Bassett Healthcare Network
Community Health Navigation

Policy Title: Standards of the Comprehensive Assessment and Practice of Person-Centered Care

Policy Number: BCHN013

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Approved By: Miranda Blakeslee

Applicable to: Health Homes Serving Adults (HHSA)

Purpose: To establish standards and clear guidance regarding Health Home (HH) person centered Plans of Care (POC) and Comprehensive Assessment, which will inform internal and partnering Care Management Agency policies and procedures.

Contents

Definitions

Behavioral Health Home and Community Based Services BH (HCBS) - Behavioral Health Home and Community Based Services (BH HCBS) provide opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. This model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals. Implementation of BH HCBS will help to create an environment where managed care plans, service providers, plan members, families, and government partner to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders.

Care Manager (CM) - Point of contact for all coordination of care related to a member enrolled in the Health Home.

Comprehensive Assessment - A mandatory functional approach for data collection, as well as an ongoing, dynamic process of information gathering and an evaluation of a member's health care and related needs. The Comprehensive Assessment identifies service needs currently being addressed, service and resource needs requiring referral, gaps in care and barriers to service access; and the members strengths, goals, and resources available to enhance care coordination efforts and empower individual choices and decision making.

Consent (DOH-5055) - The Health Home consent form allows the Health Home to share the member's protected health information (PHI) with other downstream partners agreed upon by the member and identified on the consent form. When PHI is properly shared, services can be coordinated based on a reasonable understanding of the member's health care needs and medical history.

Goals – Identified high level desired outcome(s) for a member's specific need(s)/ concern(s) and the program/service eligibility criteria, as outlined in the Plan of Care (POC).

Health and Recovery Plan (HARP) - a distinctly qualified, specialized managed care product that manages physical health, mental health, and substance use services in an integrated way for adults 21 and over who are eligible for Medicaid Managed Care and meet serious mental illness (SMI) and substance use disorder (SUD) targeting criteria and risk factors. HARPs also manage the enhanced benefit package of Adult Behavioral Health Home and Community-Based Services (Adult BH HCBS).

Formal Supports – Paid support system that provides formalized services based on the goals/needs and interventions/activities outlined in the Plan of Care (e.g. Home Health Aide).

In-Person – An interaction that must be conducted with both the member and Health Home care manager physically in the same location. This type of interaction cannot be done via telehealth.

Initial/Comprehensive Plan of Care –The first Plan of Care created for a newly enrolled member that has a required timeframe for completion of fifty-six (56) calendar days from enrollment (based on the consent date or the segment start date, whichever is later). These terms can be used interchangeably.

Interventions or Supports – The necessary activities and strategies used by the provider/service that support the member/participant's progress in accomplishing their objective(s). These terms can be used interchangeably.

Managed Care Organization (MCO) A MCO is a managed care entity that is certified by, and contracted with, the State to deliver Medicaid health benefits and additional services through a Medicaid Managed Care system. Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid Managed Care.

Member or Participant – The individual (both adults and children/youth) enrolled in the Health Home program. The term includes the parent, guardian, legal authorized representative of the member, as applicable. These terms can be used interchangeably.

Multidisciplinary Team (MDT)/Interdisciplinary Team (IDT)/ Review Meeting/Case Conference/Care Conference/Care Team Meeting members - Consists of the Health Home care manager, member, member supports (including parent, guardian, legally authorized representative), Medicaid Managed Care Plan (MMCP), healthcare, and service providers, collaterals and others approved by the member to ensure member needs are addressed in a comprehensive manner. The composition of a Multidisciplinary Team may vary at any point in time during the member's enrollment and from member to member. These terms can be used interchangeably. A non-hierarchal group of healthcare professionals who are discipline oriented but work in parallel with one another to provide comprehensive, individualized care to the member. The focus is to support the members' needs and objectives, address any potential challenges, and increase the likelihood of successful outcomes. In addition to professionals, non-professionals and family/supports identified by the member may be part of the Multidisciplinary Team (MDT)/ Interdisciplinary Team (IDT)/Case Review Meeting/Case Conference/Care Conference/Care team at any point in the member's HH enrollment.

Natural Supports – Informal, unpaid support systems as identified by the member in their case records, Comprehensive Assessment, or Plan of Care (e.g. family member).

Objectives – A member's specific and measurable actions that will help accomplish their goal. Person-Centered person-centered planning (PCP) is a process led by the person receiving support in collaboration with chosen team members that results in the cocreation of an action plan centered around the individual's most valued priorities and wellness goals.

Plan of Care - A roadmap to behavioral and physical health, and recovery which guides the providers and the member, their family, and other supports toward achieving the member's goals for successful outcomes. Based on a thorough assessment of the individual's strengths, preferences, barriers, and needs, the Plan of Care will define which paid and unpaid services and supports the person has approved to work with.

Risk Screening - Identification of a member's potential for harm to self or others, or risk of safety and wellbeing of the member by others, especially in regard to children and youth. Identification of potential risk will inform the need for possible additional assessment (by a licensed practitioner or specific practicing provider i.e., child welfare), development of a safety plan, and/or additional service coordination by the care manager. Being aware of a member's prior history of high-risk behaviors and or family situation and development of a safety plan will

help prepare a care manager in the event the member's status may require crisis intervention at any time.

Significant Life Event – Specific experiences or changes in medical and/or behavioral health or social needs that directly impact/alter the member's life. This can include, but is not limited to:

- Significant change in member's functioning or condition (including increase or decrease of symptoms or new diagnosis)
- Member admitted, discharged or transferred from hospital/detox, residential placement, arrest/detention/incarceration, or foster care
- Member's been seriously injured or has medical/behavioral health event a major
- Change in the member's caregiver (for children/youth, primary or other identified) guardian, legally authorized representative
- Significant change in caregiver's capacity/situation
- Court request or order e.g., Assisted Outpatient Treatment (AOT)
- Significant change in housing or support resources

Social Determinants of Health - conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants include:

- Economic Stability
- Poverty Employment Food Security Housing Stability
- Education High School Graduation Enrollment in Higher Education Language and Literacy
- Early Childhood Education and Development Social and Community Context
- Social Cohesion Civic Participation Discrimination Incarceration
- Health and Health Care
- Access to Health Care Access to Primary Care Health Literacy
- Neighborhood and Built Environment Access to Healthy Foods Quality of Housing
- Crime and Violence Environmental Conditions

Telehealth – the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member. Telehealth is utilized based upon the request of the member/caregiver and must be documented within the case record. Care managers must also adhere to general Medicaid telehealth guidance when delivering services via telehealth, which requires that services be based on the best interest and needs of the member, not that of the provider nor for the convenience of the provider.

For additional Telehealth guidance, including billing guidance, refer to NYS Medicaid Coverage of Telehealth or the Medicaid Telehealth Policy Manual.

Policy

As specified in the New York State Plan Amendment 14-0016, Health Homes are required to provide Comprehensive Care Management, as part of the six Health Home Core Services.

Within Comprehensive Care Management, a comprehensive health assessment that identifies medical, behavioral health (mental health and substance use) and social services is required for individuals who have been deemed eligible and appropriate for the Health Home program. This policy establishes guidance on how and when the Comprehensive Assessment and Plan of Care are created, implemented, updated, and distributed for all consented members. Documentation supporting information collected must be accessible and located in the member's electronic health record, as identified by the Health Home. The Health Home (HH) will provide clear and focused Plan of Care training requirements and maintain a quality assurance program to ensure compliance.

The CM will be the single point of contact for the member's care coordination and will have responsibility for the overall management of the member's Plan of Care. The CM facilitates collaboration with the member's Multidisciplinary Team.

Procedure

Person Centered Planning is an ongoing process of gathering information that aids in the development of a person-centered plan of care. The information gathered during the development of a comprehensive assessment is collected to inform the plan of care that supports the day-to-day care provided to the member.

Overview of the Comprehensive Assessment

A comprehensive assessment is both a mandatory functional approach for data collection, as well as an ongoing, dynamic process of information gathering, and an evaluation of a member's health care and related needs. The information collected is to inform a fully integrated Plan of Care.

Information gathered during the completion of the comprehensive assessment aids in identifying member needs and drives the creation of the individualized Plan of Care. Each member's service delivery is driven by review in the following areas:

- a screening tool that evaluates high risk behavior by the member or others that may jeopardize the individual's overall health and wellbeing;
- a detailed description of the member's medical and behavioral health (mental health and substance use), as well as psychosocial conditions and needs;
- an assessment of social determinants of health including a member's lifestyle behaviors, social environment, health literacy, communication skills and care coordination needs such as entitlement and benefit eligibility and recertification;
- self-management skills and functional ability (thinking and planning, sociability/coping skills, activity/interests); and
- the member's strengths, support system, and resources

The Health Home Comprehensive Assessment identifies service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the member's strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making. The care manager assesses for risk factors that include but are not limited to the member's chronic conditions such as HIV/AIDS; harm to self or others; safety and well-being due to the behavior of others, persistent use of substances impacting wellness; food and/or housing instabilities.

This process is not intended to be a clinical intervention, but rather an early identification of need as part of the care management process. With member consent, information is gathered from a variety of sources:

- service providers;
- family and natural supports;
- community-based resources such as housing case managers;
- faith-based organizations identified by the individual; and
- member self-report.

Information from other HH assessments or evaluation can be used to populate the full requirements of the comprehensive assessment. The HH is required to support both the CMA and DOH in understanding the link of each document and how it fulfills the comprehensive assessment requirements. The CMA is required to ensure all parts of the comprehensive assessments are completed in full.

A CM supports continuity of care and health promotion through the development of a supportive relationship with the individual and their care team. Care team members can assist the care manager in providing historical information, current service/program care plans, and reviewing outcomes of the assessment information. The care manager takes full responsibility for the assessment process and required documentation as the single point of contact for the coordination of care as outlined in this policy.

As part of the comprehensive assessment and person-centered planning with the individual, the Care Manager educates and offers the member community-based services and programs that the member might benefit from and be eligible for, to address their identified needs. Additionally, the Care Manager helps to determine what referrals and connections to the services or programs are necessary.

If a member is enrolled in a HARP Medicaid Managed Care Plan (MMCP) or is a HARP-eligible member enrolled in a HIV/Special Needs Plan, the CM must educate the member about Behavioral Health Home and Community Based Services (BH HCBS) and eligibility determination.

- If the member consents to an eligibility assessment, a care manager trained on the NYS Eligibility Assessment or a qualified State designated entity must administer the adult NYS Eligibility Assessment for BH HCBS.

Comprehensive Assessment Timeline

The initial comprehensive assessment must be completed concurrently with an initial plan of care within 56 calendar days of enrollment. An assessment may be completed over the course of several days; at least one of these encounters during the initial assessment period will be in-person.

An annual comprehensive assessment of each member is required to be completed within 365 days from the previous comprehensive assessment. The Comprehensive Assessment may inform the Continued Eligibility for Services (CES) Tool based on the risk factor(s) identified for the member's continued enrollment. The Continued Eligibility for Services (CES) Tool, which provides the Health Home with decision support regarding continued enrollment in the Health Home program, is conducted twelve (12)

months after the consent date, or the segment start date (whichever is later), and every six (6) months thereafter.

If a member experiences a Significant Life Event in medical and/or behavioral health or social needs before the next scheduled review, the CM will perform an abbreviated comprehensive assessment of the member's current status including rescreening for risk factors will be completed, and reviewed and signed by a supervisor. Any changes in the member's goals or service needs will result in an amended Plan of Care triggering a case review with a supervisor and/or applicable members of the care team. Such significant changes to the member's condition and/or POC should be reflected later in the annual reassessment.

Required Components of the Health Home Comprehensive Assessment

The Health Home consent form (DOH 5055) must be completed and include all providers referenced through the comprehensive assessment, as well as the MMCP and Behavioral Health Organization (BHO), as applicable.

> **NOTE:** If there is an area that a member does not want to or is not able to provide substantive responses to, the CM is to note that within the case record. It must be clear in the member's care record that the CM made efforts to collect information across all topic areas.
>
> A response is required for every query on the HH's comprehensive assessment. An answer of "N/A" is not an acceptable response. Examples of acceptable responses include "member has no known prior history of," "member and family deny history of," "member refused to answer question at the time of assessment," or "prior medical records/previous assessment doesn't indicate."

Documentation/verification for components of the comprehensive assessment should be obtained from various sources, including a primary care provider (PCP), PSYKES, a RHIO, or MCO.

The components of the comprehensive assessment must include the following:

- **Identification Information**
  - Health Home eligibility and appropriateness criteria (can be completed during intake and verification noted in assessment)
  - Medicaid eligible & active
  - At least two chronic conditions OR Single qualifying condition:
    - HIV/AIDS
    - SMI Appropriateness for HH services
    - Sickle Cell Disease
  - Appropriateness for HH services identified on the Initial Appropriateness including significant behavioral, medical, or social risk factors.
  - Consented (DOH 5055)
- **HIV/AIDS**
  - Current HIV status
    - CD4 Count: Date:
    - Viral Load: Date:

        - Verification method of CD4 and VL
        - Does client understand meaning of VL and T-cell Count and how to read lab results? (Explain)
    - Does client need referral for further HIV information/education?
    - Does the person need referral for HIV testing?
    - Last time tested?
    - Does client have history of STI's, injecting substances, unprotected sex?
    - Is there engagement in treatment plan/services? Identify barriers to service and treatment.
    - Is member receiving PrEP and/or PEP?
- **Mental Health Services**
    - Psychiatric history
        - Illness history (historical timeline from age of onset of mental illness)
        - Hospitalizations and other treatments Member's current problems
    - Member's current situation
        - Service use within the last 12 months
        - Current functioning
        - Symptoms and severity
        - Diagnoses
        - Dangerous/high risk behavior
        - Suicidality
        - Trauma/abuse history
        - Domestic violence (APS/CPS)
    - Strengths of member
        - Is there engagement in treatment plan/services?
        - Identify barriers to service.
- **Substance Use Disorder**
    - Systematic screening method for identifying risky use or potential SUD using an OASAS approved tool (i.e. AUDIT and DAST);
    - History of substance use and dependence (substance, route of administration, frequency, duration);
    - Treatment history, including current treatment (facility/provider, dates, duration, discharge status);
    - Current/recent use of alcohol and drugs (list substances, route of administration, amounts and frequency);
    - How substance use/dependence affects daily living: (why the person takes substances, behavior problems, daily living skills, employment, relationships, finances, psychiatric symptoms, self-medication);
    - Is the member aware of any adverse impact of substance use on their life?
    - Motivation to change;
    - Specific behavioral information on substance use & mental health disorders & how they influence each other, if applicable;

- Current Recovery Support (peers, recovery center, self/mutual help groups)
- Referral to treatment needed?
- Identify barriers to service.

- **Developmental Disability**
  - Identified condition, diagnosis, etc.
    - Intellectual and/or developmental disabilities (I/DD)
    - Determination of Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IID) Level of Care Eligibility Determination (LCED)
    - Was an assessment conducted?
    - Involvement of the Office of Persons with Developmental Disabilities
    - Current Supports
    - Current services for IDD
- **Medical Health Care**
  - Current medical diagnoses; for each diagnosis (illness), assess:
    - Illness history
    - Hospitalizations and other treatments
    - Symptoms and severity
    - Adherence to treatment
    - Is illness controlled or uncontrolled Health promotion (examples)
    - Specialist, type and purpose
  - Is there engagement in treatment plan/services?
  - Identifying barriers to services
- **Independent Living Skills**
  - Functional assessment, performance & capacity
    - meal prep/needs assistance eating
    - housekeeping/cleanliness
    - managing finances, ability to shop
    - managing medications
    - phone use/communication modes
    - transportation
    - ability to dress, bath self; personal hygiene; toileting
    - mobility, positioning, transferring
    - tie back to medical/behavioral health components
    - memory/learning - needs interpretation services
  - Interest in self-help, advocacy, and empowerment activities
  - Social support network
  - Family support systems
  - Does member have support to help with instrumental activities of daily living?
  - Strengths of member.
  - Identify barriers to service.
- **Social service needs**
  - Housing

        - risk of eviction questions (required by Gov. office)
        - what type of housing does the person have now? how long there?
        - how many times has the person moved in last 6-12 months? Social Security Supplemental Nutrition Assistance Program (SNAP) Clothing Financial resources/representative payee
    - Social Security
    - Supplemental Nutrition Assistance Program (SNAP)
    - Clothing
    - Financial resources/representative payee
    - Any additional social service needs:
        - Advanced directives
        - Legal needs/status (incarceration, probation, etc.)
        - Strengths of member
        - Identify barriers to service.
- **Vocational/educational status**
    - Level of education
    - History of employment
    - Access to vocational rehabilitation and employment programs
        - Ticket to work
        - Welfare to work
    - Skills and resources needed to achieve goals/identify strengths.
    - Strengths of member.
    - Identify barriers to service.
- **Medications**
    - Pharmacy that member uses
    - Contact information of previous prescribers
    - Current medication treatments and doses
        - Medical health meds
        - Behavioral health
        - Medication Assisted Treatment for SUD
        - Pain management
        - HIV/AIDS medication
    - Member's understanding of medication and use
    - Indication as to why member with chronic condition has no medication
    - Medication adherence.
    - Identify barriers to taking medications.
    - Identify supports that would assist with med management.
- **Providers**
    - HIV medical provider(s)
    - Mental health provider(s)
    - Medical health provider(s)/specialists
    - Substance use disorder treatment providers
    - Schools/educational institutions
    - Home and Community Based Service providers
    - Peer support provider
    - Other Community-based providers

- **Natural Supports**
  - Family members
  - Friends
  - Faith based supports
  - Other individuals identified by the member

Overview of the Plan of Care (POC)

The Plan of Care (POC) is integral to the HH model, goals, and services that are provided. The POC is a comprehensive, individualized, and person-centered living document that changes over time depending on the member's needs. It needs to be written in plain language and in a manner that is comprehensible to individuals with disabilities and persons with limited English proficiency and should reflect the cultural considerations of the member. The plan will guide day-to-day care management work and will support the required collaboration among providers and others approved by the member. Consented and approved members of the care team are listed in the POC and, on the member's HH consent (e.g., care team, MMCP, family/supports, etc.) to monitor member progress towards goals.

The member plays a central and active role in the development and execution of their Plan of Care. By signing the POC the member agrees with the identified needs, goals, interventions, and time frames contained in the Plan of Care. Needs and goals outlined by members of the Multidisciplinary Team (MDT) will also be incorporated as they are involved in the development process of the Plan of Care. The member can choose to not work on an identified need or goal, but this denial or disengagement will be documented in the members Electronic Health Record (EHR). Denials, deferrals and disengagements must be documented at the time of the conversation. These events will be addressed with the member at minimum annually in an attempt to encourage the members engagement in their health and wellness.

Core service requirements are met through providing intervention written in the Plan of Care; however, additional services may be provided based on the member's needs. The member's needs should drive the intensity and frequency of services. Changes in member's needs, goals, preferences, and interventions should be confirmed with the member and documented in the Plan of Care.

Minimally, during core service delivery to the member, the CM conducts an intervention or activity listed in the member's Plan of Care that supports the member's progress towards their goal(s). Periodically the member may require additional Health Home Care Manager services due to an unpredicted life event (e.g., Emergency Department visit, inpatient stay, incarceration, etc.) that is not reflected in the member's Plan of Care. Such CM services should be provided, but should not replace activity/s driving progress on care plan goals unless the member is unwilling/unable to work on a Plan of Care goal/s that month.

Conducting Multidisciplinary Team (MDT) Meetings

The MDT meeting is person-centered and scheduled for a time and location that is convenient for the member and caregiver. The needs and goals of the member outlined on the Plan of Care are to be discussed with MDT members. During this meeting, additional needs or goals may be identified by members of the team. The CM will review

the providers' input and incorporate the new goal(s) or need(s) into the POC, with the members approval.

An MDT meeting is conducted to develop the Initial Plan of Care, to include those healthcare and service providers already identified as serving the member. While not all necessary providers and/or service supports will be available during the first fifty-six (56) calendar days of enrollment, the CM will work to assure person-centered collaboration is achieved. If a CM has difficulty scheduling an MDT Meeting, it may be appropriate to obtain input from the care team in different ways:

- Provider is unable to attend in-person:
  - the CM 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 member Personal Health Information.
- When care team members cannot connect as a full group:
  - the CM can facilitate smaller group contacts or have direct contact with single providers/others to obtain needed information from all Multidisciplinary Team members.
- When care team members are unable to participate:
  - the CM documents in the member's record any attempt(s) made to obtain information/update from those providers and update the Plan of Care accordingly for information received. If an invitee from the Multidisciplinary Team is unable to/does not attend, a phone conference and/or summary report can be given to ensure necessary information is provided for feedback and input. The Care Manager documents the Multidisciplinary Team Meeting in the member's record. A properly documented Multidisciplinary Team Meeting fulfills program requirements even when not all members of the Multidisciplinary Team who are invited to attend actually attend.

When a Significant Life Event with the member occurs that requires a change(s) in the Plan of Care, the CM should consider contacting relevant involved providers.

A MDT Meeting is required:

- upon enrollment
- annually when the POC is reviewed.
- at the request of the member/MDT member
- due to the events that are occurring in the member's life.

CMA must have a process in place to guarantee the POC is provided to the member and the member's family and significant others (Parent, Guardian, Legally Authorized Representative), and offered to the member's MDT members. By utilizing the provided Electronic Health Record (EHR), Netsmart Care Manager to digitally upload the Plan of Care will be made easily accessible via Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) to the MMCP and other entities, such as State Agency Partners (SAP).

Plan of Care (POC) Timeline

The Plan of Care is updated when there are significant changes to the goals, interventions, services, etc. and made digitally accessible for the member in MAPP.

Initial Plan of Care

The Health Home and CMA will ensure that an Initial Plan of Care (POC) is completed concurrently with the HH Comprehensive Assessment for all newly consented members, within the first fifty-six (56) days of enrollment.

The POC must include the member's wants/need(s) associated with Eligibility and Appropriateness, Comprehensive Assessment, Social Determinants of Health (SDOH), HCBS/CORE Service Eligibility, and other assessments used to identify needs if they have not yet been completely resolved by the time the Initial Plan of Care is signed.

The Initial POC is completed in compliance with the required information outlined in the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Specification Document to be properly uploaded.

Annual Plan of Care (POC) Review

The CM continually monitors the POC ensuring progress toward goals and updating the POC, as necessary. The POC is reviewed and updated within 365 days of the previous, annually, for all HH members.

The Annual POC is signed and dated by the member and/or representative (if one exists), showing the member's involvement and approval of the changes in the Plan of Care.

Significant Life Event Plan of Care (POC) Review

Significant Life Events include specific experiences or changes in medical and/or behavioral health or social needs that directly impact/alter the member's life.

- Examples of Significant Life Events include, but are not limited to: Significant change in member's functioning or condition (including increase or decrease of symptoms or new diagnosis)
- Member admitted, discharged or transferred from hospital/detox, residential placement, arrest/detention/incarceration, or foster care Member's been seriously injured or has medical/behavioral health event a major
- Change in the member's caregiver (for children/youth, primary or other identified) guardian, legally authorized representative
- Significant change in caregiver's capacity/situation
- Court request or order e.g., Assisted Outpatient Treatment (AOT)
- Change in information or diagnosis, more information obtained

Not all Significant Life Events will require the POC to be changed (for example, when a goal/goals is achieved); however, if a POC needs to be changed as a result of a member's Significant Life Event the CM reviews and updates the POC accordingly. If a Significant Life Event is identified, the CM evaluates the

member's current status, including rescreening for risk factors. The POC is then signed and dated by the member and/or representative, showing the member's involvement and approval of the changes in the Plan of Care.

Applicable members of the MTD are notified of the changes to the Plan of Care for Significant Life Events and provided access to the updated Plan of Care.

Other Considerations for Plan of Care (POC) Review

Changes may be needed to the POC when a member changes provider, member supports and services, or when a POC goal is met. The CM ensures these types of changes to the members POC are approved by the member and communicated to appropriate providers and others. The CM documents the changes and the member's approval in the member's record and includes these changes in discussion during the next POC review.

For these changes, a new member signature is not required on the Health Home Plan of Care. However, the updated HH Plan of Care is digitally uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS), for the following changes:

- When Adult Behavioral Health, Health and Community Based Services provider changes are made to the Plan of Care
- When Adult Behavioral Health, Health and Community Based Services service changes are made to the Plan of Care
- When Health Home Care Manager service changes are made to the Plan of Care
- When a Plan of Care objective, intervention, or goal is met.

Continued Eligibility for Services (CES) Tool Outcomes and Updating the Plan of Care

Upon completion of the Continued Eligibility for Services (CES), the final recommendation, Continued Services or Disenrollment, is documented in the member's record. If a risk factor is identified that is not addressed in the current Plan of Care, the Plan of Care is updated to include this new information.

Further information related to completion of the Continued Eligibility for Services (CES) Tool can be found in the Guidance for Use of the Continued Eligibility for Services (CES) Tool and in the DOH - Health Home Continued Eligibility for Services (CES) Tool.

Change in Member Client Identification Number (CIN)

When confirming a member's Medicaid status, prior to rendering services, the CMA/CM will be able to identify if a member's CIN is inactive. When this occurs, the Health Home Care Manager follows up with the member to determine whether their Medicaid has ended completely or if the member's Medicaid is active under a new Client Identification Number.

When Medicaid is active under a new CIN, the CMA/CM enters the new CIN into the member EHR and notifies the HH who will update the Medicaid

Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).

The current Plan of Care in Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) will ***not*** automatically transfer from the current Client Identification Number to the new Client Identification Number. While completion of a new Plan of Care is not required, the current Plan of Care is copied and uploaded into the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) under the new Client Identification Number within fifty-six (56) calendar days to ensure the most current version is accessible in the system.

Goals and Interventions

During the Initial Appropriateness determination CM ensures at least one of the member's goals, or a member's high-level desired outcome for a need is identified. The Initial POC should be completed by the CM and include all relevant Goals and Interventions identified by the member, identified in assessments and communicated by the Multidisciplinary Team. If the need(s) associated with Initial Appropriateness was completely addressed and resolved at the time the Initial POC is signed, it does not have to be included in the Initial Plan of Care. However, evidence of encounters and CM activities conducted toward meeting the goal of the member's initial need(s) are documented in the member's record within the fifty-six (56) calendar day period regardless of whether it was met or is still in progress.

If a member declines to address a need identified by the MDT, the reason for declining engagement will be documented in the member's record and will not be required in the member's plan of care. When goals and interventions are identified and member declines engagement the CM will continue to address these needs on, at minimum, annually. Documentation of the members continued disengagement in those goals and interventions and CM encouragement of engagement are required in the member's record.

Identifying an associated intervention or support that will be used by the provider/service to assist the member in accomplishing their goals if required. The intervention should also include any activities or strategies that will be used by the CM to assist the member in accomplishing their goals. This would include planned Care Management interventions (e.g., Services Care Management, Referral, Access, Engagement, Follow Up, and Service Coordination) and timelines.

Home and Community Based Services (HCBS) within the Plan of Care

For members who are eligible and/or enrolled in HCBS, it is necessary for the Plan of Care to include identified and/or chosen by the member to help them attain their goals. Once the HCBS provider has met with the member and it is agreed that the service(s) will address the member's needs, the HCBS provider will determine frequency, scope, and duration for each individual service. The CM will then ensure the approved frequency, scope, and duration are then identified on the POC.

Additionally, HCBS complies with all Health and Community Based Services Final Rule requirements, including participant choice in the service(s) provided and the setting

where the service(s) is provided. The Plan of Care identifies the setting in which the member resides and if it is a community-based setting, if the member wants to reside in the setting/address, and if the member has choice where they reside based upon their identified risk factors. HCBS cannot be provided in a prohibited setting. Please visit the Health and Community Based Services Final Rule webpage for further information regarding appropriate settings and other requirements.

For additional information regarding eligibility assessment, level of service determination, and referral requirements applicable to the coordination of Adult Behavioral Health and Health and Community Based Services, please see Adult BH Health and Community Based Services Workflow Guidance.

Medicaid Managed Care Plans (MMCP) authorize Frequency, Scope, and Duration as outlined in the Health and Community Based Services Plan of Care Workflow policy. MMCP will download the ***digitized*** Plan of Care of Health and Community Based Services members for their records.

Obtaining Member Signature(s)

A member signature on the POC verifies the member's involvement in the development of, and agreement with, the contents within. Signature on the member's initial POC allows for continued billing after the initial fifty-six (56) days from enrollment. An annual POC is developed, signed and finalized within 365 days of the previous to continue to bill for services. If signature cannot be obtained billing will cease until member signature can be obtained.

If the member expresses reservations about signing the POC, the CM will explore the source of the concern and works with the member to amend the Plan of Care so it meets their approval. The member then signs the POC to demonstrate that approval.

If the member continues to refuse to sign the POC, and the CM is unable to amend it such that the member will sign, then the CM is to explain to the member the significance of the Plan of Care. The POC is the foundation summarizing the scope of the work the CM and the member will engage in, together, for the benefit of the member. The CM is to further explain that without an agreed-upon POC, as demonstrated by the member's signature, a member cannot remain in the program. The reasons and discussion held with the member is documented in the case record.

If after discussion with the member, they are still not willing or able to agree to a Plan of Care and/or sign a Plan of Care, the CM engages with their supervisor to explore other options before proceeding to disenrollment procedures. The CM or supervisor is to document all efforts made. If after all reasonable efforts to develop a Plan of Care the member is still unwilling to sign, the program may proceed towards disenrollment. For additional information and guidance for the member disenrollment process.

Signature and date are required for the following:

- Initial Plan of Care
- Annual Plan of Care
- Significant Life Event

Contingent upon the member's consent and upon request, the Plan of Care is then to be provided by the Care Manager to the member and the member's family and significant others (Parent, Guardian, Legally Authorized Representative). The Plan of Care is also offered to the member's Multidisciplinary Team members and made accessible via Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) to the Medicaid Managed Care Plan (MMCP) and other entities, such as State Agency Partners (SAP).

Signatures on the Plan of Care can be obtained by the Care Manager through wet (ink on paper) or electronic means. The practice of obtaining member signature via electronic means is acceptable as long as CMA/CM are in compliance with all applicable New York State and Federal laws.

NOTE: Refer to sections above for Initial, Annual, Quarterly High Fidelity (HFW), Significant Life Event and Other Plan of Care regarding requirement for digitally uploading the Plan of Care into Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).

Health Home Members Under Court-Ordered Assisted Outpatient Treatment (AOT)

If a member with an active Assisted Outpatient Treatment (AOT) order refuses to sign a Plan of Care (POC), the court order on file will supersede the refusal and care management services will continue. The CM documents the refusal in the member's record but **does not** proceed with disenrollment. The CM writes "AOT order" on the signature line with the date.

Training

Care Manager's will be provided training by the HH and/or CMA regarding the following topics:

- Comprehensive Assessment
  - Timeframes for administrations
  - Purpose and function
- Plan of Care and required timelines for completion:
  - Timeframes for administrations
  - Purpose and function
  - Signature and date requirements
  - Updates and changes to the Plan of Care
- Recovery-oriented, person-centered care planning
- Motivational interviewing
- Conducting Multidisciplinary Team Meetings

The Health Home utilizes Netsmart Care Manager as the electronic health record system that qualifies under the Meaningful Use provisions of the Health Information Technology for Economic and Clinical Health Act, which allows the member's health information and Plan of Care to be accessible to care team.

Quality Monitoring

The Health Home has a person-centered Plan of Care quality assurance process in place to comply with policies and procedures as outlined in the Health Home Quality Management Program policy. Quality indicators may include:

- Comprehensive assessment and Plan of Care are administered within required timeframes
- Documentation/verification has been obtained using various sources, including primary care provider (Primary Care Provider), behavioral health and substance abuse provider, PSYKES, a Regional Health Information Organizations (RHIO), Statewide Health Information Network for New York (SHIN-NY), or Managed Care Organization within thirty (30) days
- Completion of the Appropriateness Criteria for enrollment
- Timely completion of Continued Eligibility for Services (CES) Tool (Adults)
- Comprehensive assessment is administered annually
- All required components are addressed
- Member's care team included during assessment process
- Supervisor was engaged for members/evidence of adverse event

Supporting Policies and Resources

NYS Medicaid Coverage of Telehealth

Medicaid Telehealth Policy Manual.

Guidance for Use of the Continued Eligibility for Services (CES) Tool and in the DOH - Health Home Continued Eligibility for Services (CES) Tool

Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations

Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) Segment End Date Category & Reason Codes Crosswalk and Guidance Chart