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| LOCAL COMMISSIONERS MEMORANDUM |
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DSS-4037EL (Rev. 9/89)

Transmittal No: 90 LCM-197

Date: December 5, 1990

Division: Medical Assistance

TO: Local District Commissioners

SUBJECT: Social Services District Coordination with Comprehensive
Medicaid Case Management (CMCM).

ATTACHMENTS: There are no attachments to this LCM.

The purpose of this memorandum is to clarify the coordinative responsibilities of local social services districts (LDSS) in regard to State initiated Comprehensive Medicaid Case Management (CMCM) programs. Clarification is provided on the following topics:

- (1) LDSS cooperation in the implementation of State initiated CMCM programs,
- (2) Representative payee functions and CMCM programs,
- (3) Relationships between LDSS case workers and CMCM case managers.

BACKGROUND:

Please review this communication with previously conveyed information on CMCM including: 89 ADM-29, 89 LCM-131, 90 LCM-16 and 90 LCM-36. A brief background summary follows.

CMCM refers to a Medicaid service which has certain unique characteristics:

- (1) It is intended to increase access to and efficiency of the existing community support system for the purpose of maintaining clients in the community in their most productive and independent states.

- (2) It is targeted to specific populations who require a focused effort to improve access or the effect of community services.
- (3) These community services are not limited to medical services and include all supports necessary to keep individuals in the community.
- (4) A separate State Medicaid Plan Amendment is prepared by the State Department of Social Services Division of Medical Assistance (SDSS DMA) for each targeted population. The amendment is developed from an approved proposal submitted by either a State oversight agency (e.g. the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities) or the LDSS in accordance with administrative directive 89-29.
- (5) Each proposal and State Plan Amendment may, within the parameters of 18 NYCRR 505.16, be tailored to the needs of the target population.
- (6) Provider entities are enrolled as Medicaid providers of CMCM to the targeted population on the basis of the approved proposal and designation by either the LDSS or the State oversight agency, whichever entity submitted the proposal.
- (7) A provider entity may serve only the population for whom it is designated.

Although the essence of CMCM is social rather than medical, CMCM is claimed through Title XIX as a Medicaid service and, for most clients, requires a twenty-five (25) percent local share. CMCM requires local district cooperation in several ways, including entry of data to the WMS RE/EXC subsystem for the target population. However, the LDSS has an important coordinative role in regard to shared services caseloads.

I. LDSS Cooperation in the Implementation of Statewide CMCM Programs:

The first topic for clarification pertains to whether CMCM program implementation through WMS data entry is optional to the LDSS.

Local districts have the option to develop CMCM programs within their community to address needs identified by community planners. The local initiative process is described in 89 ADM-29.

Previously, local districts were given the option to implement their Teenage Services Act (TASA) mandate either through direct services or through use of community agencies with payment to the community agencies through Medicaid claiming. While provision of TASA is mandated, TASA as a Medicaid (i.e. CMCM) service is at the district's option.

However, the implementation of State CMCM programs is not a local option. State initiated CMCM programs are developed in accordance with State established priorities to serve particular population groups whom the Department of Social Services and other agencies have determined to be in particular need of coordination of services. These are often the same clientele groups who are frequent users of local human services agencies including local districts, police, hospitals, schools and mental health organizations. These population groups have been selected because of documented need for assistance in maintaining themselves in the community.

To date local districts have been notified about the approval of two State programs: Office of Mental Health's (OMH) CMCM-Intensive Case Management (ICM) program (89 LCM-131) for the most seriously and persistently mentally ill who have been unserved or underserved by the mental health system, and the Office of Mental Retardation and Developmental Disabilities' (OMRDD) CMCM program (90 LCM-36) for developmentally disabled individuals in the community for whom there is no or insufficient resource coordination. Specific designated provider agencies are identified in subsequent Local Commissioner Memoranda.

All local districts must enter the necessary data on MMIS/WMS per 90 LCM-16 to facilitate program services to the clients of approved agencies.

If discrepancies between program design and actual operation are identified following implementation, they should be documented and referred to SDSS DMA for follow-up with the State oversight agency as described later in this LCM.

The Division of Medical Assistance is currently working with the State Department of Health on an AIDS CMCM proposal and on an interagency initiative targeted to pregnant or parenting women living in certain New York City zip codes who are at risk of substance abuse. Local districts will be advised of future State initiatives prior to submission of a State Medicaid Plan Amendment for the target groups and will be invited to comment on implementation issues.

II. Representative Payee Functions and CMCM Programs:

The second topic requiring clarification involves how the representative payee functions performed by LDSS staff as part of Protective Services for Adults (PSA) or another adult services plan relate to CMCM providers' responsibilities to assist eligible individuals with financial service.

This was identified as a particular problem within the Office of Mental Health's ICM program since this population is more often in need of representative payee service than are other CMCM populations. However, the responsibility for referral to financial services applies to all CMCM programs. Specifically according to interpretations from the Health Care Financing Administration (HCFA), CMCM providers may not have the legal control of a client's money and, therefore, may not be representative payee; they are, however, responsible for referral of clients to financial management services if these services are needed. In some of these cases it will be the responsibility of the local district to act as the clients representative payee as part of a protective service for adults care plan.

The responsibility of the district to provide protective services for adults are discussed in 90 ADM-40, Protective Services for Adults: Client Characteristics.

An agreement between SDSS and OMH described in an April 24, 1990 joint letter from Commissioners Surlles and Perales clarifies the LDSS responsibilities specifically for ICM clients.

III. Relationship Between LDSS Case Workers and CMCM Case Managers:

A third topic which has been raised by several local districts relates to the appropriate service role of the LDSS agency and its case workers in those cases which also involve a CMCM.

Although the CMCM target populations are diverse, most will require the services and entitlements provided through LDSS in addition to the services provided by the CMCM. The purpose of CMCM is to integrate the client into the community support system, including LDSS, as much as possible. It is therefore, appropriate that the CMCM will both encourage and assist the client in using the system. Several professionals may be working with each CMCM client across the various human services provided in the community. The workers involved will each need to assess the individuals they are responsible for and develop a plan to accomplish the goals and objectives of the client and program. Accomplishment of the goals and objectives will require knowledge of the community resources and linking among the human services providers. The CMCM case manager is the key to the linking functions which may include sharing of assessments and plans of actions with goals, objectives and methods of accomplishing these. Each human services provider should provide its unique services and work with the other provider to coordinate those services which may be offered by more than one contributing entity.

It may often be necessary for the LDSS and the CMCM to have coordinative roles with the client. The LDSS will remain the primary provider of certain aspects of the care system including entitlements and mandated services such as child protective and preventive cases, but the CMCM case manager is the client's contact with the wider service system and is often in a good position to assess and mitigate crisis situations and to interface between the client and the other support systems during these crises. There is a need for a collaborative approach between the CMCM case manager and the district worker which recognizes the expertise, role and responsibilities of both workers. The emphasis should be a team approach to service coordination using case conferences as a means of resolving specific case issues and insuring a coordinated direction for the entire case. For example: for risk issues affecting children, the role of the CMCM case manager in determining client need would not supersede that of the Child Protective Service (CPS) or preventive services caseworker. The CPS and preventive caseworkers and the CMCM case managers would each have legitimate functions in the case which should be specified through case conferences.

For adult cases, the CMCM worker may have a more independent role and will ordinarily be the client's first line resource in a crisis. The CMCM case manager will assess the nature of the precipitating situation, determine the client's needs and enlist whatever other community agencies, entitlements or service providers are necessary to fulfill those needs. However, this does not preclude the possibility that the LDSS or other community agencies positioned to be called upon in emergencies will, from time to time, be the first contacted to intervene. When this happens the agency should respond to the client's situation as with non CMCM clientele then provide an update on the case to the CMCM case manager as soon as possible.

We recognize that the broadened responsibilities undertaken under CMCM is new to many CMCM agencies and that there might be an overreliance on social services districts to perform certain functions. We expect that social services districts will take an active role in educating CMCM providers about district mandates and capabilities as well as other community resources. When the local district rather than the CMCM becomes the primary crisis contact for the provider's clientele (i.e. when the number or nature of contacts exceed what is expected in the ordinary course of business), the district should document the number and nature of the contacts and bring them to the attention of the CMCM agency's administrative staff and suggest corrective action.

In general the respective responsibilities of all CMCM programs and the LDSS are outlined below.

- A. CMCM providers are expected to:
- o assess the client's situation and, with the client, develop and pursue a plan which addresses the client's goals/objectives and the activities needed to accomplish them. (The CMCM plan is expected to address all of the client's service needs);
 - o be knowledgeable about the community resources, in addition to LDSS, which are available to the target population and which are necessary to fulfillment of the plan;
 - o work with these community resources and LDSS toward fulfillment of the plan;
 - o be knowledgeable about DSS' and other agencies' services and entitlement programs in order to assist their clientele in the application processes;
 - o share case assessments with the LDSS when the LDSS has a responsibility for services in the case and coordinate with the LDSS on various plan goals, objectives and the activities related to accomplishing the goals and objectives;
 - o identify to the LDSS when there are barriers to LDSS entitlements and other services for the clientele group; and

- o advise the State oversight agency when the provider agency identifies locally unresolvable impediments to services within the LDSS. The State oversight agency, SDSS DMA and, as appropriate, other divisions of SDSS are responsible to: determine the nature of the impediments, articulate options to address the impediments and initiate resolution.

- B. The LDSS is expected to:
 - o cooperate in the WMS registration of CMCM clients;

 - o categorize the shared caseload in terms of LDSS services, develop LDSS participation criteria and share these criteria with the CMCM provider;

 - o share community resource information with the CMCM provider agency both generally and with regard to particular cases;

 - o when necessary, assist CMCM providers to access entitlements and other resources on behalf of clients;

 - o when LDSS has a service role with a client, participate in case coordination conferences with the CMCM;

 - o address systemic barriers to DSS entitlement and services for the target population which have been identified by the CMCM provider and refer those not within the purview of LDSS to SDSS DMA;

 - o document locally unresolvable CMCM coordination efforts and advise SDSS DMA; and

 - o document discrepancies between expectation and performance by the CMCM entities in regard to shared clientele and advise SDSS DMA. In these cases, DMA will refer situations for investigation to the State oversight agency. The State oversight agency is responsible for investigation, and, if necessary, instituting corrective action. The DMA is responsible for monitoring the oversight agency's investigation and follow up and is the determiner of whether or not to continue a Medicaid provider agreement with a particular entity.

Specific questions about the LDSS responsibility for providing a given program or service to CMCM clients, should be referred to SDSS DMA which will consult with the SDSS division having policy making responsibility for the program or service. That division and DMA will review the CMCM proposal, pertinent legislation and regulations and, after discussion with the State oversight agency, will determine the appropriate allocation of functions.

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If you have any questions regarding this release please call Catherine P. Moylan at (518) 474-9279.

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