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Adult OMH Legacy Care Management State Aid Guidance
Health Home Non-Medicaid 2620
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Introduction

Starting in 2012, the Office of Mental Health's (OMH) Medicaid funded Adult Targeted Case Management (TCM) program transitioned to the Health Home (HH) program administered by the Department of Health (DOH). In this document, TCM programs previously monitored by OMH will be referred to as Legacy providers.

The OMH continues to provide State Aid for Legacy providers of care management to serve non-Medicaid eligible individuals (2620)[1]. For this reason, OMH is providing further guidance for non-Medicaid care management.

Legacy providers administer services to individuals with Medicaid enrolled in HH Care Management and also provide services to individuals without Medicaid. OMH recognizes there will be different documentation procedures for the Medicaid and non-Medicaid populations.

Population

OMH State Aid funding will continue to be used to serve individuals with Serious Mental Illness(SMI) who are in need of care management services and cannot be enrolled in a HH because they are without Medicaid. This would include special populations such as those receiving Assisted Outpatient Treatment (AOT) and other high-need SMI populations.
For individuals who are without Medicaid but may be eligible for Medicaid and/or Managed Care service packages, the care manager should work with the individual, whenever possible, to establish these benefits and transition the individual to Health Home Care Management.

Funding

Funding for serving individuals with SMI who are without Medicaid is provided by OMH via State Aid letter with the appropriate Local Government Units(LGUs). LGUs directly contract with and govern the oversight of county and local not-for-profit service providers.

Referral Process for Non-Medicaid Individual

It is expected that the LGUs or SPOA (Single Point of Access) and provider(s) will work

[1] Program code for Health Home Non-Medicaid Care Management paid for with State Aid

collaboratively on managing non-Medicaid individuals being served. The LGU/SPOA has oversight responsibilities for high-need populations and facilitates access to behavioral health services, including care management. Referrals can come from multiple sources including community providers, shelter outreach teams, ACT teams, forensics, hospitals, etc. The referral source may supply documentation to support that the individual has an SMI diagnosis. Referrals for Health Home Non-Medicaid Care Management will continue to be processed through the LGU/SPOA.

Upon receipt, the LGU/SPOA will assign the referral to a Legacy provider. In counties that have multiple Legacy providers, the LGU should have a referral distribution process that considers each provider's capacity to serve non-Medicaid individuals.

Rapid access to a care manager should be given for individuals on Assisted Outpatient Treatment (AOT), high-need SMI populations, and those returning to the community from institutional settings.

Care Management Record

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

Caseload and Contact Requirements

With the implementation of Health Homes, Legacy Providers transitioned out of the previously defined staffing and caseload requirements of the TCM programs (Intensive Case Management, Supportive Case Management, Blended Case Management). With respect to this change, and because the same staff are likely serving both Medicaid (under Health Home) and non-Medicaid individuals (not eligible for Health Home), caseload sizes should ensure the following:

- The caseload size should always allow for adequate time providing care management based on individual need.
- For care managers serving individuals receiving AOT (Kendra's Law), requirements must be followed accordingly.

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

- If the individual is AOT, at least four (4) face-to-face contacts must be made within the month; refer to AOT HH+ Guidance.

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

Needs Assessment

Legacy providers serving the non-Medicaid population will be required to complete a needs assessment no later than 60 days from the time of admission. Reassessment may be conducted as needed including if there is an adverse event. The needs assessment should evaluate the following:

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

Plan of Care (POC)

For all non-Medicaid eligible individuals receiving care management services, a POC must be developed no later than 60 days from the time of admission. The POC should include, at minimum, the following elements:

- The individual’s person-centered goals
- Description of planned care management interventions
- The individual’s preferences and strengths
- Any involved behavioral/medical/community providers and supports

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

Transition/Discharge from Non-Medicaid Care Management

Individuals will be discharged in accordance with their needs, recovery goals and preferences. The individual along with their providers and natural supports should be involved in the development of a discharge plan. The plan should include any linkages and/or information to support the individual’s health, service needs, and safety post discharge. Reasons for disenrollment may include but not limited to:

- The individual, care manager, and providers/natural supports agree that the individual has met the goals of his/her Plan of Care and no longer requires the services of a care manager
- The individual no longer wants to receive care management
- The Individual has relocated outside of New York State
- The individual is lost to contact
- The individual has obtained Medicaid

For individuals disengaged in services, the Legacy provider shall make efforts to re-engage the individual. Efforts to re-engage may include letters, phone calls, face-to-face visits and outreach to known providers or supports.

Notification should be made to the LGU for individuals discharged from the Health Home Non-Medicaid Care Management Program.

- For AOT individuals, legacy providers should follow discharge procedures in accordance with AOT HH+ Guidance.

LGU oversight

LGUs are responsible for oversight for Health Home Non-Medicaid Care Management. Each LGU may have additional requirements for serving this population beyond the program requirements outlined above. Providers should work with the LGU to ensure all local requirements are met.

Reporting Requirements and Monitoring

LGUs will continue to be required to submit the County Allocation Tracker (CAT) and the Consolidated Claim Report (CCR) as outlined in the State Aid Letter.

LGUs who receive State Aid should have monitoring and management procedures in place for the use of this funding, assuring that individuals with behavioral health needs are being served. LGU's are also required to notify the regional OMH Field Office of any significant fiscal or programmatic problems as they become known. Providers receiving 2620 Health Home Non-Medicaid Care Management funding are subject to audit by the State.

On an annual basis, the LGU will be required to complete and submit the Annual Statistical Summary Report (ASSR). Completion of the ASSR will be requested in the calendar year 2020 for calendar year 2019 data.