POLICY 1.014 Health Home Plus (HH+) for Serious Mental Illness Population (SMI)

Health Home Plus (HH+) is an intensive Health Home Care Management (HHCM) service established for defined populations with Serious Mental Illness (SMI) who are enrolled in a Health Home (HH) serving adults. To ensure the intensive needs of these individuals are met, the NYP Health Home must ensure HH+ individuals receive a level of service consistent with the requirements for caseload ratios, face-to-face visits, and minimum levels of staff experience and education outlined below. The differential monthly rate for HH+ is higher compared to the Health Home High Risk/Need Care Management and Health Home Care Management rates, and is intended to appropriately reimburse for the intense and consistent support needed for this population.

Care Management Agencies (CMAs) eligible to serve HH+ individuals

Prior to May 2018, ability to serve and bill the HH+ rate code for individuals meeting HH+ eligibility criteria was limited to former Office of Mental Health (OMH) Targeted Case Management (TCM) providers, also known as OMH Legacy CMAs.

As of May 2018, all other CMAs have the ability to serve the HH+ population. OMH has established HH+ CMA Credentials that must be met by any non-OMH Legacy CMAs or non-Legacy CMAs who will serve the HH+ population and receive the HH+ reimbursement.

ACT programs may also serve individuals who are eligible for HH+. However, ACT programs are not eligible to receive the HH+ rate since these programs bill the ACT rate code, and therefore, are not included in this guidance document.

Attestation

The NYP Health Home is responsible for submitting written attestation to Department of Health (DOH)/OMH of all contracted CMAs who will provide HH+ and that meet the staff qualifications and credentials for HH+.

CMAs must be in good standing with the HH this is determined by The NYP Health Home's attestation process described below:

1. The NYP Health Home will conduct quantitative analysis and surface results to CMAs
2. CMA will submit Narrative Attestation Form if eligible per quantitative thresholds
3. The NYP Health Home will evaluate the narrative in conjunction with various QMP data
4. CMA will be added to HH attestation and submitted to DOH, OMH, and LGUs
5. CMA will attend HH+ policy training

Any CMA wishing to provide services to the HH+ population must demonstrate compliance in three areas including 1. a billable review 2. Passing score in the most recent quality and / or billing review 3. Approved narrative attestation.

A. Billable Review

Patient Population: HARP Enrolled, HIV+ and/or AOT enrolled

1. % of patients had a billable service provided each enrollment month
2. % of patients had at least 2 core services provided each enrollment month
3. % of Care Managers noted at least one contact with a provider* within the review period contact with provider defined as successful encounter with any Case Conference type.

B. Quality Management Program Compliance

CMA must have an acceptable compliance score result for self and lead Health Home chart reviews in order to qualify for Adult Home plus Attestation and CONTINUED attestation for "grandfathered" providers. CMA must have completed self-chart reviews and other required quality measures as determined by The NYP Health Home.

C. Narrative Attestation

CMA must provide the narrative attestation and staff member directory that confirms CM and supervisor qualifications.

The NYP Health Home will evaluate eligibility for HH+ attestation during the quality review cycle.

OMH/DOH will have joint oversight of HH+ compliance, including the approval of attestation forms. The NYP Health Home and CMA's who are approved for the HH+ rate, are subject to audit by the State and other Medicaid authorities. Agencies shall understand that failure to comply with HH+ requirements may jeopardize the agency's opportunity to bill the HH+ rate, and potentially affect a CMA's status as a downstream Health Home Care Management provider.

Staff Qualifications

HH+ shall always be delivered by a CMA with staff who have the education and experience appropriate to serve the high-need, behavioral health population. The following Minimum Qualifications apply:

1. Education 1. A bachelor's degree in one of the fields listed below5; or 2. A NYS teacher's certificate for which a bachelor's degree is required; or 3. NYS licensure and registration as a Registered Nurse and a bachelor's degree; or 4. A Bachelor's level education or higher in any field with five years of experience working directly with persons with behavioral health diagnoses; or 5. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC). Qualifying education includes degrees featuring a major or concentration in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing or other human services field.

   and

   Experience Two years of experience: 1. In providing direct services to people with Serious Mental Illness, developmental disabilities, or alcoholism or substance abuse; or 2. In linking individuals with Serious Mental Illness, developmental disabilities, or alcoholism or substance abuse to a broad range of services essential to successful living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services). A master's degree in one of the listed education fields may be substituted for one year of Experience.
   and
   Supervision from a licensed level healthcare professional (e.g., RN, licensed clinician, psychologist) with prior experience in a behavioral health clinical setting or care management supervisory capacity; OR Master's level professional with three (3) years prior experience supervising clinicians and/or CMs who are providing direct services to individuals with SMI/serious SUDs.

   Eligible Population

   HH+ services will be available for adults with SMI and who meet certain indicators for high need, such as risk for disengagement from care and/or poor outcomes (e.g., multiple hospitalizations, incarceration,

and homelessness). These individuals may benefit from the enhanced support of HH+ for up to 12 consecutive months.
Individuals with SMI who fall within at least one of the following categories are eligible for HH+ services, hereafter referred to as "High-Need SMI" populations:

1. Assertive Community Treatment (ACT) step down: o Individuals transitioning off ACT to a lower level of service.

2. Enhanced Service Package / Voluntary Agreement:

    - Identified by the Local Government Unit (LGU). An agreement signed by individuals otherwise considered for AOT by the LGU but agreeing that he/she will adhere to a prescribed community treatment plan rather than be subject to an AOT court order.

      These agreements are most frequently used as trial periods before initiating a formal AOT order. The agreement can also be used following a period of AOT when the individual is deemed ready to transition off an AOT order.

3. Homeless:

- Meeting the Housing Urban Development's (HUD) Category One (1) Literally Homeless definition - An individual who lacks a fixed, regular, and adequate nighttime residence:
- Has a primary nighttime residence that is a public or private place not meant for human habitation, such as a car, park, sidewalk, abandoned building, bus or train station, airport, or camping ground; Is living in a publicly- or privately-operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing); or

4. Is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

5. High utilization of inpatient/emergency department (ED) services. This population is typically known to staff in emergency departments, inpatient units, as well as to providers of other acute and crisis services. Individuals will have had the following:

- Three (3) or more psychiatric inpatient hospitalizations within the past year.
- Four (4) or more psychiatric ED1 visits within the past year.
- Three (3) or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar.

6. Criminal Justice involvement: Release from incarceration (jail, prison) within the past year and requires linkage to community resources to avoid reincarceration. Eligible individuals have been incarcerated due to poor engagement in community services and supports.
Ineffectively engaged in care:

- No outpatient mental health services within the last year and two (2) or more psychiatric hospitalizations; or
- No outpatient mental health services within the last year and three (3) or more psychiatric ED visits.

i. ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs.
ii. ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs.

7. Clinical Discretion: SMI individuals who do not fall within at least one of the above high need categories could still be eligible for HH+ services based on the clinical discretion of the local Single Point of Access (SPOA) and/or Managed Care Organization (MCO).

- MCOs coordinate physical and behavioral health services for Medicaid Managed Care Plan enrollees. MCOs - including mainstream plans, HIV-SNPs and HARPs - have responsibility in ensuring high-need members have positive health outcomes and receive needed services.
- The LGU/SPOA has oversight and responsibility for the high-need SMI population and ensuring their access to services best able to meet their needs. SPOA is uniquely qualified to make a recommendation for HH+ eligibility based on their current work triaging referrals for ACT and AOT, as well as the non-Medicaid behavioral health population. The SPOA/MCO may consider social determinant factors in relation to the individual's psycho-social needs. Some examples may include but are not limited to the following:
- An individual who is frequently at-risk for homelessness due to psycho-social related tendencies such as hoarding.
- Transition-age youth: Individuals transitioning out of child/adolescent services who require intensive care coordination through this transition.
- Individuals experiencing initial onset of mental illness without connection to mental health treatment. An individual's substance use is a barrier to engaging in community-based treatment and service
- Individuals placed on an ACT waitlist who would benefit from enhanced care coordination while awaiting placement with ACT services. LGU/SPOA and MCO should work with the assigned HH+ Care Manager (CM) to assist with planning for other care that may be needed in the interim.
- Care Management Agencies (CMAs) will need to develop a protocol for safely transitioning individuals on and off HH+ care management services, based on individual need. Individuals transitioning off from HH+ will receive the Health Home High Risk/Need Care Management rate for a period of six (6) months to support the transition to a less intensive level of care management.
- Individuals meeting High-Need SMI HH+ criteria may also be receiving AOT. These individuals are eligible for the HH+ rate for as long as the active AOT order is in place. Please refer to the program requirements described in separate guidance for AOT HH+ Guidance.

Documentation of HH+ Eligibility:

The NYP Health Home requires all HH+ attested CMAs to implement clearly documented processes to determine HH+ eligibility. The process can include:

- CM determination based on the above criteria reviewed by a Supervisor
- A standard screening form that is scanned into the patient record
- A Psykes flag, MCO or LGU determination that a member is HH+ eligible AND a clear progress note and supporting documentation in a patient chart

The process must include a progress note documenting the method for which eligibility was determined and supporting documentation must be included in the patient record, before billing the HH+ rate. The progress note must be entered in the month the member is identified as a HH+ member assigned to a caseload that meets DOH requirements as described in this policy and must:

I. Identify if a member is HIV or SMI HH+ eligible and the specific social determinant factors in relation to the individual's psycho-social needs listed 1-10 above
II. Identify the verification document uploaded in the electronic platform, including the name and date the document was entered.
III. The name of supervisor that confirmed eligibility and date of supervisory review

IV. For the members who are Criminal Justice Involved (category 8) the note must define the issues – supporting the appropriateness criteria - using the language found in the DOH Notice of Eligibility and Notice of Denial Forms and the definition of ineffectively engaged in care documented above.

- You are currently at risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- You currently do not have adequate social/family/housing support
- You currently have serious changes in family relationships
- You currently do not have adequate connectivity with healthcare system
- You currently do not adhere to treatments
- You currently do not have difficulty managing medications
- You currently do not have impairments in activities of daily living, learning or cognition issues

AND are ineffectively engaged in care:

- No outpatient mental health services within the last year and two (2) or more psychiatric hospitalizations; or

- No outpatient mental health services within the last year and three (3) or more psychiatric ED visits. ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs.

V.

For example,
"Patient has been determined as SMI HH+ eligible, due to criminal justice involvement and lack of appropriate support. Patient does not have connectivity to the healthcare system and does not have adequate social support. The member is ineffectively engaged in care as evidenced by the members need to be connected to a mental health provider and lack of a mental health outpatient services in the last twelve months. A letter from the client's parole office has been uploaded on July 5, 2018 named "Parole Officer Verification". Supervisor NAME reviewed this HH+ identification on July 3, 2018."

Program Requirements

2. Program requirements for HH+ enrollees are to be carried out consistent with the existing "Health Home Standards and Requirements for Health Homes, Care Management Providers and Managed Care Organizations" guidance distributed by the Department of Health.

3. The required caseload ratio for HH+ enrollees shall be one (1) full-time employee (FTE) to 12 HH+ recipients, but no greater than 1:15. THE NYP HEALTH HOME will require each CMA to conduct self-audits and attest to caseload compliance.

4. A minimum of four (4) Health Home core services must be provided per month, two (2) of which must be face-to-face contacts, or more when the individual's immediate needs require additional contacts. The HH+ rate code can be billed only when this requirement is met and clearly documented in the individual's record. Each CMA is required to have a quality assurance process in place to confirm the minimum encounters are met include a single point of accountability overseeing the HH+ compliance.

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

6. If the minimum service requirements are not provided in a given month, but all other requirements as outlined in this guidance are met; and at least one (1) Health Home core service was provided: the Health Home High Risk/Need Care Management rate code may be billed for that given month.

7. The HH+ rate code can be billed for 12 consecutive months starting from the point an individual's HH+ eligibility becomes known to the CM and HH+ services have been provided.

8. If a HH+ individual continues to meet eligibility at the end of the 12-month initial time frame, HH+ billing may continue for 12 more months with supporting documentation.

9. For example, an individual began receiving HH+ services in January after stepping down from ACT. In December, the CM determines they still meet HH+ eligibility due to three (3) inpatient psychiatric stays within the last year. HH+ services may continue another 12 months.

10. CMA must inform the THE NYP HEALTH HOME when HH+ eligibility becomes known to the CM and HH+ services will be provided. This is done by choosing the HH+ required fields in the HML assessment.

Care Management Models That Meet HH+ Requirements

To meet the changing and complex needs of the HH+ population, CMAs may utilize different models of care management to affect successful transitions, continuity of care and improved outcomes. CMAs have the option to adopt any of the following models of care management offered below. To ensure HH+ individuals on a given caseload receive the required level of service, certain parameters will apply.

Mixed Caseload (HH+ and non-HH+ individuals): For the purposes of caseload stratification and resource management; a caseload mix of HH+ and non-HH+ is allowable if and only if the HH+ ratio is less than 12 recipients to one (1) Health Home Care Manager. Caseload sizes should always allow for adequate time providing care management as outlined in this guidance to HH+ individuals while allowing for thoughtful consideration of the care coordination needs of non-HH+ recipients.

Team Approach: A CMA may choose to use a team approach to serve a caseload consisting of HH+ individuals. However, use of this approach mandates the following requirements are met:

1. The team caseload must maintain the ratio of 12 to 15 HH+ individuals per each FTE on the team. For every 30 HH+ individuals, the team must have at least one qualified HH+ care manager. For example, a team serving 40 HH+ individuals shall have two (2) qualified HH+ care managers on the team.

- A qualified HH+ care manager must provide at least two (2) Health Home core services per month, one (1) of which must be a face-to-face contact for HH+ individuals. The remaining contact requirements can be provided by the additional team members.

- CMA must conduct random audits on a monthly basis of each team to ascertain the HH+ care manger is providing at least two core services a month.

- A primary care manager meeting the staff qualifications outlined above to serve HH+ individuals shall be identified and will conduct the Comprehensive Assessment, develop the Plan of Care, and provide

oversight regarding coordination of interventions in accordance with the Plan of Care. The care manger is to be listed in the RMA including phone number and email address.

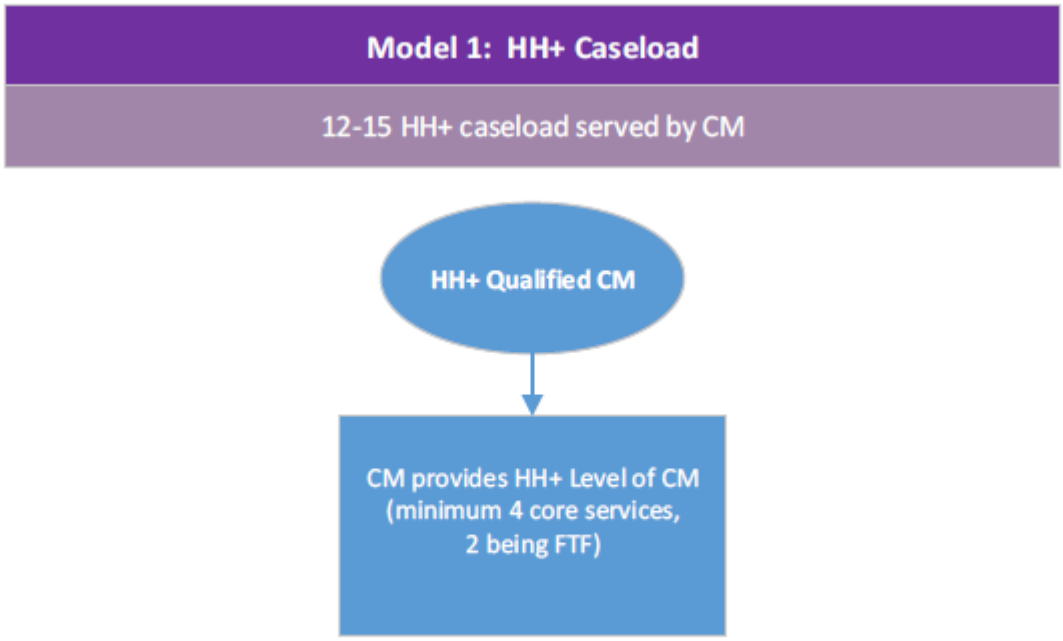
Caseload Stratification Examples

Individuals enrolled in HH+ must receive a level of service intensity consistent with a ratio 1:12 no more than 1:15 caseload range.

Option One: Traditional model of care management where services are provided by one qualified care manager and caseload capacity is determined by a fixed number of cases. Program requirements that apply to this model include:

- The required caseload ratio for HH+ enrollees shall be one (1) full-time employee (FTE) to 12 HH+ recipients, but no greater than 1:15.

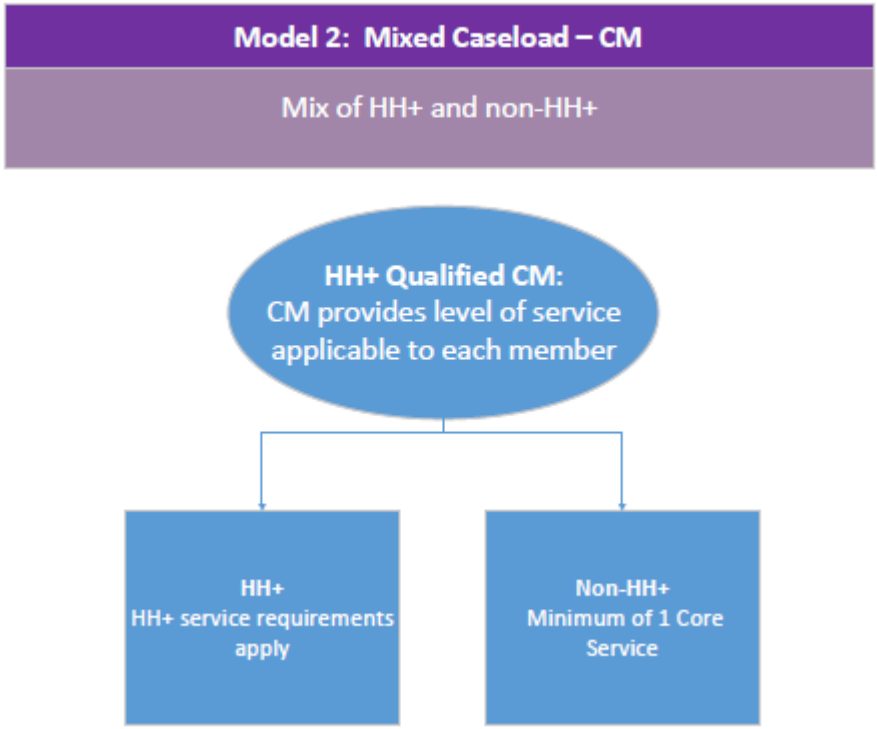
- The qualified HH+ care manager must provide a minimum of four (4) Health Home core services per month, two (2) of which must be face-to-face contacts, or more when the individual's immediate needs require additional contacts.
- If the individual is AOT, at least four (4) face-to-face contacts must be made within the month; refer to AOT HH+ Guidance.



Option Two HH+ Mixed Caseload:

For the purposes of caseload stratification, resource management and overall flexibility, CMAs may choose to have a mixed caseload of HH+ and non-HH+ individuals when there are less than 12 HH+ individuals on a caseload.

- Non-HH+ Minimum of 1 Core Service
- HH+ HH+ service requirements apply
- HH+ Qualified CM: CM provides level of service applicable to each member
- Mix of HH+ and non-HH+



One suggested approach for formulating a mixed caseload while factoring in varied levels of need is a weighted point system. Under this model, caseload capacity is determined by point accumulation as opposed to a traditional model, where capacity is based on a fixed number of individuals. Each individual is assigned a point value based on the individual's category as determined by the CMA.

The table below outlines recommended categories and point values a CMA could adopt when using the weighted point system approach for caseloads that include HH+ individuals:

Category	Description	Point Value
HH+	For any individual receiving HH+ services.	3
High Touch	For individuals not receiving HH+ services but require a high level of service intensity. Some factors a CMA could consider for this category include: non-SMI Homelessness, HARP Enrollment, HH+ step down, chronic Substance Abuse etc. May include individuals that meet the Health Home High Risk/Need rate.	2
Low Touch	For individuals not receiving HH+ services and require a low level of service intensity. May include individuals that meet the Health Home Care Management rate.	1

The CMA can take the following steps to calculate caseload capacity using the values recommended above:

1) Determine a point range for the caseload. To maintain a level of service intensity consistent with a ratio of 1:12 no more than 1:15 caseload, the recommended point range would be 36-45 points. This recommended point range is based on the following calculation: Ratio Calculation (using HH+ cases only) Points
1:12 12 HH+ individuals x 3 (point value) = 36 points
1:15 15 HH+ individuals x 3 (point value) = 45 points

The point range should always allow for adequate time providing care management as outlined in this guidance to HH+ individuals while allowing for thoughtful consideration of the care coordination needs of non-HH+ recipients.

Ratio	Calculation (using HH+ cases only)	Points
1:12	12 HH+ individuals x 3 (point value) =	36 points
1:15	15 HH+ individuals x 3 (point value) =	45 points

2) Using the table above, identify the individual's category and the point value.

3) Assign individuals to a caseload and add the subsequent point values to equal no more than the established point range.
Below is an example of a mixed caseload for one care manager formulated using the weighted point system.

Example of mixed caseload using weighted point system			
Category	Number of Individuals	Calculation	Points by Category
HH+ (3 points)	7	7 (individuals) x 3 (points) =	21
High Touch (2 points)	6	6 (individuals) x 2 (points) =	12
Low Touch (1 point)	9	9 (individuals) x 1 (point) =	9
	Total 22		Total 42

In this example, the caseload ratio is 1:22 composed of a mix of 7 HH+ (3 points each), 6 High Touch (2 points each) and 9 Low Touch (1 point each) totaling 42 points, which is in the recommended mixed caseload point range of 36-45 points.

CMA developed point systems are not allowed by THE NYP HEALTH HOME.

HH+ Team Approach: HH+ Only: To best meet the needs of the individuals and to provide the necessary interventions in accordance with the person-centered Plan of Care, a team model of care management may be utilized by a CMA. Under this model, HH+ individuals can receive services by an array of staff members that is led by a primary care manager. Team members may include but not limited to Registered Nurses, peers and/or additional Health Home Care Managers.

- 12-15 individuals can be served per every 1 FTE team member.
- Minimum HH+ Service Requirements met by team.
- Primary (HH+ Qualified) CM:
  provides minimum of 2 core services per month including 1 FTF. Performs assessments/develops POC. F acilitates coordination of services among CM team.
- Other team members could be: RN, HHCM, Peer, etc

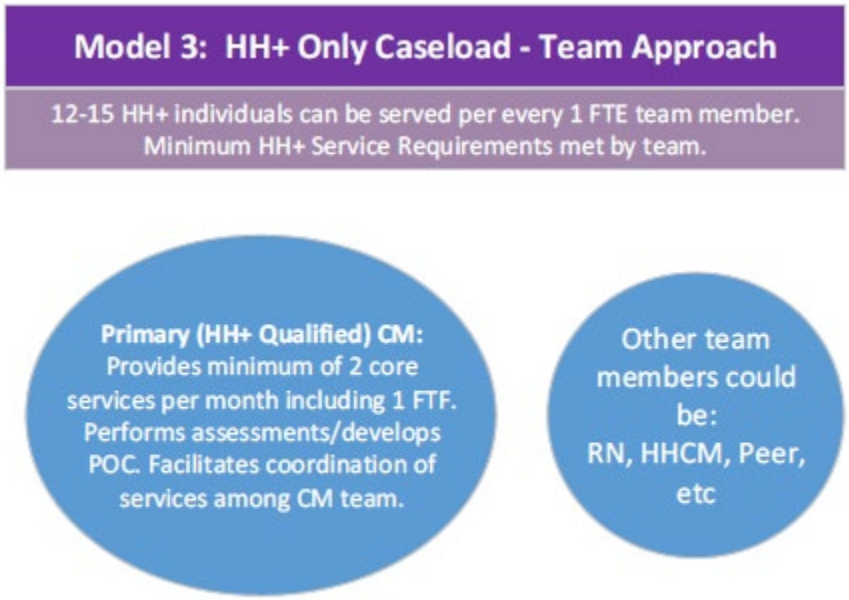
HH+ Team Approach: Mixed Caseload
When using a team approach, program requirements would include:

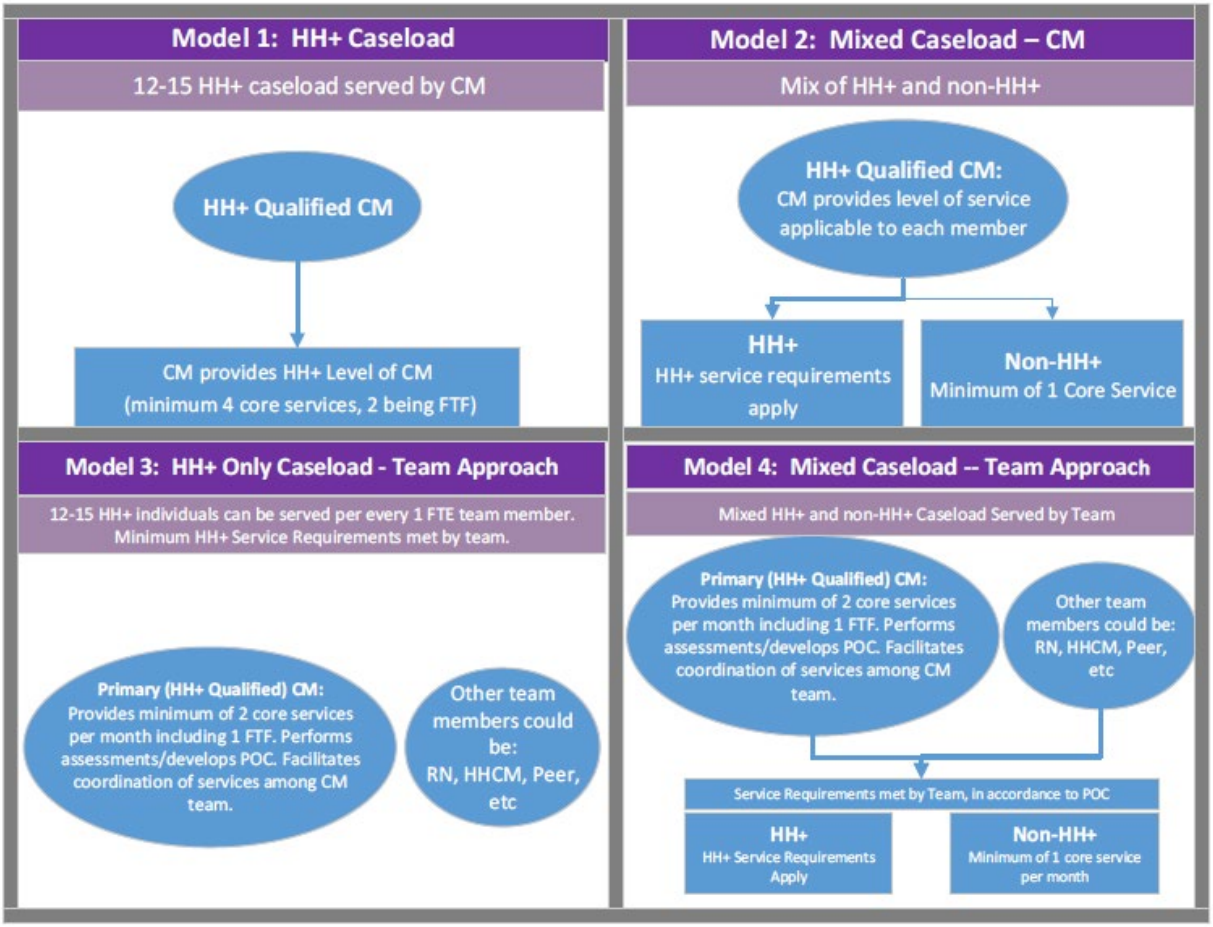
The required team caseload shall be 12 to15 HH+ individuals per one FTE on the team.

- A team must have at least one qualified HH+ care manager for every 30 HH+ individuals. For example, a team serving 40 HH+ individuals must have two (2) qualified HH+ care managers on the team.

- A primary care manager meeting the staff qualifications outlined in the guidance to serve HH+ individuals shall be identified and will conduct the Comprehensive Assessment, develop the Plan of Care, and provide oversight regarding coordination of interventions in accordance with the Plan of Care.

- A qualified HH+ care manager must provide at least two (2) Health Home core services per month, one (1) of which must be a face-to-face contact. The remaining contact requirements can be provided by the additional team members.





Referral for HH+

Referrals can come from multiple sources including community providers, shelter outreach teams, ACT teams, forensics, MCOs, hospitals, etc. The referral source can supply documentation to support that the individual meets high need indicators for HH+.
If the referral goes to the Health Home, the Health Home must ensure that the individual is assigned to a CMA qualified to serve the HH+ population. The NYP Health Home will ensure prompt assignment is made to allow the care manager the ability to participate in the planning process for continuity of care, whenever possible. HH+ referrals will be assigned to a CMA no later than 2 business dates after receipt.

Referrals sent through SPOA should be assigned to HH/CMA which has attested to serve the HH+ population. The SPOA is responsible to ensure that referrals are coordinated in a timely and efficient way for this high-need population to benefit from the intensive services. CMAs must have a working relationship with SPOA and ensure protocols are in place to receive referrals.

Comprehensive Transitional Care

It is expected that the HH/CMA staff and the referral source will coordinate efforts in a way that provides for warm hand-off and/or immediate engagement working with high-need individuals. The care

manager should initiate contact with the individual and/or referral source upon receiving the referral. CM is to contact the patient no later than 2 business days after receiving the referral.

A warm hand-off is best practice to ensure optimal transition to HH+ services when an individual is being discharged/transitioned from either a program or facility. An introduction with the individual prior to discharge/transition can help orient the individual to HH+ services while allowing the care manager to be a participant in the discharge planning.

Billing and Tracking Guidance

For reimbursable Health Home Care Management and HH+ services delivered, CMAs are to attest that billable services were provided (minimum required HH+ services or HHCM core service) in a given month by completing the HML questionnaire in the RMA platform.

The Department of Health (DOH) Medicaid Analytics Performance Portal ("MAPP") will be used to identify individuals as HH+. MAPP users will be prompted in the monthly HML questionnaire with the question "Is the member in the expanded HH+ population?" If the user responds "Yes", the user is then prompted with "Were the minimum required HH+ services provided?" By responding "Yes", the CMA attests that the minimum service requirements for HH+ have been provided.

The MCOs will use the MAPP HHTS billing support to pay the Health Homes. THE NYP HEALTH HOME will bill eMedNY for Health Home enrollees not in mainstream MCOs (including mainstream plans, HIV-SNPs and HARPs). THE NYP HEALTH HOME will send the Health Home funds for a CMA, less the contracted administrative fee, to the CMA.

Billing and Tracking System

- The unique rate code for HH+ services (1853).
- The NYP Health Home as an Downstate Designated Health Home will be reimbursed $800 for each HH+ client

References:

Health Home Plus Program Guidance for High-Need Individuals with Serious Mental Illness May 1, 2018

Health Home (HH) Care Management Agency (CMA) Credentials to Serve Health Home Plus (HH+) for Members with Serious Mental Illness (SMI) May 1, 2018

Health Home Plus Program Guidance for High-Need Individuals and High-Risk Categories of Health Home Care Management for Individuals with HIV/AIDS who are Virally Unsuppressed or at High Risk for HIV Effective May 1, 2018

Health Home Plus Program Guidance State Psychiatric Center ("State PC") and Central New York Psychiatric Center and its Corrections Based Mental Health Units(located within NYS DOCCS Prison System) ("CNYPC) Adult Discharges October 11, 2016