CARE MANAGEMENT STANDARDS MANUAL
CONDENSED

Health Homes of Upstate New York

Chautauqua County Department of Mental Hygiene
Huther Doyle Memorial Institute
Lake Shore Behavioral Health
New York Care Coordination Program
Onondaga Case Management Services

Issue Date: December, 2015
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This is a condensed version of the HHUNY Care Management Standards Manual. The purpose of this is to have a smaller document that care managers can bring with them while working with clients. For further clarification or greater detail, please refer to the full version of the HHUNY Care Management Standards Manual.
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<th>Managed Care Plan Contacts for Health Homes and Care Management Agencies</th>
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<th>Representative</th>
<th>Email</th>
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<td>Chris Zeppieri</td>
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<td>June Hutchinson</td>
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<td>Lori Lubba</td>
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<td>Amy Sanborn</td>
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<td>Louis Donato</td>
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<td>Eva Sanders</td>
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<td>Christine Oh</td>
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<tr>
<td><strong>Hudson Health Plan, Inc.</strong></td>
<td>Angela Vidile</td>
<td><a href="mailto:avidile@hudsonhealthplan.org">avidile@hudsonhealthplan.org</a> 914-372-2091</td>
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<tr>
<td><strong>Merging with MVP 1/1/16</strong></td>
<td>Laura Aponte</td>
<td><a href="mailto:laponte@hudsonhealthplan.org">laponte@hudsonhealthplan.org</a> 914-372-2234</td>
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<tr>
<td><strong>Dutchess, Orange, Rockland, Sullivan, Ulster, Westchester</strong></td>
<td>Elizabeth Torhan</td>
<td><a href="mailto:etorhan@hudsonhealthplan.org">etorhan@hudsonhealthplan.org</a> 914-372-2030</td>
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<tr>
<td><strong>Independent Health</strong></td>
<td>Kathy Messer</td>
<td><a href="mailto:kmesser@independenthealth.com">kmesser@independenthealth.com</a> 716-635-4918</td>
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<tr>
<td><strong>Erie, Niagara</strong></td>
<td>Narda Duchene</td>
<td><a href="mailto:Duchen@metroplus.org">Duchen@metroplus.org</a> 212-908-8557</td>
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<tr>
<td><strong>MetroPlus Health Plan, Inc. (SNP)</strong></td>
<td>Lauren Leverich</td>
<td><a href="mailto:leverl@metroplus.org">leverl@metroplus.org</a> 212-908-8592</td>
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<td><strong>Castaldo</strong></td>
<td>Issy Romano</td>
<td><a href="mailto:romanoii@metroplus.org">romanoii@metroplus.org</a> 212-908-5204</td>
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<tr>
<td><strong>Brooklyn, Bronx, Manhattan, Queens</strong></td>
<td>Larry Klein</td>
<td><a href="mailto:Kleinl@metroplus.org">Kleinl@metroplus.org</a> 212-908-8536</td>
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<tr>
<td><strong>MVP Health Care</strong></td>
<td>Angela Vidile</td>
<td><a href="mailto:avidile@hudsonhealthplan.org">avidile@hudsonhealthplan.org</a> 914-372-2091</td>
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<tr>
<td><strong>Albany, Genese, Jefferson, Livingston, Monroe, Ontario, Rensselaer, Saratoga, Schenectady, Warren</strong></td>
<td>Laura Aponte</td>
<td><a href="mailto:laponte@hudsonhealthplan.org">laponte@hudsonhealthplan.org</a> 914-372-2234</td>
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<tr>
<td><strong>Total Care, A Today's Option of NY Health Plan</strong></td>
<td>Patty Smith</td>
<td><a href="mailto:Ps1@totalcareny.com">Ps1@totalcareny.com</a> 315-233-7125</td>
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<tr>
<td><strong>Cortland, Onondaga, Tompkins</strong></td>
<td>Kathleen Schisa</td>
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<td><strong>United HealthCare</strong></td>
<td>Sanrose Russell</td>
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<td><strong>Albany, Bronx, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Essex, Fulton, Genese, Herkimer, Jefferson, Kings, Madison, Monroe, Nassau, Niagara, Manhattan, Oneida, Ontario, Onondaga, Orange, Oswego, Queens, Rensselaer, Richmond, Rockland, Seneca, St. Lawrence, Suffolk, Tioga, Ulster, Warren, Wayne, Westchester</strong></td>
<td>Laura Squadrito</td>
<td>Laura a <a href="mailto:squadrito@uhc.com">squadrito@uhc.com</a> 952-202-9151</td>
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<tr>
<td><strong>WellCare of New York, Inc.</strong></td>
<td>Rose Anne Nagy</td>
<td>HH 716-595-6735</td>
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<tr>
<td><strong>Allegany, Cattaraugus, Chautauqua, Erie</strong></td>
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<td>HH 716-565-6734</td>
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<tr>
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<tr>
<td><strong>Bronx, Kings, Manhattan, Queens</strong></td>
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Section 1: Assignment

Potential Health Home clients are identified and submitted to HHUNY from the Department of Health (DOH), Managed Care Organizations (MCO), community referrals and Legacy Care Management agencies.

HHUNY will assign clients based upon their needs to downstream Care Management Agencies for Health Home services. The Care Management Agencies are responsible for verifying eligibility for every client.

Each Health Home enrollee will then be assigned one dedicated care manager who is responsible for overall management and coordination of the enrollee’s care plan which will include medical, behavioral and social service needs and goals.

Identifying Potential Members

Legacy Care Management Recipients

HHUNY has transitioned clients previously receiving Legacy Case Management from the following programs into Health Homes Care Management:

- COBRA HIV Case Management / TCM services
- OMH TCM Programs
- Substance Use Case Management Services through MATS program
- The Chronic Illness Demonstration Project (CIDP)

Converting programs should assign their clients to a Health Home that best meets that client’s needs. The converting program is required to contact the Health Homes they are assigning each client to and supply them with required patient information.

HHUNY will send all required member information to upstream providers such as the DOH or MCO.
DOH Assignment List

Currently NYS identifies individuals who may be eligible for Health Home services through an analysis of claims and encounter data and provides a list of these individuals to HHUNY for outreach and engagement. These are known as “list assigned” clients and may be assigned directly by the DOH or by a client’s MCO.

**Designation on the DOH list does not verify eligibility**

When a Care Management Agency receives a DOH List assignment they are responsible to verify eligibility and Medicaid status. Outreach and engagement efforts should follow the Outreach and Engagement guidelines and policy.

Community Referrals

Clients may be referred to HHUNY from other providers or entities including physicians, emergency departments and community based providers, supportive housing providers, shelters and family members. A client may also complete a self-referral. These referrals are known as “community referrals”.

If a Care Management Agency receives a community referral, they should submit the referral to HHUNY. HHUNY will review the preliminary criteria and verify if the client is available for assignment. HHUNY will follow up with the referring Care Management Agency once this information is obtained.

For instruction on how to complete a community referral, please see the “How to Complete a Community Referral” document.

Rejection of an Assignment

If a Care Management Agency identifies a potential client as being ineligible or inappropriate for services, the Care Management Agency should submit the rejection to HHUNY via Netsmart Care Manager 2.0 or a tracking file. The Care Management
Agency should indicate the reason for the rejection using the preapproved Rejection Codes.

See Rejection Reason Codes document.

Once rejected, the client will never be assigned to the rejecting Health Home again. A Care Management Agency or HHUNY can recommend a more suitable Health Home assignment, however, the client will not necessarily be assigned to the suggested Health Home.

**Rejection Rules:**

- Rejection records can only be submitted for Medicaid clients that did not begin an outreach and engagement segment or an enrollment segment
- Rejected clients will not be reassigned to the rejecting Health Home again
- When the rejected record is processed daily at midnight, the client will be removed from the rejecting Health Home’s assignment file
How to complete a Community Referral Form

This is a quick cheat sheet to ensure referral sources complete a more accurate Health Home Community Referral. Incorrect or incomplete Health Home referrals impede the processing of the referral, which means a delay in services for the client.

When checking boxes for Eligibility and Risk Factors, please provide detailed information. This will give HHUNY Community Referral Coordinator the information needed to make an appropriate assignment.

Here is a brief check list for completing a HHUNY Community Referral.

Check to make sure all pages were faxed or (secure) emailed completely.

- Please make sure the Medicaid CIN Number is on the referral (It is two letters, followed by 5 numbers, and one letter). Example: (AA12345A).

- Eligibility Category Information: Make sure to specify the Diagnosis.
  - Example: Serious mental illness - 296.8 Bipolar Disorder NOS
  - Example: Other Chronic Conditions-COPD
  - If 2 in category C, must provide info on BOTH; Substance Use Disorders included.

- Risk Factor – Give some detail information concerning member’s risk factors: Example: Member is a risk for hospitalization due to non-adherence with medication.

- No Referral can be processed without the member’s consent form, which is included in the referral. Referral will not be processed without a consent; per DOH, this can include noted verbal consent. CONSENT TO DISCLOSURE OF HEALTH INFORMATION from HHUNY referral is needed.
How to complete a Community Referral Form, page 2

- If you are an agency assisting a member in completing a **self-referral**, make sure to list your contact information along with the member’s information. Often the Community Referral Coordinator may not be able to reach the member, which holds up the referral.

- **If referrals are coming from an Inpatient unit please provide:**
  - Name of hospital and contact info for the Discharge Planner.
  - Admission and planned discharge date.
  - Reason for admission
  - *The goal of HHUNY is to make the community referral a user friendly and timely process. For more information, please visit the Health Homes area of [www.carecoordination.org](http://www.carecoordination.org)*
How to Submit a Community Referral to HHUNY

1. Complete the Community Referral Application Form, including as much detail as possible to allow HHUNY to verify eligibility for health home services.
2. Attach a signed “Consent to Disclosure of Health Information” Form.
3. Send the completed Application and Consent via secure email or fax, or mail to:

**HHUNY Community Referral Coordinator**

- **Email:** tmarchese@hhuny.org
- **Fax:** 585-613-7670
- **Mail:**
  - Community Referral Coordinator
  - New York Care Coordination Program
  - Health Homes of Upstate New York
  - 1099 Jay Street, Bldg. J
  - Rochester, NY 14611

Approved individuals will be assigned to a Care Management Agency who will conduct outreach and attempt to engage the person in health home services. Health Home services are voluntary and the individual will be asked to consent during the outreach and engagement process.

If you have questions regarding the completion of this application, please contact: HHUNY Community Referral Coordinator at 585-613-7642.

*HHUNY provides Health Home services in the counties of Allegany, Cayuga, Cattaraugus, Chautauqua, Chemung, Cortland, Erie, Genesee, Livingston, Madison, Monroe, Onondaga, Ontario Orleans, Oswego, Schuyler, Seneca, Steuben, Tompkins, Tioga, Wayne and Yates County. Please contact the Community Referral Representative to make a referral for services in any of these counties.*
Section 2: Eligibility

Clients are deemed to be eligible for Health Home services if they meet the requirements set forth by the NYSDOH. They are identified through an analysis of claims and encounter data (see Assignment section for more detail.)

To determine eligibility of a potential Health Home client, a Care Management Agency must verify:

- Medicaid eligibility and status
- Diagnosis of a qualifying chronic condition(s)
- Presence of risk factor associated with the chronic condition(s).

An assessment or eligibility screen must be performed for all presumptively eligible clients to evaluate whether the person has significant risk factors and is appropriate for Health Home Care Management services.

Determining Medicaid Eligibility

Medicaid reimbursement for Health Home services can only be provided to individuals who are enrolled in Medicaid. It is the Care Management Agency’s responsibility to verify Medicaid for both community referrals and list assignments.

If a client is found to be Medicaid eligible but their Medicaid is currently inactive, the Care Management Agency can opt to assist the client in recertifying for their Medicaid. If a client is found to be ineligible for Medicaid, the assignment should be rejected.

It is important to note that:

- Medicaid eligibility and status may change frequently
- Medicaid coverage may be granted retroactively
Chronic Condition Qualifiers

To be eligible for Health Home services, a client must have either two chronic conditions or one single qualifying condition. Care Management Agencies are responsible for ensuring all identified medical and psychiatric diagnoses are verified before enrollment of a client into services. This is completed via the Eligibility Screening process.

Single Qualifying Condition

NYS has identified the single qualifying conditions as HIV or a qualifying serious mental illness.

A diagnosis of a serious mental illness must be associated with a functional impairment (risk factor) due to the mental illness in-order to be considered a single qualifying condition for Health Homes. Examples of functional impairment include:

- Marked difficulty with self-care
- Restrictions to activities of daily living
- Difficulties maintaining social functioning and/or social relationships
- Deficiencies of concentration, persistence or pace

Serious mental illness diagnoses that meet the requirements to be a single qualifying condition include:

- Psychotic Disorders
- Bipolar Disorders
- Obsessive Compulsive Disorders
- Major Depressions
- Other Mood Disorders
- Anxiety Disorders
- Personality Disorders

For a more specific list, please see Qualifying SMI Conditions page.
Two Qualifying Chronic Conditions

If a client does not have a single qualifying condition, they can be eligible for Health Homes based on having two chronic conditions. Having one chronic condition and being at risk of developing another condition does not qualify a client for Health Homes. The chronic condition should:

- Require ongoing monitoring and care
- Have a significant impact on their health and well-being

Major categories of qualifying conditions include:

- Alcohol and Substance Use including associated problems such as liver disease
- Mental Health Condition such as depression
- Cardiovascular disease such as coronary artery disease, congestive heart failure and hypertension
- Metabolic Disease such as diabetes or renal failure
- Respiratory Disease such as asthma

For a more extensive and complete listing of qualifying chronic conditions please see Eligible Chronic Conditions page.

Risk Factors

A client must be assessed and be found to have significant behavioral, medical or social risk factors to deem them appropriate for Health Home services. Client’s that meet the eligibility criteria but manage their own care effectively do not need the level of care management provided by a Health Home.

Determinants of medical, behavioral and social risk can include:

- Probable risk for adverse events including death, inpatient admission
- Lack of or inadequate social, family and/or housing support
- Lack of or inadequate connectivity with health care system
- Non adherence to treatments or medications
- Difficulty managing medications
- Recent release from incarceration
- Recent psychiatric hospitalization
- Deficits in activities of daily living
- Learning or cognition issues
Qualifying SMI Conditions

Any **ONE** of these conditions will qualify a client for Health Home services if the severity and duration of mental illness results in substantial functional disability.

Anxiety Disorder NOS  
Avoidant Personality Disorder  
Bipolar I Disorders  
Bipolar II Disorder  
Borderline Personality Disorder  
Cyclothymic Disorder  
Delusional Disorder  
Dissociative Identity Disorder  
Dysthymic Disorder  
Generalized Anxiety Disorder  
Histrionic Personality Disorder  
Major Depressive Disorder  
Mood Disorder NOS  
Narcissistic Personality Disorder  
Obsessive Compulsive Disorder  
Panic Disorder with or without Agoraphobia  
Paranoid Personality Disorder  
Personality Disorder NOS  
Posttraumatic Stress Disorder  
Psychotic Disorder NOS  
Schizoaffective Disorder  
Schizoid Personality Disorder  
Schizophrenia  
  - Disorganized Type  
  - Catatonic Type  
  - Paranoid Type  
  - Residual Type  
  - Undifferentiated  
Schizotypal Personality Disorder
**Health Home Chronic Conditions**

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<tr>
<th>Condition</th>
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<td>Acquired or Congenital Hemiplegia and Diplegia</td>
<td>Chronic Neuromuscular and Other Neurological Diagnoses</td>
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<td>Acquired or Congenital Paraplegia</td>
<td>Chronic Neuromuscular and Other Neurological Diagnoses</td>
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<td>Acquired or Congenital Quadriplegia</td>
<td>Chronic Non-Lymphoid Leukemia w/wo Remission</td>
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<td>Acute Lymphoid Leukemia w/wo Remission</td>
<td>Chronic Obstructive Pulmonary Disease and Bronchiectasis</td>
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<td>Chronic Pain</td>
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<td>Alcoholic Liver Disease</td>
<td>Chronic Pancreatic and/or Liver Disorders</td>
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<td>Alcoholic Polyneuropathy</td>
<td>(Including Chronic Viral Hepatitis)</td>
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<td>Alzheimer's Disease and Other Dementias</td>
<td>Chronic Pulmonary Diagnoses</td>
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<td>Angina and Ischemic Heart Disease</td>
<td>Chronic Renal Failure</td>
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<td>Anomalies of Kidney or Urinary Tract</td>
<td>Chronic Skin Ulcer</td>
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<td>Cirrhosis of the Liver</td>
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<td>Atrial Fibrillation</td>
<td>Cleft Lip and/or Palate</td>
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<td>Coagulation Disorders</td>
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<td>Cocaine Abuse</td>
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<td>Complex Cyanotic and Major Cardiac Septal Anomalies</td>
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<td>Conduct, Impulse Control, and Other Disruptive Behavior Disorders</td>
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<td>Chronic Lymphoid Leukemia w/wo Remission</td>
<td></td>
</tr>
<tr>
<td>Chronic Metabolic and Endocrine Diagnoses</td>
<td></td>
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</tbody>
</table>
Fitting Artificial Arm or Leg
Gait Abnormalities
Gallbladder Disease
Gastrointestinal Anomalies
Gastrostomy Status
Genitourinary Malignancy
Genitourinary Stoma Status
Glaucoma
Gynecological Malignancies
Hemophilia Factor VIII/IX
History of Coronary Artery Bypass Graft
History of Hip Fracture Age > 64 Years
History of Major Spinal Procedure
History of Transient Ischemic Attack
HIV Disease
Hodgkin's Lymphoma
Hydrocephalus, Encephalopathy, and Other Brain Anomalies
Hyperlipidemia
Hypertension
Hyperthyroid Disease
Immune and Leukocyte Disorders
Inflammatory Bowel Disease
Intestinal Stoma Status
Joint Replacement
Kaposi's Sarcoma
Kidney Malignancy
Leg Varicosities with Ulcers or Inflammation
Liver Malignancy
Lung Malignancy
Macular Degeneration
Major Anomalies of the Kidney and Urinary Tract
Major Congenital Bone, Cartilage, and Muscle Diagnoses
Major Congenital Heart Diagnoses Except Valvular
Major Liver Disease except Alcoholic
Major Organ Transplant Status
Major Personality Disorders
Major Respiratory Anomalies
Malfunction Coronary Bypass Graft
Malignancy NOS/NEC
Mechanical Complication of Cardiac Devices, Implants and Grafts
Melanoma
Migraine
Mild / Moderate Mental Retardation
Multiple Myeloma w/wo Remission
Multiple Sclerosis and Other Progressive Neurological Diagnoses
Neoplasm of Uncertain Behavior
Nephritis
Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's
Neurofibromatosis
Neurogenic Bladder
Neurologic Neglect Syndrome
Neutropenia and Agranulocytosis
Non-Hodgkin's Lymphoma
Obesity
Opioid Abuse
Osteoarthritis
Osteoporosis
Other Chronic Ear, Nose, and Throat Diagnoses
Other Malignancies
Pancreatic Malignancy
Pelvis, Hip, and Femur Deformities
Peripheral Nerve Diagnoses
Peripheral Vascular Disease
Persistent Vegetative State
Pervasive Development Disorder
Phenylketonuria
Plasma Protein Malignancy
Post Traumatic Stress Disorder
Postural and Other Major Spinal Anomalies
Prematurity - Birthweight < 1000 Grams
Progressive Muscular Dystrophy and Spinal Muscular Atrophy
Prostate Disease and Benign Neoplasms - Male
Prostate Malignancy
Psoriasis
Psychiatric Disease (except Schizophrenia)
Pulmonary Hypertension
Recurrent Urinary Tract Infections
Reduction and Other Major Brain Anomalies
Rheumatoid Arthritis
Schizophrenia
Secondary Malignancy
Secondary Tuberculosis
Severe / Profound Mental Retardation
Sickle Cell Anemia
Significant Amputation w/wo Bone Disease
Significant Skin and Subcutaneous Tissue Diagnoses
Spina Bifida w/wo Hydrocephalus
Spinal Stenosis
Spondylarthropathy and Other Inflammatory Arthropathies
Stomach Malignancy
Tracheostomy Status
Valvular Disorders
Vasculitis
Ventricular Shunt Status
Vesicostomy Status
Vesicoureteral Reflux
Section 3: Outreach & Engagement

Receiving Assignments

Health Home Care Management Agencies are to begin outreach and engagement activities in a timely manner once they have received a Health Home client assignment. Outreach and engagement must start within 3-5 business days from receipt of the assignment, as specified below and as per the outreach and engagement policy.

AOT:
- Upon receipt of an assignment of a client with an AOT order, the Care Manager Agency must begin outreach and engagement activities within 3 business days.

Inpatient Clients:
- Upon receipt of an assignment of a client who is presently in an inpatient program, the Care Manager Agency must begin outreach and engagement within 3 business days or prior to the client’s discharge, whichever is sooner with the intent being to connect with the client prior to discharge.

Resources

Health Home Care Management Agencies are to utilize information provided by the Health Home as well as various outreach methods to locate the individual who is eligible for Health Home Services including:

- Office-based outreach (phone calls, letters, collateral contacts)
- Community-based outreach
Examples of Community-based outreach include:

- Client’s home/neighbors/landlord
- Community locations (corner store, drop in centers, faith-based organizations)
- Last known service providers (doctors, hospitals, dentist, etc.)
- Managed Care Organizations
- Family Members
- Homeless shelters/social service providers
- Jail/prison
- LGU/SPOA and other community networking groups
- Health Information databases (PSYCKES, Regional Behavioral Health Organization (RBHO), and/or claims data provided from DOH in the Member Tracking System)

Sharing PHI

Prior to the signing of the DOH-5055 consent, if a Health Home or Care Management Agency has a contract in place with the client’s Managed Care Organization, then it is permissible for information to be shared between the different network providers in the interest of enrolling the client. See the link below for further information about the policy regarding sharing PHI prior to the signing of DOH-5055 consent.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/docs/policy_for_sharing_protect_hlth_info.pdf

Documentation/Billing

New York State Medicaid Update, April 2012 provides the following information regarding Outreach and Engagement:

The outreach and engagement Per Member Per Month payment will be available for three months. If outreach and engagement is unsuccessful (defined as not locating the member and/or not enrolling the member), the provider may continue outreach and engagement but may not bill again for these activities until the conclusion of a three-month interval.
All efforts must be clearly and properly documented and progressively intensive over these three billable months. If at the end of the three months the client has not been located, and/or initially engaged, the Care Management Agency is to determine if efforts to locate the individual will continue beyond these initial three months. Billing for outreach activity shall be in compliance with NYS DOH guidelines.

**Contacting the client**

Once a Health Home client has been contacted, the Health Home Care Manager ensures the individual has a clear understanding about NYS Health Homes and the services to them through Care Management. The Health Home Care Manager will consider how the individual understands this information based on their cognitive, language, and reading abilities.

**Enrolling the client**

HHUNY defines the ending of outreach and engagement and the commencement of ongoing care management as being the point where the individual is verbalizing willingness to participate in Health Home services and the assessment process is able to begin. The date indicating the start of on-going care management must be documented in the contact note.

*For clients who have opted-out of Health Home services, see the [Opt-Out section of this manual](#).*
Outreach and Engagement (OE)

1. **Accepted client assignment**
2. **Is the client presently in an inpatient program?**
   - Yes: **Begin OE within 3 business days of receiving the assignment or prior to the individual’s discharge**
   - No: Continue with the next step.
3. **Does the client have an AOT Order?**
   - Yes: Begin OE within 3 business days of receiving the assignment or prior to the individual’s discharge.
   - No: Continue with the next step.
4. **Begin OE within 5 business days of receiving the assignment, unless MCO requires earlier contact.**
5. **Contact Types:** Collateral contacts, in-person attempts, phone calls and letters
6. **Were you able to contact the client?**
   - Yes: **Ensure client has a clear understanding of HH Services**.
   - No: **Perform progressively intensive OE for 3 months**.
7. **Do you want to attempt OE for another 3 months?**
   - Yes: **Put Client in Hiatus for 3 months if not found**.
   - No: **Complete Opt-Out Form and close from program**.
8. **Document verbal willingness, have client sign consent & assessment process can begin**
9. **Client is Enrolled**
Section 4: Enrollment

Enrollment is defined as the ongoing care management once a client has verbalized willingness to participate in Health Home Services. This is the end of outreach and engagement and the start of the assessment process.

Health Home Documentation
Each Health Home client will have a single care management record which will minimally include the following documentation:

- Health Home Patient Information Sharing Consent Form and any additional consent forms
- Health Home Opt-Out Form (if applicable)
- Health Home Patient Information Sharing Withdrawal of Consent Form (if applicable)
- Comprehensive Assessment
- Plan of Care
- Plan of Care Review
- Crisis Plan
- Contact Notes
- FACT-GP
- Health Home Functional Questionnaire
Health Home Care Managers must be fully aware of NYS Health Home rules regarding the completion of the Health Home Patient Information Sharing Consent Form (DOH-5055). This form and instructions for its use are included in this section. These resources, in numerous languages, may also be found on the Health Homes section of the NYS DOH website by following the link: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/. It is the Health Home Care Manager’s responsibility to assure that the client understands the information, has the opportunity to ask questions and has the form made available in the client’s primary language (as made available by DOH). For clients with concerns about the consent form, Health Home Care Managers are encouraged to seek engagement of others, utilize a supervisory consult, and/or peer services. It is important that the client be fully informed about the consent process.

The consent form must be provided to all relevant parties and maintained in the care management record.
Enrollment Workflow

- Client has verbalized willingness to participate in Health Homes
  - Client agreed to sign DOH 5055.
    - Provide active care management
  - Client declined to sign DOH 5055.
    - Do not exchange any data. Provide limited care management services and encourage client to sign DOH 5055.
      - Did client reconsider and agree to sign DOH 5055?
        - Yes
          - Client agreed to sign DOH 5055.
        - No
          - Continually declining to sign DOH 5055 will eventually lead to client disenrollment.
Section 5: Assessments

Comprehensive Assessment

New York State Health Home requires that each client has a Comprehensive Assessment completed, which is used to identify the client’s physical and mental health, chemical dependence and social service needs, as applicable. On-going care management includes the process of re-assessing the client’s interests and needs, annually or after a significant event such as a hospital admission.

Timeframe:

- Needs to be completed within 30 days from the date of enrollment.

Appreciating the barriers and challenges that some of the clients experience, if the Care Manager is unable to complete the comprehensive assessment within 30 days, there must be documentation that details ongoing efforts to engage the enrollee in completing the assessment.

Domains:

HHUNY requires that all of the following domains are addressed:

- Physical Health
- Mental Health
- Chemical abuse/dependency
- Housing, transportation, financial, employment, education
- Relationships, community involvement
- Identification of all current providers
- Enrollee identified barriers, strengths and priorities

FACT-GP and the Health Home Functional Assessment

New York State requires the FACT-GP and the Health Home Functional Assessment to be completed for each client at enrollment, annually and at discharge. Care Managers are to complete these documents as outlined in the Scoring Guidelines for FACT-GP/Health Home Functional Assessment. These documents are available in numerous languages and can be found electronically on the Health Homes section of the NYS DOH Website.
Assessment Workflow

Client is Enrolled

Complete Comprehensive Assessment and FACT-GP within 30 days

Complete reassessment as necessary

- Did client have a significant life event (i.e. hospitalization)?
  - Yes: Continue to provide active care management
  - No: Continue to provide active care management

- Is it a yearly anniversary from date of enrollment?
  - Yes: Continue to provide active care management
  - No: Continue to provide active care management

- Has client been discharged from HH services?
  - Yes: Complete FACT-GP and HH Functional Assessment
  - No: Complete FACT-GP and HH Functional Assessment

Complete comprehensive reassessment

Complete comprehensive reassessment, FACT-GP and HH Functional Assessment

Complete FACT-GP and HH Functional Assessment
Section 6: Plan of Care

Each client will have a comprehensive, individualized, patient centered plan of care. The plan of care will be based on information obtained from the comprehensive assessment domains. The plan of care will identify the client’s progress in meeting goals and reflect any changes in needs as they occur.

Timeframe

The Plan of Care is to be completed within 30 days after the completion of the Comprehensive Assessment. As with the Comprehensive Assessment, appreciating the barriers and challenges that some of the clients experience, if the Care Manager is unable to complete the Plan of Care within 30 days, there must be documentation that details ongoing efforts to engage the client in completing the Plan of Care.

The Plan of Care is to be reviewed minimally every 6 months to monitor and evaluate client progress and ongoing needs. These reviews will involve the Health Home client and include discussion regarding their progress towards identified goals, the effectiveness and satisfaction of interventions identified in the Plan of Care, and address integration of new strengths/barriers identified. Plan of Care reviews shall also include dialogue (by phone and/or by use of conference tools) with involved service providers to assure that changes in treatment or medical conditions are addressed as well.

Documentation

The Plan of Care must be:

- Written in a manner that is understandable to the individual (at their reading and comprehension level)
- Written in the clients primary language or translated to the client through translation services, family members or care manager
- Reviewed and signed by the client.

Particular attention should be paid to developing plans that address periods of transition such as a discharge from an inpatient setting back to the community and discharge from the Health Home.
New York State Plan Amendment

Requirements

- Include and integrate the client’s medical, behavioral health and rehabilitative services, long term care and social service needs as applicable.
- Identify the Interdisciplinary Care Team
- Include goals, interventions and timeframes for improving the client’s health and their overall health care status
- Engage the client in their own care and promote continuity of care
- Periodic re-evaluation of the client’s needs, goals and progress
  - Changes in the client’s needs will be reflected in the plan of care

Interdisciplinary Care Team

The Care Manager is responsible for developing an Interdisciplinary Care Team that includes the client, treatment/care and support providers including primary care providers, specialists, behavioral health providers, community networks and others identified by the client as important (i.e. family members, peers, natural supports). The Plan of Care is to be developed with the client and the Care Team. With the appropriate consents, the Plan of Care, including progress and updates, is to be shared among all relevant parties. Mechanisms for sharing the Plan of Care must comply with PHI guidelines.

HHUNY Requirements

In addition to what is required by the State, HHUNY further requires that the Plan of Care includes:

- What is important and of priority to the client
- A client goal statement written in the clients own words and reflecting what the client wants for themselves
- Strengths which promote goal attainment
- Barriers which impede goal attainment
- Interventions
  - Interventions must address who will do what, where, and within what timeframe
Developing the Plan of Care

- Client has completed the Comprehensive Assessment

Were you able to meet with the client within **30 days**?

- Yes
  - Review needs in Comprehensive Assessment
  - Identify client priorities, strengths and barriers
  - Create interventions
  - Who will do what, where and within what timeframe
  - Create interdisciplinary care team
  - Create client goal statement using client's words
  - Clearly document in notes the efforts to engage client to complete plan of care. Keep trying to locate client

- No
  - Transfer client back to Outreach & Engagement

- No
  - Clearly document in notes the efforts to engage client to complete plan of care. Keep trying to locate client

Input into an EHR

Review minimally every 6 months with client and communicate with involved service providers to ensure that any changes are addressed
Section 7: Crisis Plan

The Crisis Plan is a guide to give clients, providers and families guidelines for preparedness and actions that are adaptable for any crisis situation a client may face. Components of good crisis planning stimulates thinking about the crisis preparedness process, provides ways to avoid crisis and includes practical examples of what has worked for the client in the past.

**Timeframe**

The Crisis Plan should be completed face to face with the client within 30 days of enrollment.

A good time to develop a crisis plan is when developing the client’s care plan and completing the comprehensive assessment. Crisis plans should be updated every six months or if a client has any significant life changes.

**Participants in Plan Development**

*Mandatory:* The client and the Care Manager

*Optional:* A neutral and unbiased facilitator, a person to record what is being shared, parents/guardians or other family members, friends, professionals and anyone else who has a personal interest in the client.
Documentation Requirements

A good plan will:

- Identify people willing to help and providers the client wants contacted
- Include an emergency contact and any limits or specifications for communication
- List the phone numbers of the mental health providers or crisis team
- Identify any health needs or diagnoses to be mindful of in a crisis
- Include a list of current medications and their dosages
- Identify key words or calming techniques that have worked in the past
- Include arrangements for children, family or pets in the care of the client

Considerations:

- Clients’ cultural, religious, and ethnic needs can impact their response to a crisis
- The best time to work on the plan is during times of stability for the client
- Good plans should be continually updated based on the changing needs of the client
- The client can fill the plan out alone or in a conversation with someone else
Crisis Plan Workflow

1. **Client is Enrolled**
   - Complete within 30 Days
   - **Is the client in a place of stability?**
     - **Yes**
       - Include:
         - Client’s personal needs
         - People and providers willing to help
         - Names and numbers of Mental Health providers
         - Medications, Diagnosis
         - Calming Techniques
       - Complete Crisis Plan
     - **No**
       - Provide services needed to stabilize client and then develop Crisis Plan

2. **Complete Crisis Plan**
   - **Has it been six months?**
     - **Yes**
       - Update Crisis Plan
     - **No**
       - Continue to provide active care management
   - **Has there been a significant life change?**
     - **Yes**
       - Update Crisis Plan
     - **No**
       - Continue to provide active care management
Section 8: Active Care Management

Core Services

Active Care Management is characterized by the delivery of DOH defined core services which engage the client towards the achievement of their personal goals. Core services must be active, progressive and ongoing. Care Management Agencies must provide at least one of the five core (excluding HIT) services per member, per month.

The six (6) Core Health Home services are:

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care
4. Individual and family support
5. Referral to community and social support services
6. The use of HIT to link services

The Core Health Home services are expected to assist in coordinating and supporting continuity of care during the following events:

- ED Visits
- Hospital Inpatient stays
- Residential and Rehabilitation Stays
- Crisis Intervention
- Use or need for acute and outpatient medical, mental health and substance abuse services
- Use or need for community based social support services, including housing

The mode of contact for core service delivery may include but is not limited to:

- Face to face meetings
- Mailings
- Electronic Media
- Telephone calls
- Case conferences
The goal of these core services is to:

- Ensure access to appropriate services
- Improve health outcomes
- Reduce preventable hospitalizations and emergency room visits
- Promote use of Health Information Technology (HIT)
- Avoid unnecessary care

Health Home providers will be required to maintain written documentation that clearly demonstrates how these core requirements are being met.
**Core Service Intervention and Activity Examples**

**Comprehensive Care Management**

- Complete a comprehensive health assessment and reassessment
- Complete and revise an individualized patient-centered plan of care
- Consult with multidisciplinary team on client care plan, needs and goals
- Consult with primary care physician and any specialists involved in the treatment plan
- Conduct client outreach and engagement
- Prepare client crisis intervention plan

**Care Coordination and Health Promotion**

- Coordinate with service providers to secure necessary care
- Share crisis intervention and emergency info
- Link client to needed services to support care plan goals
- Conduct case reviews with interdisciplinary team
- Advocate for services and assist with scheduling of needed services
- Coordinate with treating clinicians to assure that services are provided
- Monitor, support and accompany the client to scheduled medical appointments
- Crisis intervention

**Comprehensive transitional**

- Follow up with hospitals and ER’s upon admission and/or discharge
- Facilitate discharge planning
- Notify and consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation
- Link client with community supports to assure that needed services are provided
- Follow up post discharge with client and family to assist with care planning

**Individual and family support**

- Develop and review an individual’s plan of care with the family
- Consult with client and client’s family on advanced directives and client rights
- Refer client and family to peer supports, support groups, social services, entitlement programs
- Collaborate and coordinate with community based providers to support utilization of services

**Referral to community and social support services**

- Link client with community supports as needed
- Coordinate with community base providers to support utilization of services

The above is a limited list of the identified core services descriptions. For a more extensive and complete listing of core services please see Health Home Care Management Responsibilities (Draft: July 31, 2014).
Active Care Management Workflow

Provision of Services

Did services provided qualify as a core service?

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Services

No

Does not qualify as a billable Health Home service
Reattempt Active Care Management

Yes

Did services engage the client toward their goal(s)

No

Continue Active Care Management

Yes

Can services be described as:

- Active
- Progressive
- and
- Ongoing

No

Yes

Continue Active Care Management
Section 9: Ending Services

The Health Home program is voluntary. A client may decline to participate at any time and during any stage of service, including Outreach and Engagement, Hiatus or Enrollment. In many cases, the client is eligible to re-engage in services when they are ready and meet eligibility requirements. The Health Home Care Manager is responsible for notifying all relevant parties, including HHUNY and any legal entities involved in AOT cases, if a client declines or ends services. The reason for ending services should be identified in all cases and submit to HHUNY via a tracker file or Netsmart Care Manager 2.0.

All health information is protected even when the individual decides to discontinue participation in the Health Home program.

(For information pertaining to rejecting an assignment before services have been provided, see the “Assignments” section)

Maintenance of Records

Health Homes shall and shall require Health Home Services Providers to maintain Member medical records for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after the age of majority or six (6) years after the date of service, whichever is later, or for such longer period as required by law, regulation or the contract between MCO and NYSDOH. This provision shall survive the termination of this Agreement regardless of the reason.
Ending Services- Outreach and Engagement:

If a client is found during Outreach and Engagement and declines services, an Opt-out form should be completed. If a client is not found during Outreach and Engagement and an agency decides not to continue to pursue the client, the Care Management Agency needs to identify the reason for ending services and submit to HHUNY.

**Opt-Out (DOH-5059)**

For clients who are found and decide to opt out of Health Homes during the Outreach and Engagement period, the DOH-5059 Opt-out form should be utilized and the decision should be clearly documented within a client’s notes. The client is considered disenrolled from Health Homes once the form is completed. The reason for ending services must be identified and submitted to HHUNY.

During the Opting out process, the care manager should ensure that the client:

- Is eligible for Health home services and Medicaid
- Is currently in Outreach and Engagement status and has not signed the DOH-5055 Consent
- Understands the benefits of participating in Health Homes and Care Management Services
- Understands that they can continue to utilize Medicaid services if they opt-out of Health Homes
- Is informed about the process to re-enroll in Health Homes if they chose to do so in the future

If a client declines to sign or is unable to sign the Opt-out form, the Care Manager may complete the form without a client signature. The reason for opting out of the program must be included on the Opt-out form.
**Ineligible**

If a client becomes ineligible for Health Home services while in Outreach and Engagement then the Care Management Agency needs to identify the reason for ending services and submit to HHUNY. Examples of what would constitute a client becoming ineligible would be relocation out of state or county or if they are deceased.

**Unable to Locate**

If you are unable to locate a client within the initial three months of outreach and engagement, a client enters into a three month Hiatus period. (See Hiatus section.) If a Care Management Agency decides not to continue to attempt to locate the client, then the Care Management Agency needs to identify the reason for ending services and submit to HHUNY.

A Care Management Agency can opt to attempt a second three month round of Outreach and Engagement following Hiatus. If a client is not located during this time period, the Care Management Agency end services and submit to HHUNY.

If the Care Management Agency feels there are extenuating circumstance that make a third round of Outreach and Engagement beneficial for the client, the Care Management Agency should contact HHUNY for guidance on how to continue to serve the client.

**Loss of Medicaid**

If a client loses their Medicaid while in Outreach and Engagement, the Care Management Agency must decide if they will assist the client in recertifying for Medicaid. They may not bill for services or enroll a client during this time.

If the Care Management Agency decides not to continue to perform Outreach and Engagement, then the agency needs to identify the reason for ending services and submit to HHUNY.
**Transfer**

If a client chooses to be in a different Health Home, they should notify their MCO or assigned Health Home immediately. The transfer would be effective the first day of the next month. The Health Homes involved need to discuss the timing of the transfer.

Only one Health Home may bill for a member in a given month.

The three month outreach and engagement consecutive billing maximum is still in effect if a Health Home passes along a member’s information to another Health Home to continue outreach and engagement services. In order to bill for outreach and engagement again after the initial three month period of payment for this service, a lapse of three months must occur before outreach and engagement can be billed again.

The process for transferring clients will change with the implementation of MAPP.

**Incarceration**

If a client is found to be incarcerated while in Outreach and Engagement, the Care Management Agency should decide if they want to delay starting Outreach efforts until the client is released or if they want to close the client taking into account the length of incarceration and status of Medicaid.

If at any time a client loses their Medicaid while incarcerated, the Care Management Agency should not continue to bill for services and follow the Loss of Medicaid guidelines when applicable.

The process for ending services for an incarcerated client will change with the implementation of MAPP.
Ending Services- Hiatus

At any time during the Hiatus period, a client can be closed or opt out of the Health Home program. The guidelines for closing a client while in active Outreach and Engagement should be followed for closing a client during the Hiatus period however you cannot bill for any services provided.

The process for ending services within the Hiatus period will change with the implementation of MAPPS.
Ending Services- Enrollment

The enrollment period for a client can end at any time. Possible reasons for disenrollment include transfer to another agency or Health Home, incarceration, becoming lost to services, loss of Medicaid, becoming ineligible for services or withdrawal of consent.

Transfer

If a client chooses to be in a different Health Home or Care Management Agency, they should notify their MCO or assigned Health Home immediately. The transfer would be effective the first day of the next month. The Health Home or Care Management Agency involved needs to discuss the timing of the transfer.

Only one agency may bill for a member in a given month.

The process for transferring clients will change with the implementation of MAPP.

Incarceration

If a client is incarcerated sixty days or less without the loss of Medicaid, the Care Management Agency should continue to provide active Care Management for the client as able through contact with the Criminal Justice System and Interdisciplinary Care Team. If the incarceration will last more than sixty days, the client should be closed from the Health Home program. If at any time a client loses their Medicaid while incarcerated, the Care Management Agency should not continue to bill for services and follow the Loss of Medicaid guidelines when applicable.

The process for ending services for an incarcerated client will change with the implementation of MAPP.
Lost to Services

It is the policy of HHUNY to consider an enrolled client to be Lost to Services if a care manager cannot successfully contact the client for 60 days past a missed schedule contact. It is expected that:

- Upon missing an appointment, the care manager will attempt to follow up with the client
- Subsequent follow up will be made on a regular and progressive basis with the client, available social supports, and referred providers
- The Care Manager would be actively attempting to re-engage the member in the program through all available venues

If all attempts to locate the member do not result in direct contact with the member for 60 days from the last scheduled contact, the enrollment segment will be ended.

The Care Management Agency should then decide whether to discharge the client or put them back into Outreach and Engagement. If the agency opts to transfer the client back into Outreach and Engagement then:

- They must notify HHUNY via a tracker file or Netsmart Care Manager 2.0 (see HHUNY Lost to Service Policy for procedural directions)
- The client must be dis-enrolled from the Health Home program if not found after three months
- Outreach and Engagement will begin on the first day of the month following the date of dis-enrollment
- The client will be reinstated in an active enrollment segment if found and re-engaged

Additional segments of hiatus and billable outreach are not appropriate for members Lost to Services. Billing for outreach/engagement after a client is determined lost to services is acceptable only if a three month period has lapsed since the Health Home last billed for outreach/engagement for the member.
**Loss of Medicaid**

If a client loses their Medicaid while enrolled, the Care Management Agency is encouraged to assist the client in recertifying for Medicaid.

If the Care Management Agency decides not to continue to provide services, then the agency would proceed with discharging the client.

**Withdrawal of Consent (DOH-5059)**

Members who want to dis-enroll or no longer need Health Home services because they have accomplished their goals and have already signed a patient consent (DOH-5055) need to sign a Withdrawal of Consent form (DOH-5059.) If a Health Home withdrawal of consent form is signed, permission to share new data among Health Home partners is negated and the designated Health Home loses RHIO and PSYCKES access for that member. The assigned care management agency is required to identify the reason for ending services and submit to HHUNY. The Withdrawal Form must be provided to all relevant parties and maintained in the care management record.
Disenrollment Reasons:
- Transfer
- Incarceration
- Lost to services
- Loss of Medicaid
- Ineligible for the HH NOT due to loss of Medicaid (i.e. Moved)
- Client does not want to be in or does not need the HH program

**Flowchart:**
1. Notify MCO and involved Health Homes
2. Does the client have Medicaid and has it been less than sixty days?
   - Yes: Begin Active Care Management
   - No: Continue to attempt to find the client
3. Do you want to continue to attempt to find the client?
   - Yes: Contact HHUNY
   - No: Transfer client back into OE for 3 months
4. Are you going to assist in recertifying?
   - Yes: Begin Active Care Management
   - No: Can not bill until Medicaid is active
5. Submit End Segment information to HHUNY via CM2.0 or Tracker File
6. Complete Withdrawal of Consent Form

**End Enrollment**
Section 10: Documentation of Services

Health Home Care Manager’s documentation must accurately and objectively reflect Health Home activities. Health Home Care Managers should consider all audiences when creating any documentation and assume that all involved in the Plan of Care, including the client, will have access to the materials in the client’s care management record.

**Timeframe**

Documentation of services must be completed within 5 business days. Documentation of significant events (hospitalization, emergency health condition, arrest, etc.) will be documented by the next business day. Changes to client’s contact information (phone number, address, etc) must be documented within 5 business days.

**New York State Requirements**

The following are needed to support monthly billing:

- At least one of the five (excluding HIT) core Health Home services
- Active and progressive movement towards enrollment and goal achievement
- Face-to-face meetings, mailings, electronic communications and/or telephone calls
- Outreach and engagement activities until enrolled
- Plan of Care development followed by active Care Management according to the Plan of Care

*Documentation that supports Medicaid billing MUST meet Medicaid requirements.*

**HHUNY Requirements**

In addition to State requirements, HHUNY requires that each documentation of service includes:

- Clear identification of the Health Home client, including the Medicaid CIN
- Full name of Care Manager
- Date of service
- Type of contact/service delivery (FTF, phone, correspondence)
- Identification of who participated in service delivery (client, collateral, provider, etc.)
- Clear indication of which of the core services are being provided at time of contact
Documentation Workflow

Did it meet Medicaid and NYS billing standards?

Was it a significant event?

Was a core service performed?
Was it active and progressive?
Was it an appropriate contact?

Provided active care management

Document attempts in an informational/non-billable note

Continue to provide active care management

Documentation due within 5 business days

Yes

Yes

Yes

No

No

Yes
CONTACT INFORMATION

NYS SERVICES

EMERGENCY .............................................................. 911
CARE INFORMATION / LIFE LINE ........................................ 211
CHILD PROTECTIVE SERVICES ............................................ (800) 342-3720
ADULT PROTECTIVE SERVICES ............................................. (844) 697-3505
NATIONAL SUICIDE PREVENTION LIFELINE ................ (800) 273-TALK
NATIONAL DOMESTIC VIOLENCE HELPLINE ...................... (800) 799-SAFE
MEDICAID HELPLINE ................................................................ (800) 541-8831
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE .... (518) 402-3096
DEPARTMENT OF VETERAN AFFAIRS ...................................(877) 222-VETS
SOCIAL SECURITY ADMINISTRATION ...................................... (800) 272-1213
STATE FAIR HEARING ...................................................... (800) 342-3334
NYS DEPARTMENT OF HEALTH ........................................... (518) 402-0836
NYS OFFICE OF MENTAL HEALTH ..................................... (800) 597-8481
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES ...(866) 946-9733
COPY OF BIRTH CERTIFICATE ................................................ (518) 474-3077
HEALTH INSURANCE ......................................................... (855) 355-5777
SNAP; HEAP; TEMPORARY ASSISTANCE ......................... (800) 342-3009

HHUNY INFORMATION

MAIN LINE ............................................................................. (585) 613-7659
TOLL FREE LINE .............................................................. (855) 613-7659
COMplaint LINE ................................................................. (855) 209-1142