each time an annual HCBS/LOC Determination is conducted, new documents/forms are needed to re-establish Population and Risk Factor Eligibility.

7. If HCBS services are not started after a member is found eligible for HCBS, the LOC will expire six months after the finalization date.

8. An LOC may be re-done prior to the annual due date if there is a significant change in the member's circumstances, such as:

- Significant change in child's functioning (including increase or decrease of symptoms or new diagnosis)
- Service plan or treatment goals were achieved
- Child admitted, discharged, or transferred from hospital/detox, residential setting/placement, or foster care
- Child has been seriously injured in a serious accident or has a major medical event
- Child's (primary or identified) caregiver is different than on the previous HCBS /LOC
- Significant change in caregiver's capacity/situation
- Child is likely no longer eligible for HCBS (or may never have been eligible for HCBS)

9. If a child/youth is initially found HCBS/LOC ineligible and there is a change in circumstances or target population, the child/youth can be reassessed at any time, as there is no waiting period between assessments.

10. If the member is found eligible the DOH Capacity Management Team will assign the member a slot in the waiver. DOH Capacity Management receives a daily report of finalized HCBS/LOC Assessment Outcomes. The capacity management team will contact the HHCM via the Secure File Transfer located in the Heath Commerce System (HCS) within 24 hours of a finalized HCBS/LOC determination. DOH will then instruct the Local Department of Social Services (LDSS) to add a K-code to the member's Medicaid case.
    10.1. The K-code is the proof that the member was found eligible and has been given a slot in the waiver program.

Capacity Management Webinar
Care Manager Required Communication with Capacity Management for the Children's Waiver
Required HCS Secure File Transfer to Communicate with Capacity Management

11. Once the HHCM sees that the K-Code has been added to the member's Medicaid case, they must issue the Freedom of Choice – DOH-5276 form to the member and review the Participants Rights Form, prior to starting the HCBS referral process.

12. If a child with a K-code (i.e., was found eligible and given a slot) changes their mind prior to completing the DOH-5276 and decides they would no longer want to be referred for HCBS then they would indicate that on the Freedom of Choice – DOH-5276 form, and then the Participants Rights Form is no longer needed.
    12.1. The HHCM must contact the Capacity Management Team within 5 business days to let DOH know that the family/member has declined to participate, and record the change on their Plan of Care.
    12.2. If they initially declined but later decide to peruse HCBS (within 6 months). The HHCM can contact the capacity management team to see if there is a slot available. If there is no slot available, they will be placed on the waitlist.

12.3. If they initially decline but later decide to peruse HCBS (after 6 months) then the HCBS/LOC Determination will need to be re-completed in full at that time, or when a slot becomes available. The HHCM will need to communicate with the Capacity Management Team about slot capacity.

Including HCBS on the POC

1. HCBS Needs, Goals, and Tasks must be included on the POC for any member who is at risk of institutionalization and is interested in a referral, regardless of the outcome of the LOC.
   1.1. The HHCM must update the POC with the HCBS Need, Goals, and Tasks within 30 days of the HCBS/LOC Eligibility Determination being conducted.
   1.2. When adding HCBS Needs/Goals/Tasks to a POC it is not necessary to immediately identify the specific HCBS providers. Providers should be specified once it is assured the HCBS provider identified and chosen has availability to accept the referral.
   1.3. Once an HCBS Provider has accepted a referral, they must provide the HHCM with the F/S/D of the services they will provide to the member[43]. The HHCM then updates the POC to include the F/S/D of the HCBS services within 10 days and obtains member signature.
   1.4. The MCO reviews the POC within MAPP.
   1.5. HHCM will contact member/family and HCBS provider within 45 days of the signed POC to confirm that the HCBS service(s) identified on the POC have started at the planned F/S/D.

Referring to HCBS Provider(s)

1. Prior to making referrals to HCBS providers, the HHCM must provide a choice of HCBS providers in the member's community who can deliver the service(s). If the member is enrolled in a MCO then the provider must be In-Network.

2. The HHCM will need to ensure that the DOH-5201/DOH-5055 contains the providers' information to send the HCBS referral(s), as the referral paperwork contains member PHI.

3. Once the member identifies the HCBS services and providers they are interested in, the HHCM will submit the referral through the Children's HCBS Referral Portal.
   3.1. The HHCM can submit multiple referrals at once, or request multiple services from the same provider.
   3.2. A new referral will need to be sent whenever there is a request to add a service or change providers.

4. For Managed Care enrollees, prior authorization is not required for the first 60 days, 96 units or 24 hours of HCBS.

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[43] Effective August 2024, F/S/D will be entered by the HCBS Provider in the Children's HCBS Referral Portal, and synced to the POC.

4.1. Once the HCBS provider has completed their intake with the member and decided to provide HCBS service(s) to them, then the HCBS provider must request authorization of HCBS needed beyond the initial 60 days, 96 units, or 24 hours.

4.2. To request continued authorization, the HCBS provider will complete the Children's HCBS Authorization and Care Manager Notification Form- Fillable. This form must be completed and sent immediately once the provider has agreed to provide HCBS and must include the F/S/D of the service(s)[44].

Frequency: Outlines how often the service will be offered to the child and/or family. Services may be delivered on a weekly, biweekly or monthly basis, according to the needs of the child and family.
Scope: The service components and interventions being provided and utilized to address the identified needs of the child.
Duration: How long the service is expected to last.

If the member is enrolled in a Managed Care Plan:

- HCBS Provider will complete the HCBS Authorization and Care Manager Notification Form and send it to the MMCP.
- The plan will complete service authorization review and issue a determination to the HCBS provider and the member.
- When the authorization process is complete, the HCBS provider will complete Section 2 of the authorization form and send a copy to the HHCM within 5 business days.
- The HHCM will update the Plan of Care with Frequency, Scope, and Duration.

If the Member is Not enrolled in a Managed Care Plan:

- HCBS Provider will complete Section 1 of the HCBS Authorization form and send it to the HHCM.
- The HHCM will update the Plan of Care with Frequency, Scope, and Duration.

Ongoing Management of HCBS

1. HHCM have an additional level of responsibility when it comes to management of HCBS, as compared with other referrals they may put in place for the member, called "Monitoring Access to Care".

   1.1. "Monitoring Access to Care", means that there is monthly contact with the member to ensure that they are receiving the HCBS indicated in the POC at their identified F/S/D, and ongoing contact with the HCBS providers to ensure child/youth and family are attending the appointments and working toward established, identified goals.

[44] Effective August 2024, the entire authorization process will be fully automated through the Children's Referral Portal, with the F/S/D entered by the HCBS Provider, and synced to the POC.

1.2. The monthly contact with HCBS Provider(s) and member may be done via any contact method, but if HHCM is the identified HCBS service (Family of One cases Only), the contact with the member must be in person[45].
1.3. The requirements for contact involved with Monitoring Access to Care for HCBS services continue regardless of the member's acuity level determined by the CANS-NY. For example, if they are receiving HHCM as their only HCBS, then they will have to have monthly in person contact to maintain compliance with the HCBS waiver, regardless of the in-person frequency requirements tied to their CANS-NY acuity.

2. In addition to monitoring receipt of a monthly HCBS service, HHCMs are responsible for ensuring that each member enrolled in the Children's Waiver is seen for an annual physical exam.
   2.1. HHCMs are required to use all resources available to them, inclusive of MCO Gaps in Care ("Well-Care" measures), quarterly lists from DOH sent to them by CCMP, and conversations with the PCP, member, and their family to ensure they know when the member last had their annual physical, and when it is next due.

C-YES and Family of One

1. C-YES is the Independent Entity that is contracted with the Department of Health to provide Care Management services to those members who peruse HCBS but decline or are not eligible for Health Home services.

2. If a member wishes to disenroll from Health Home Care Management but continue receiving (or being referred for) HCBS, or a potential member is not interested in Health Home Care Management but is interested in HCBS, then the HHCM must make a referral/transfer to C-YES so that C-YES can take over the ongoing management of their HCBS.

3. Children in NYS who would not normally qualify for Medicaid can be provisioned with a special kind of Medicaid case, called "Family of One", if they are found eligible for HCBS. They will be given Medicaid so that they can receive HCBS. Once they have active Medicaid, they can receive many other Medicaid services, they are not limited only to HCBS. This process is managed by C-YES, as children without Medicaid would not be eligible for HHCM.

4. Once C-YES has determined HCBS Eligibility and turned on a "Family of One" Medicaid case, if a child is interested in receiving HHCM they may be referred to a HHSC CMA.
   4.1. Likewise, if a HHCM is working with a child who has HCBS, and the child becomes ineligible for Medicaid, but wants to continue their HCBS, the HHCM can disenroll from HHCM and refer the case

[45] It is not clear if this requirement can be 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*

to C-YES so that C-YES can help the child apply for "Family of One" Medicaid. Once the "Family of One" case is turned on, the child may then be referred back to the HHSC CMA for HHCM, if that is what the child wants, or they may continue to only receive HCBS, monitored by C-YES.

4.2. This is not an option for children whose Medicaid becomes inactive, but they are still Medicaid eligible. In those cases, the HHCM must assist the family with re-activating the Medicaid case.

5. HHCMs must know which of their members have Medicaid "Family of One". This is indicated in EMEDNY with the "KK" code. If these members discontinue their HCBS services they will lose their Medicaid case, along with any other Medicaid services that are in place. For this reason, there are special policies around "Family of One" cases:

Process for Renewing and Establishing Medicaid for Children´s Waiver Participants
Medicaid Status Impact on HCBS Eligible Children

6. Members with a "Family of One" Medicaid case may choose to have HHCM be their HCBS service, particularly if there is a delay in accessing the traditional HCBS services.
   6.1. In these cases, "Health Home Care Management" must be explicitly listed on the HH POC as the HCBS Service, along with F/S/D.
   6.2. In this situation the monthly HHCM service must be provided in person, as it is considered the HCBS service.

7. If a member is using HHCM as their HCBS service to keep their Medicaid case active and decides that they are no longer interested in HHCM (either explicitly or via disengagement with the program), they must be educated that without participation in HHCM they will lose their waiver slot and their "Family of One" Medicaid case will close, which may result in loss of other Medicaid services.

Disenrolling from the Children's Waiver

1. There is a difference between a specific HCBS Provider disenrolling the member from their service, and the member being disenrolled from the Children's Waiver.
   1.1. Regular contact with the HCBS Provider is key to knowing when there are changes in the services, particularly if the member is no longer participating in or being disenrolled from the services.
   1.2. The HHCM can always refer the member to a different HCBS Provider, if the member wants.

2. Members can disenroll from the Children's Waiver for various reasons and may or may not be actively receiving an HCBS service at the time of their Waiver disenrollment. Below are the most common reasons for disenrollment from the Children's Waiver.

3. The member is admitted to an Excluded Setting for more than 90 days.
   3.1. If a member receiving HCBS enters an excluded setting, the HHCM must notify the HCBS provider, and follow the Excluded Settings Policy.

3.2. If the member is in an excluded setting longer than 90 days, the member will need to be disenrolled from the HCBS Waiver.
3.3. HHCM will need to complete the DOH-5288 Notice of Decision for Discontinuance in the NYS 1915c Children's Waiver form, 10 days before the member will lose HCBS.

4. The member no longer qualifies for the Children's Waiver – Annual HCBS/LOC Determination
   4.1. The member can stay in Health Home and receive Health Home Care Management services; except for Family of One. Family of One members will lose their Medicaid status and will need to be Disenrolled.
   4.2. HHCM will need to complete the DOH-5288 Notice of Decision for Discontinuance in the NYS 1915c Children's Waiver form, 10 days before the member will lose HCBS.

5. The Member and/or Family request Disenrollment from the Children's Waiver
   5.1. The Member and/or family will be able to stay enrolled in the Health Home and receive Health Home Care Management if they are still eligible for Health Home.
   5.2. HHCM will need to complete the DOH-5288 Notice of Decision for Discontinuance in the NYS 1915c Children's Waiver form, 10 days before the member will lose HCBS.

6. Any time a member is disenrolled from the Children's Waiver, the DOH Capacity Management Team must be notified of the member's disenrollment from the Children's Waiver program so that they can have the K codes removed.
   6.1. If the member is also disenrolling from HHCM, the notification is done via the use of End Reason Code -56.
   6.2. If the member is continuing in HHCM, HHCM notifies CCMP, who notifies Capacity Management.
   6.3. The CMA must monitor the case after disenrollment from waiver to ensure the K codes are removed within 30 days of disenrollment from waiver. If the CMA needs assistance with this, they must reach out to CCMP.

7. Any time a member is disenrolled from the Children's Waiver, the HHCM must ensure that the HCBS Provider(s), MCO, and any affected Care Team members are notified.

Documenting in the FCM Children's Waiver Tab

1. Effective June 2024, there is a tab in the member's FCM chart dedicated to the Children's Waiver.

2. HHCM's must follow the instructions in the CCMP Children's HCBS Trainings and the FCM Support Page to ensure that all workflow requirements are completed.
   2.1. The Children's HCBS Workflows are designed to support the HHCM in following all Children's HCBS policies, and to allow for better reporting and oversight of the program.

<u>Training and Compliance</u>

CCMP provides training on the Children’s HCBS Policy in the TalentLMS Learning Platform monitors compliance with chart audits and metrics, per the Quality Management Program Policy.

Children's CFTSS Policy

TBD, in the interim materials on Children's CFTSS are available here:

Designated Children's HCBS and Children and Family and Support Services (CFTSS)

Designated Children's Crisis Intervention Provider Contacts and Hours of Operation

Section 5: SUPPORTING MATERALS

Supplemental Resource Links

DOH Health Home Basics

DOH Health Home Policies
DOH HHSC Website
DOH Authorization for Release and Complaint Forms

CTACNY Resources

CFTSS and Children's HCBS

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

Asthma and Children Fact Sheet | American Lung Association
Type 1 Diabetes: A Guide for Families
Children with Diabetes - New York State Department of Health
Hypertension in Children | Causes, Symptoms & Treatment

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

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.

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.

Attestation of Qualifications for High Acuity Children

Community Care Management Partners
HEALTH HOME

CCMP CMA Attestation of Qualifications for High Acuity Children

To be used instead of submitting copies of resumes/waivers directly to CCMP

Name of Employee	Qualifies with resume or DOH waiver?	Name of Employee	Qualifies with resume or DOH Waiver?

New York State Department of Health requires Health Home Care Managers working with High Acuity Children to meet separate qualification standards, evidenced by experience and education on a resume or DOH Waiver.

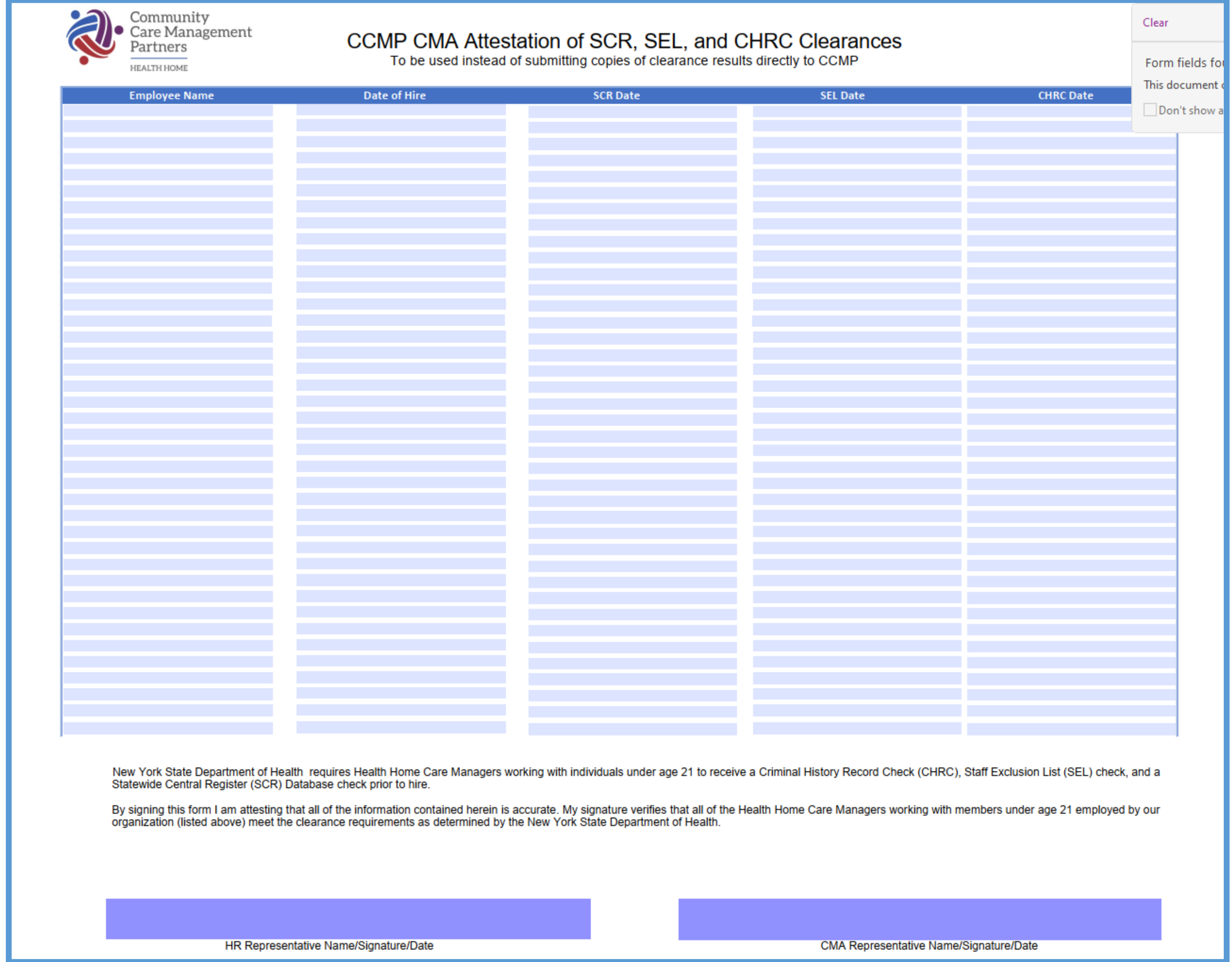
By signing this form I am attesting that all of the information contained herein is accurate. My signature verifies that all of the case management staff serving High Acuity Children meet the qualifications requirements as determined by the New York State Department of Health.

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.

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

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.

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.

CCMP Children's Health Home Referral Form

COMMUNITY CARE MANAGEMENT PARTNERS HEALTH HOME

Children's Health Home Referral Form
Send via Encrypted Email: Referrals@ccmphealthhome.org

Section A: Member Demographics		
Last Name:		First Name:
DOB:____________ Gender: ◯ Male ◯ Female ◯ Other	Is member currently in Foster Care? ☐ *Yes ☐ No *If yes, HH cannot process referral. Only LDSS/ NYCVFCA may create referral for children in Foster Care*	CIN# ______________________________ ☐ Active Medicaid FFS ☐ MCO MCO Name: ______________________ Preferred Language: _____________________
Primary Phone Number: _______________________ ☐ Home ☐ Cell ☐ Other: _______________		
Address: ____ Member resides with: ______________________________ ☐ Parent(s) ☐ Legal Guardian		
Type of Residence: ☐ Private Residence ☐ Public Housing ☐ Homeless (street, park, drop-in center, or other undomiciled) ☐ Homeless Shelter or Emergency Housing ☐ Other: __________________________		
Is this minor's parent/guardian currently enrolled in a HH? ☐ Yes ☐ No ☐ Unknown If Yes, please provide parent/guardian's name & CIN#: ______________________________________ If Yes, please provide name of HH: ____		

Section B: Referral and Consent Information	
Referral Source: ☐ Family/Legal Guardian ☐ Hospital: _____________ ☐ Self ☐ Other: _______________	
Referring Agency/Program/Facility:	
Referring Worker's Name:	
Referrer's Phone Number:	
Have one the following consents for this referral been obtained from the parent, legal guardian, or the self-consenting child? ***Please provide CCMP HH with a copy of consent*** ◯ Non-Self Consenting Child: DOH-5201-HH Consent Under 18 years of age ◯ Self-Consenting Child: DOH-5055-HH Consent 18-21 years of age or minors that are married, pregnant, or a parent ☐ Verbal consent to refer. Please specify if granted by: ○ Parent ○ Guardian ○ Self-Consenting Child Please provide consenter's contact information: ____	

Updated 2/27/24

This is a screenshot of the first page of the form, the full document is available to CMAs here.

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.

Additional Children's Consent Forms Guidance

In addition to the "Health Home Consents" required at the time of enrollment (DOH-5055 for Self-Consenting Children, and FAQs/DOH-5201 for Non-Self-Consenting Children), there are several other consent forms commonly used in the HHSC program.

Detailed instructions on how to complete these forms, with examples, are available to CMAs in the CCMP Enrollment Training in TalentLMS.

Health Home Release of Educational Records Consent Form (DOH 5203)

- Provides consent so that a child's school or Early Intervention program can share educational records with the CMA.
- Most often used to allow for Individualized Education Plan (IEP), or Individualized Family Services Plan (IFSP) sharing.
- Signed by either the Self-Consenting Child, or the Non-Self Consenting Child's parent, guardian, or legal representative.
- Not a requirement for Health Home participation; but a key component of quality care management. Assessment and Plan of Care development should reference educational needs and goals, particularly if there is an IEP or IFSP.
- This consent can be withdrawn at any time by completing the Health Home Withdrawal of Release of Educational Records Form (DOH 5204).

Other consent forms

- CMAs may have many other consent forms that they use for various reasons.
- With any consent form, the instructions for that form must be followed.
- With any consent form, all required fields on the form must be filled out.
- 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.

Form Number	Form Title	Used For:
DOH 5059	Health Home Opt-Out **NOTE: THIS FORM IS NO LONGER IN USE EFFECTIVE: May 1, 2022.**	• Adults and Children/adolescents
DOH 5055	Health Home Patient Information Sharing Consent	• Adults • Children/adolescent 18 years of age or older, or child/adolescent under age 18 if they are a parent, pregnant or married and able to self-consent
DOH 5058	Health Home Patient Information Sharing Withdrawal of Consent **NOTE: THIS FORM IS NO LONGER IN USE EFFECTIVE: May 1, 2022.**	
FAQ	Health Home Consent Frequently Asked Questions For Use with Children and Adolescents Under 18 Years of Age	• Children/adolescents under age 18 who are *not* a parent, pregnant and/or married and cannot self-consent and need a parent, guardian, or legally authorized representative to consent
DOH 5200	Health Home Consent Enrollment For Use with Children and Adolescents Under 18 Years of Age **NOTE: THIS FORM IS NO LONGER IN USE EFFECTIVE: May 1, 2022.**	
DOH 5201	Health Home Consent - Enrollment and Information Sharing For Use with Children and Adolescents Under 18 Years of Age	
DOH 5202	Health Home Withdrawal of Health Home Enrollment And Information Sharing Consent Form For Use with Children and Adolescents Under 18 Years of Age **NOTE: THIS FORM IS NO LONGER IN USE EFFECTIVE: May 1, 2022.**	
DOH 5203	Health Home Consent Information Sharing of Educational Records	
DOH 5204	Health Home Consent Withdrawal of Release of Educational Records For All Individuals in Health Home Program	
DOH 5230	Functional Assessment Consent Form For Use with ALL Enrolled Health Home Serving Children's program children/adolescents up to the age of 21 years old for the documentation of the member's CANS-NY information within the Uniformed Assessment System (UAS) **NOTE: THIS FORM IS NO LONGER IN USE EFFECTIVE: May 1, 2022.**	

Source:

DOH Policy #HH0009 Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents

CCMP SED VERIFICATION FORM

Verification of SED as a Single Qualifying Condition for Health Home Enrollment or Continued Enrollment

A child or adolescent (under the age of 21) has Serious Emotional Disturbance (SED) if they have a designated mental illness diagnosis in the Diagnostic and Statistical Manual (DSM) categories below as defined by the most recent version of the DSM of Mental Health Disorders AND have experienced functional limitations listed below due to emotional disturbance over the past 12 months from the date of assessment on a continuous or intermittent basis as determined by the treating or assessing Licensed Practitioner of the Healing Arts (LPHA) or Licensed Practitioner under the supervision of an LPHA. The functional limitations must have been moderate in at least two areas or severe in at least one area.

This verification form is to be filled-out by a LPHA who has the ability to diagnose within their scope of practice under New York State law (or Licensed Practitioner under the supervision of an LPHA). The form should be completed by a practitioner who is actively treating the child, or treated the child within the last 12 months, or has completed a comprehensive evaluation to verify diagnoses and determine if the child meets SED criteria.

Child's Information			
Last Name	First Name	MI	Date of birth

Verification of Meeting Serious Emotional Disturbance Criteria

Diagnostic Criteria

☐ **I verify that the child/youth has at least one primary DSM diagnosis in the following categories.**

Select at least one DSM Qualifying Mental Health Category	Current Diagnosis	Select Primary Diagnosis	Select Severity Indicator	Date of Diagnosis
Anxiety Disorders		◉	Low ☐ Medium ☐ High ☐	
Bipolar and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Depressive Disorders		○	Low ☐ Medium ☐ High ☐	
Disruptive, Impulse-Control, and Conduct Disorders		○	Low ☐ Medium ☐ High ☐	
Dissociative Disorders		○	Low ☐ Medium ☐ High ☐	
Obsessive-Compulsive and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Feeding and Eating Disorders		○	Low ☐ Medium ☐ High ☐	
Gender Dysphoria		○	Low ☐ Medium ☐ High ☐	
Paraphilic Disorders		○	Low ☐ Medium ☐ High ☐	
Personality Disorders		○	Low ☐ Medium ☐ High ☐	
Schizophrenia Spectrum and Other Psychotic Disorders		○	Low ☐ Medium ☐ High ☐	
Somatic Symptom and Related Disorders		○	Low ☐ Medium ☐ High ☐	
Trauma- and Stressor-Related Disorders		○	Low ☐ Medium ☐ High ☐	
Attention Deficit/Hyperactivity Disorder		○	Low ☐ Medium ☐ High ☐	
Elimination/Sleep/Wake Disorders		○	Low ☐ Medium ☐ High ☐	
Sexual Dysfunctions		○	Low ☐ Medium ☐ High ☐	
Medication Induced Movement Disorders/Tic Disorders		○	Low ☐ Medium ☐ High ☐	

This is a screenshot of the first page of the form, the full document is available to CMAs here.

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 LOC/Referral status

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.	**Children's HCBS Tab**	Status of HCBS Assessment Use of HCBS Plan for HCBS Engagement/Assessment
Initial Appropriateness (segment screen),	Verification of appropriateness for services	**Background Tab/POC/Overview**	Verification of eligibility
Intake/Enrollment Note/Form	Verification of eligibility and appropriateness	**Background Tab/POC**	Strengths, support systems, and resources Barriers to service access
		Summary	Service needs being met already Service needs needing referral Verification of continued appropriateness for services

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 multidisciplinary 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 service providers 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 case reviews with interdisciplinary team to monitor/evaluate member status/service needs.
	Advocate for services and assist with scheduling of needed services.
	Coordinate with treating clinicians 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.

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 LOC (Initial and Annual)

CANS-NY (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 services 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. Solely 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**[46] 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.

[46] 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.

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.

Hospitalization Checklist

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.

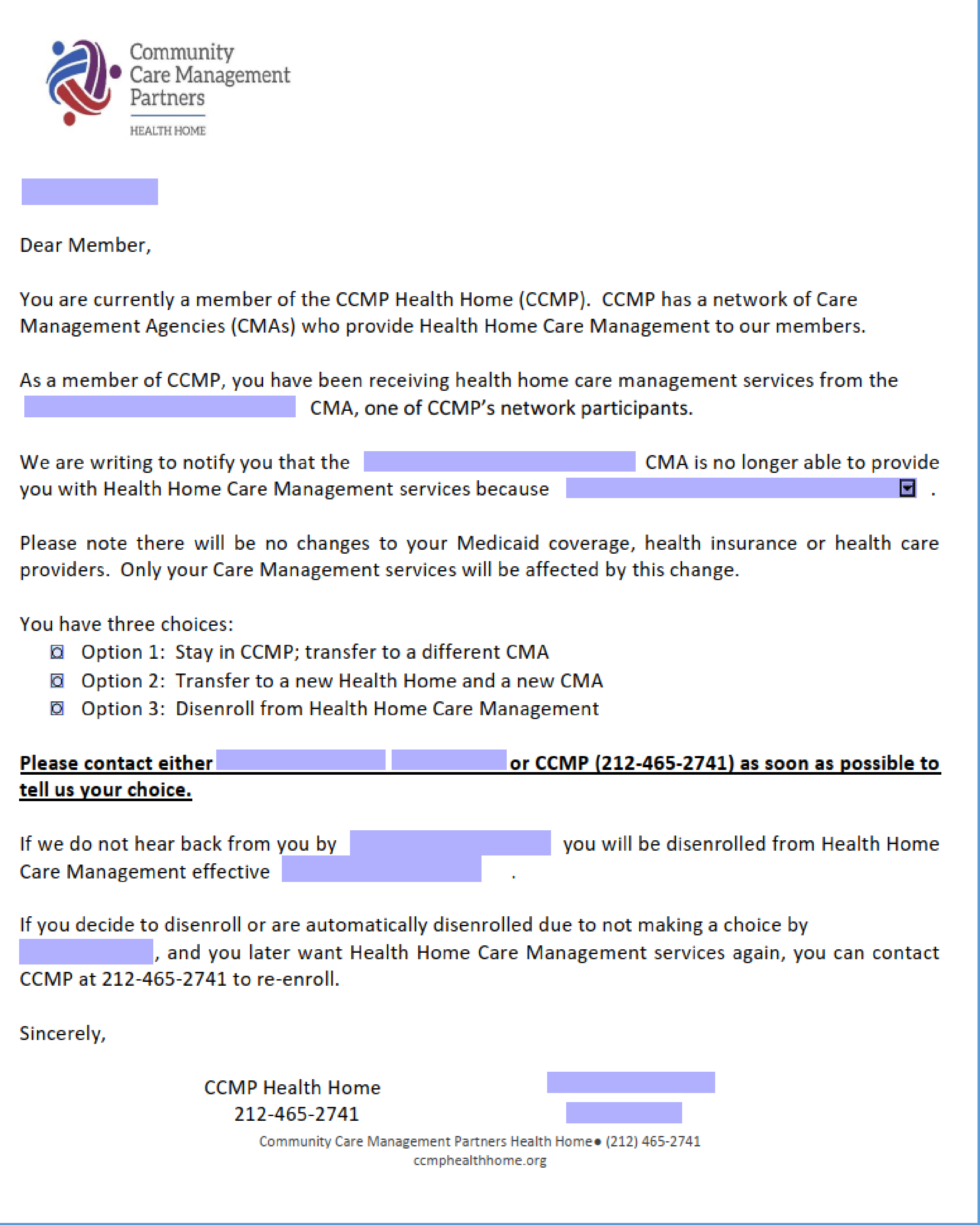
LONG TERM HOSPITALIZATION

- ☐ If there is no immediate plan for discharge to the community, consult the Excluded Settings Policy.

COMMUNITY CARE MANAGEMENT PARTNERS HEALTH HOME

This is a screenshot of the checklist, the full document is available to CMAs here.

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.

Template Disenrollment Letters

Disenrollment Letter Template (Involuntary-for use with DOH-5235)

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.

Children’s HCBS Disenrollment Workflow

Children’s HCBS Disenrollment Workflow

HCBS Children’s Waiver

Member/family request disenrollment from HCBS waiver but would like to continue with HHSC.

- Issue Notice of Discontinuance (DOH 5288)
- Notify Care Team members, including HCBS provider(s)
- Notify CCMP/Capacity Management via Capacity Management Communication Form

Member/family request disenrollment from BOTH HCBS waiver and HHSC.

- Issue Notice of Discontinuance (DOH 5288).
- Notify Care Team members, including HCBS provider(s)
- Notify CCMP/Capacity Management via End Reason Code 56.

Member/family requests disenrollment from HHSC but would like to continue with HCBS Waiver

- With member consent, refer case to C-YES using the C-Yes Transfer Form
- If C-Yes accepts the case, notify CCMP to transfer the case in MAPP
- Conduct warm hand-off with C-YES
- Notify Care Team, including HCBS provider(s) regarding HHSC disenrollment.
- Notify Capacity Management via End Reason Code 57.

Member is no longer eligible for HCBS Children’s Waiver

- Complete HCBS Annual LOC
- Upload ineligible HCBS Annual LOC full report
- Issue and Upload Notice of Decision (DOH 5287)
- Notify Care Team members, including HCBS provider(s)
- Notify CCMP/Capacity Management via Capacity Management Communication Form

- Issue and upload HHSC Disenrollment Letter (VOLUNTARY).

Enter Disenrollment Note

Update the Disenrollment Workflow in the Children’s HCBS Tab

This is only a screenshot of the first page of this document – the full document can be found here:

Children's NON-HCBS Disenrollment Decision Tree

Disenrollment Decision Tree for Children Not Receiving HCBS

** See page 2 for definitions of Voluntary vs. Involuntary disenrollment and links to the required forms. ** See page 3 for the list of End Reason Codes and definitions.*

Is member/family in agreement with disenrollment*?

- Yes (*Voluntary**)
  - Discuss with a supervisor
  - • Discuss discharge plan with member/family.
    • Notify care team, including MCO, of disenrollment.
  - Provide Voluntary Disenrollment Letter.
  - • Update POC and change status to abandoned or completed.
    • If requested, provide member/family copies of pertinent FCM documents.
  - End segment with appropriate End Reason Code. **
- No (*Involuntary**)
  - Discuss with a supervisor
  - • Discuss reason for disenrollment and discharge plan with the member/family.
    • Notify care team, including MCO, of disenrollment.
  - Provide Disenrollment Letter & NOD at least 10 days prior to effective date of disenrollment.
  - • Update POC and change status to abandoned or completed.
    • If requested, provide member/family copies of pertinent FCM documents.
  - End segment with appropriate End Reason Code**.
- Member is lost to contact
  - Was patient placed in Diligent Search for at least one month?
    - Yes
      - Discuss disenrollment with supervisor
      - Notify care team, including MCO, of disenrollment. (→ Provide Disenrollment Letter & NOD at least 10 days prior to effective date of disenrollment.)
    - No
      - Do not proceed with disenrollment. Place patient in Diligent Search for at least 1 month.
- Member deceased
  - Discuss with a supervisor
  - Complete an incident report if cause of death is homicide, suicide, unexplained, accidental, or COVID related
  - Provide family support/ bereavement, as needed
  - • Notify care team, including MCO, of patient's death and disenrollment.
    • Update POC and change status to abandoned.
  - End segment with End Reason code 4- Individual deceased.

This is only a screenshot of the first page of this document – the full document can be found here:

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.

Diligent Search Activities Table

Diligent Search Activities Table for HHSC

First Issued: 5/14/19
Reviewed by Quality Committee: 4/9/19
Revised: 10/29/19

Diligent Search Activities
Notify consented MCO and HH of the member's disengagement (**required** in Month 1)
Self-Consenting Children: Successful in person visit with a different Care Team member each month (**required** in all months)
Non-Self Consenting Children: Successful in person visit with parent, guardian or legal rep (**required** in Month 1), successful in person visit with a different Care Team member than in the prior months (**required** in months 2 and 3)
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.

The majority of 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.

Re-Engagement Form

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 Child's Demographic Information		
First Name:	Last Name:	DOB:
Address:	City:	Zip Code:
Email:	Phone Number(s):	
Is the child over 18, pregnant, married, or a parent? ☐ Yes ☐ No If 'No", who should be signing forms for the child?		

Verify Primary Caregiver's 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

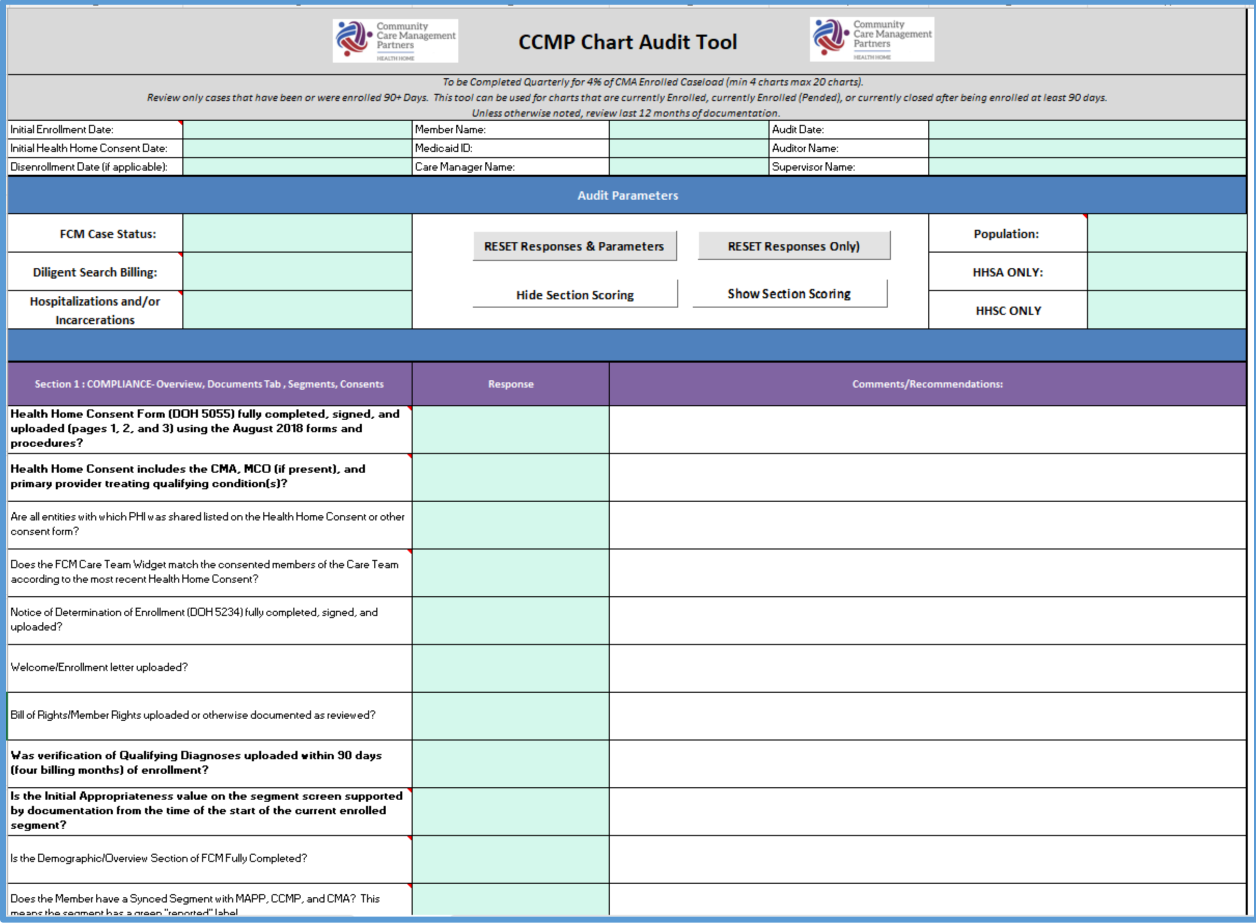
Continued Appropriateness for Health Home Service (must have at least one of the below risk factors)

- ☐ *Probable risk for adverse events (e.g., death, disability, inpatient hospitalization, nursing home admission, mandated preventive services, or out of home placement)*
- ☐ *Recent release from psychiatric hospitalization, incarceration, detention, or out of home placement ____________________(date)*
- ☐ *Lack of or poor connectivity with healthcare system*
- ☐ *Non-adherence to treatments or difficulty managing treatments or medication(s)*
- ☐ *Deficits in activities of daily living, learning or cognition issues*
- ☐ *Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home*
- ☐ *Lack of or poor social/family/housing support, or serious disruptions in family relationships*

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 includes monthly contact, in person meetings (home, community, and office) as needed but at least every six months (twice a month for medium/high acuity) 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/CANS-NY, and/or POC, and update in RMA.		

This is a screenshot of thse form; the full document is available to CMAs here.

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.

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 Care 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? [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 on core services (if above answer is "No")						
Back up documentation uploaded to RHH justifies level of billing (Proof of incarceration, homelessness, IHP 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, [illegible]	

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.

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		

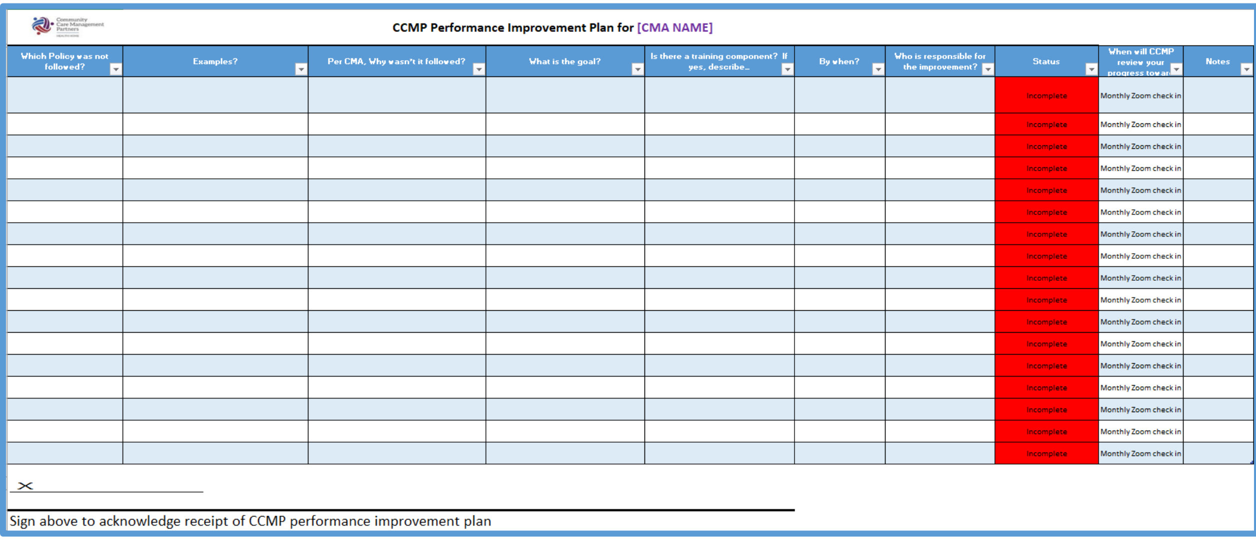
This is a screen shot of part of the interactive, self-scoring, consent audit tool. Full tool is available to CMAs here.

Tool may be updated periodically; all updated versions are distributed to the Quality Committee.

Guidance Document on Step Up/Step Down Options

In development

CCMP Performance Improvement Plan (PIP)



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 towar	Notes
							Incomplete	Monthly Zoom check in	
							Incomplete	Monthly Zoom check in	
							Incomplete	Monthly Zoom check in	
							Incomplete	Monthly Zoom check in	
							Incomplete	Monthly Zoom check in	
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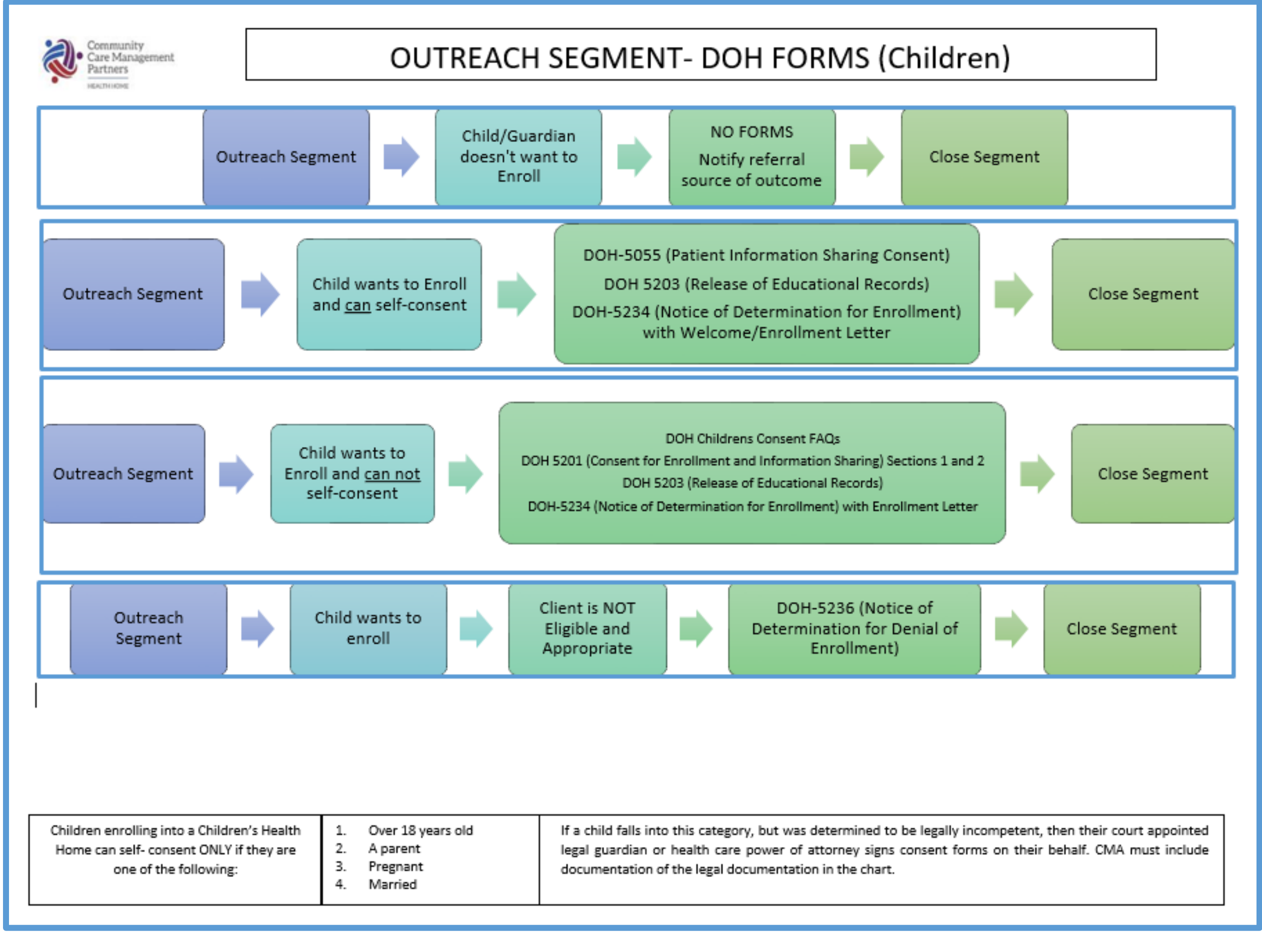
							Incomplete	Monthly Zoom check in	
							Incomplete	Monthly Zoom check in	
							Incomplete	Monthly Zoom check in	

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.

DOH Forms Workflow



This is a screenshot of the workflow (Outreach Segment); the full document is available to CMAs here.

Community Care Management Partners HEALTH HOME

ENROLLED SEGMENT- DOH FORMS (Children)

Enrolled Segment → Child wants to disenroll and can self consent (VOLUNTARY) **they can disenroll at anytime for any reason** → Disenrollment Letter DOH 5204 (Withdrawal of Consent for Release of Educational Records) → Close Segment

Enrolled Segment → Child wants to disenroll and can not self consent (VOLUNTARY) **they can disenroll at anytime for any reason** → Disenrollment Letter DOH 5204 (Withdrawal of Consent for Release of Educational Records) → Close Segment

Enrolled Segment → You want to disenroll the child, but they don't want to disenroll (INVOLUNTARY). → DOH-5235 (Notice of Determination of Disenrollment) with Disenrollment Letter → Close Segment

Enrolled Segment → You want to disenroll the child, but you haven't been able to contact them to discuss it. → DOH-5235 (Notice of Determination of Disenrollment) with Disenrollment Letter → Close Segment

This guidance is not about Discharge Reasons (End Reason Codes), but rather when to use which DOH form at case closure. The same Discharge Reason can require different forms in different circumstances; for example, a "graduation" does not require a DOH form if it is voluntary but would require a DOH-5235 if it is involuntary. See the Discharge Codes Definitions tool for explicit guidance on Discharge Reasons.

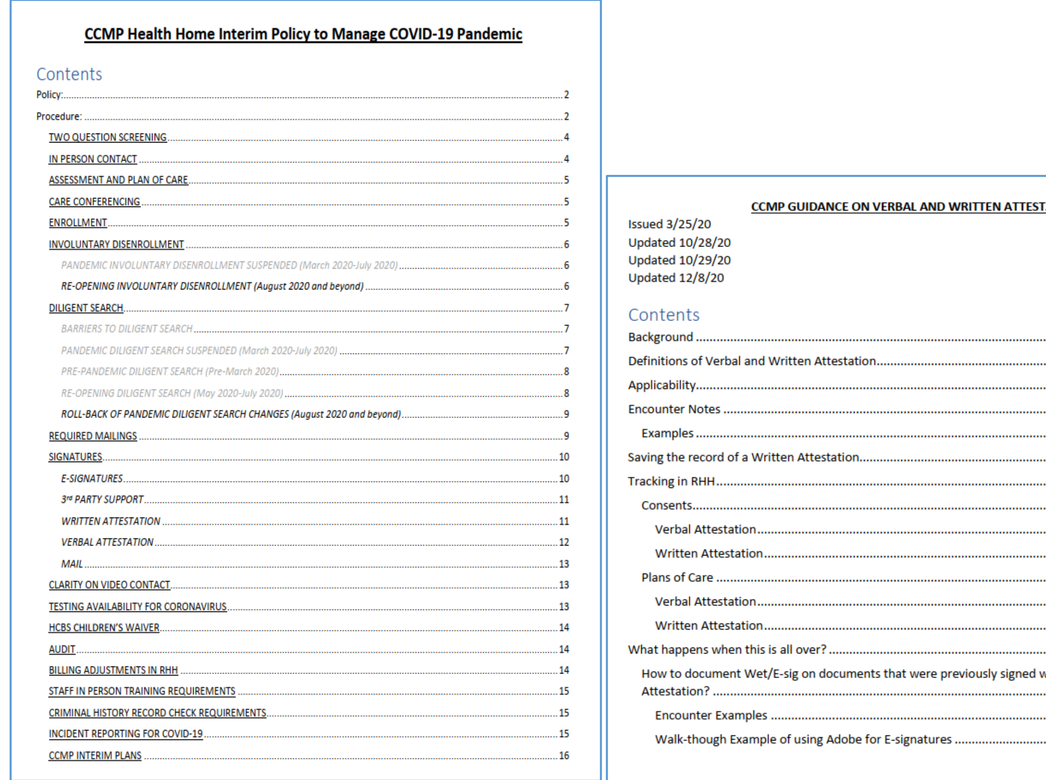
This is a screenshot of the workflow (Enrolled Segment); the full document is available to CMAs here.

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 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.



CCMP Health Home Interim Policy to Manage COVID-19 Pandemic

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CCMP GUIDANCE ON VERBAL AND WRITTEN ATTESTATION

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[CCMP Health Home Interim Policy on Managing the COVID-19 Pandemic]

[CCMP Guidance on Verbal and Written Attestation]

MSHH Children's Comprehensive Assessment Tool

Mount Sinai Health Home Serving Children Comprehensive Assessment

Child/Youth's Name: ____________ **DOB:** ____________

Demographic Information	
Child's Name	
Child's DOB	
Child's Address	
Child's Phone	
Child's email	
Child's Preferred Language	
Child's Secondary Language	
Child's Race	
Ethnicity/Cultural Background	
Spirituality/Faith	Do you have any religious affiliations? ☐No ☐Yes. Specify:
Cultural/Spiritual Considerations	Are there any cultural or religious preferences that will impact Health Home participation or service delivery? ☐No ☐Yes. Explain:
Gender Identity	
Sexual Orientation	
Gender Expression	
Primary Caregiver's Name	
Primary Caregiver's Relationship to Child	
Primary Caregiver's Address (if different from child)	
Primary Caregiver's Phone	
Primary Caregiver's email	
Primary Caregiver's Preferred Language	
Additional Caregiver's Secondary Language	
Additional Caregiver's Name	
Additional Caregiver's Relationship to Child	
Additional Caregiver's Address (if different from child)	
Additional Caregiver's Phone	
Additional Caregiver's email	
Additional Caregiver's Preferred Language	
Additional Caregiver's Secondary Language	
Is a Translator Needed?	☐No ☐Yes. Explain:
Literacy	Are there literacy concerns or needs? ☐No ☐Yes. Explain:

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This is a screenshot of the first page of the tool, the full document is available to CMAs here, and instructions are available here.

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