Health Home Guidance: Local Government Unit[1]/Single Point of Access (LGU/SPOA)
January 28, 2013

In response to questions received regarding the role of the LGU/SPOA in a Health Home environment, the NYS Office of Mental Health (OMH) and the NYS Department of Health (DOH) are issuing joint clarifying guidance. The LGU has a statutory role as described in Mental Hygiene Law §41.05 and §41.07. Concurrently, New York State is implementing Health Homes to integrate physical and behavioral health care.

Prior OMH guidance on this topic is superseded by this new guidance below, effective January 28, 2013.
The LGU will continue to contract with the Health Home Care Management (HHCM) programs (former OMH Targeted Case Management (TCM)) and it is expected that Health Homes will also contract with these same programs.

The Health Home will look to care management as a tool that can assist with the development of an integrated plan of care and for utilization management of the members of the Health Home. The LGU/SPOA will look to the legacy capacity[2] from TCM as it is converted into HHCM and will require rapid access for individuals on assisted outpatient treatment status and those who are returning to the community from non-Medicaid settings (e.g., prison, jail, state hospital).

In order for rapid access (as described above) to occur, the HHCM program will need to manage its capacity and prioritize assignment of the referrals. The process to implement this policy will be determined locally in partnership among the LGU/SPOA, Health Home, HHCM program and the Managed Care Organization (MCO).

OMH has provided guidance specific to the assisted outpatient treatment (AOT) program and individuals who have volunteered to participate in enhanced service plans. This guidance is located at: http://www.omh.ny.gov/omhweb/guidance/aot_programs.pdf. (60kb)

LGU/SPOA process in a Health Home Environment:

The LGU/SPOA may make direct referrals for Health Home care management for individuals who meet the Health Home eligibility criteria. The following is the link to these criteria: http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/chronic_conditons_spa_11-56_phase.pdf pages 2 through 4. The "ground up" referral process for legacy capacity will take a different path than list-based referrals (referrals to Health Homes of eligible candidates provided by DOH for fee-for-service Medicaid participants and from Managed Care Organizations for Medicaid Managed Care participants) as follows:

[1] LGUs govern the oversight of county and local not-for-profit service provider funded mental health programs that receive funding from the NYS Office of Mental Health.

SPOAs are part of the county's existing community based mental health system to improve coordination and effective resource allocation in the mental health service delivery system.

[2] Legacy capacity is the total number of slots funded in the former TCM program.

1. Fee-for-service Medicaid enrolled individuals may be referred directly to a Health Home care management program by a county. The process to implement this policy will be determined locally in partnership among the LGU/SPOA, Health Home, HHCM program and the MCO. Each locality should indicate what entities in their community may refer directly to a HHCM program (e.g., SPOA, inpatient units, treatment programs). The care management program will add the individual to their tracking form that is submitted each month to the Health Home. An "R" will be entered on the tracking form to indicate that the person is newly referred (the date of service should be the first day of the month outreach and engagement to the individual began). For "legacy" TCM programs you will also enter a "Y" on the tracking form to indicate that you will be billing directly to eMedNY. Note this supersedes previous guidance to contact DOH to make the Health Home assignment.
2. For Medicaid Managed Care members the same process will be followed as in number one but the tracking form will be forwarded by the Health Home to the managed care company.
3. For people who: a) are on AOT status, b) have an enhanced service plan, c) are being discharged from an institute for mental disease (IMD) setting, or d) are being released from prison or jail (if over 30 days and the individual's Medicaid status is on suspension but the individual remains Medicaid eligible) the LGU/SPOA will expect that all referrals from these settings will be accepted and the Health Home/MCO will ensure rapid (as defined by the LGU) access to the care management resource.

Please be aware that in agreement with the Health Home, a former TCM program may expand capacity above the former legacy capacity. The LGU will need to be aware of where individuals are being referred for expansion capacity. This will assist the LGU and/or the SPOA to identify where capacity is available for referrals of individuals on assisted outpatient treatment status and who are returning to the community from non-Medicaid settings (e.g., prison, jail, state hospital). To assist this notification DOH is building a portal system (health commerce system) for the LGU to access.

For individuals not enrolled in Medicaid, the LGU will continue to contract with the legacy TCM programs for State-funded care management services. These resources may only be expended on people with serious mental illness.

The LGU will also continue contracting for service dollars (100% State-funded) which may be expended on people with serious mental illness enrolled in both Medicaid and HHCM, as well as individuals described in the above paragraph.

The LGU will also be involved in monitoring the quality of the HHCM program. It is expected that the LGU will have access to reports that DOH will be producing on a variety of quality indicators. All parties, OMH, DOH, LGU, MCO, HH and HHCM will need to partner in assuring that individuals participating in HHCM services are receiving the appropriate intensity of care as is indicated by their assessed need.