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

**Description**

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, Health Homes must assure 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.

HH+ was first introduced in 2014, targeting the Assisted Outpatient Treatment (AOT) population enrolled in Health Home. In December of 2016, the HH+ population expanded to include individuals discharged from State Psychiatric Centers and those released from Central New York Psychiatric Center (CNYPC) and its corrections-based mental health units. This guidance below identifies additional populations considered to have the highest care management needs within the SMI population and would benefit from HH+ services.

**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:
  - 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. History of an expired AOT court order within the past year.
  4. 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
      - 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 ED<sup>1</sup> 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.
  7. 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<sup>2</sup> visits.

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<sup>1</sup> ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs.

<sup>2</sup> ED may also include Comprehensive Psychiatric Emergency Department (CPEP) under an observation status, or other psychiatric emergency/respite programs.

8. 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 services.*
- *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](#).

## **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.

With the addition of other high-need individuals with SMI to the HH+ eligible population, the State acknowledges the need to increase CMA capacity for HH+. Beginning May 2018, all other CMAs will have the ability to serve the HH+ population<sup>3</sup>. 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; see [Health Home \(HH\) Care Management Agency \(CMA\) Credentials to Serve Health Home Plus \(HH+\) for Members with Serious Mental Illness \(SMI\)](#).

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**

Lead Health Homes are 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+. Health Homes must have formal policies and procedures in place for ensuring such qualifications and credentials are current at the time of HH+ service delivery. For more information on the attestation process, please visit the [OMH website](#).

OMH/DOH will have joint oversight of HH+ compliance, including the approval of attestation forms. Health Homes and CMAs 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<sup>4</sup> apply:

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<sup>3</sup> At this time, ability to serve and bill HH+ for individuals on AOT will remain limited to former OMH legacy CMAs only.

<sup>4</sup> CMA Supervisors who requested a waiver of qualifications needed to supervise HCBS Assessors and were approved prior to 11/15/16, will be considered qualified Supervisors for HH+ for that CMA. The CMA has the option to arrange for a licensed or Master's level professional within the organization to provide regular clinical supervision to the CMs, jointly with the care managers' direct program supervisor.

Care managers whose requests for HCBS Assessor qualification waivers were approved prior to 11/15/16 will be considered qualified to serve HH+ individuals (all HH+ populations) for that CMA.

*NOTE: If a Supervisor or CM currently permitted to serve HH+ individuals (as described above) later leaves the agency, the CMA is required to replace them with new staff that meet the HH+ Staff qualifications*

## Education

1. A bachelor's degree in one of the fields listed below<sup>5</sup>; 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).

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

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.

## Program Requirements

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

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<sup>5</sup> 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.

- 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.
- 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.
- 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.

*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.*

- Communicating with Managed Care Plans (MCOs) regarding HH+ individuals:
  - The CMA must inform the Health Home when HH+ eligibility becomes known to the CM and HH+ services will be provided.
  - The Health Home must inform the MCO of the individuals' HH+ status.

## **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. *Please refer to Appendix A for examples on these models.*

### **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:

- 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.
- 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.

### **Referral for Health Home Plus**

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 Health Home shall ensure prompt assignment is made to allow the care manager the ability to participate in the planning process for continuity of care, whenever possible.

Referrals sent through SPOA should be assigned to HH/CMA who 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.

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 use either the MAPP HHTS or the Health Home's own system (which then feeds into MAPP HHTS) to attest that billable services were provided (minimum required HH+ services or HHCM core service) in a given month. The MCOs will use the MAPP HHTS billing support to pay the Health Homes. Health Homes will bill eMedNY for Health Home enrollees not in mainstream MCOs (including mainstream plans, HIV-SNPs and HARPs). The Health Homes are to send the Health Home funds for a CMA, less the contracted administrative fee, to the CMA.

## Billing and Tracking System

- There is a unique rate code for HH+ services (1853).
- There is one HH+ payment rate for Downstate and one for Upstate.

<b>Rate Code</b>	<b>Rate Description (OMH) HH+</b>	<b>Monthly HH+ Rate</b>
1853	Downstate (applicable to Dutchess, Putnam, Rockland, Westchester, Nassau and Suffolk counties, and New York City.	\$800
	Upstate (applicable to all counties other than Downstate)	\$750

- The HH+ rates were added to lead Health Home rate profiles in eMedNY effective December 1, 2016 to allow lead Health Homes to bill on behalf of Care Management Agencies providing HH+ services.
- 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.



## Appendix A

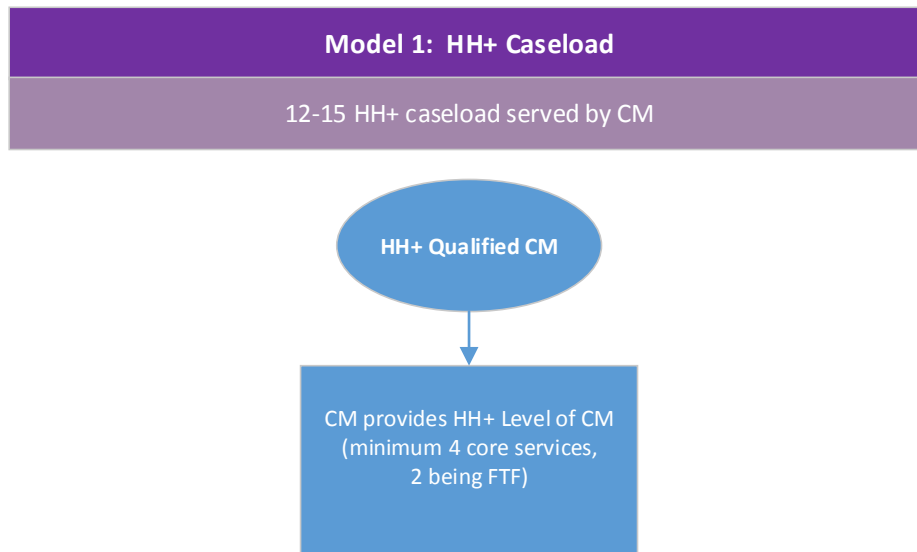
### Caseload Stratification Examples

Individuals enrolled in HH+ must receive a level of service intensity consistent with a ratio 1:12 no more than 1:15 caseload range. The State understands that for the purposes of transitions, continuity of care, and the changing needs of the individual, there are opportunities for CMAs to utilize different models of care management to formulate a caseload. Below are some models and examples CMAs may use for the purposes of caseload stratification that also adheres to the program requirements outlined in the guidance.

#### **HH+ Only Caseload:**

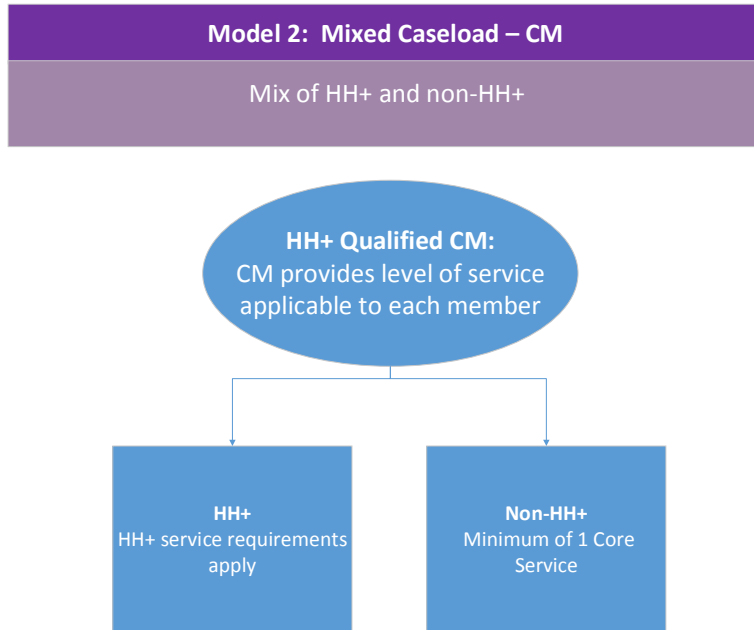
A traditional model of care management where services are provided by one qualified care manager and caseload capacity is determined by a fixed number of cases. Program requirements that apply to this model include:

- 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](#).



**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.



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.

- 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

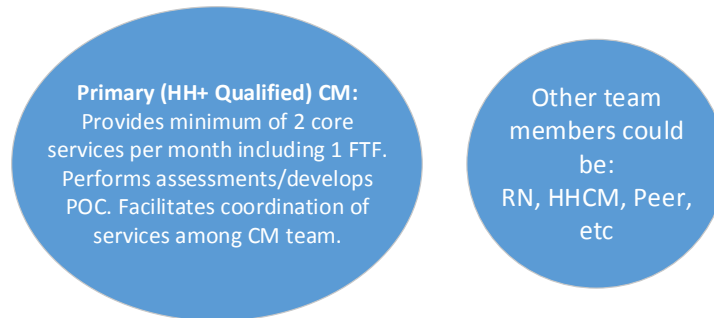
In this example, the caseload ratio is 1:22 composed of a mix of 7 HH+ (3 points each), 6 High Touch (2 points each) and 9 Low Touch (1 point each) totaling 42 points, which is in the recommended mixed caseload point range of 36-45 points.

**HH+ Team Approach:**

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.

**Model 3: HH+ Only Caseload - Team Approach**

12-15 HH+ individuals can be served per every 1 FTE team member.  
Minimum HH+ Service Requirements met by team.



When using a team approach, program requirements would include:

- The required team caseload shall be 12 to 15 HH+ individuals per one FTE on the team. The table below outlines the number of FTEs to the possible caseload range:

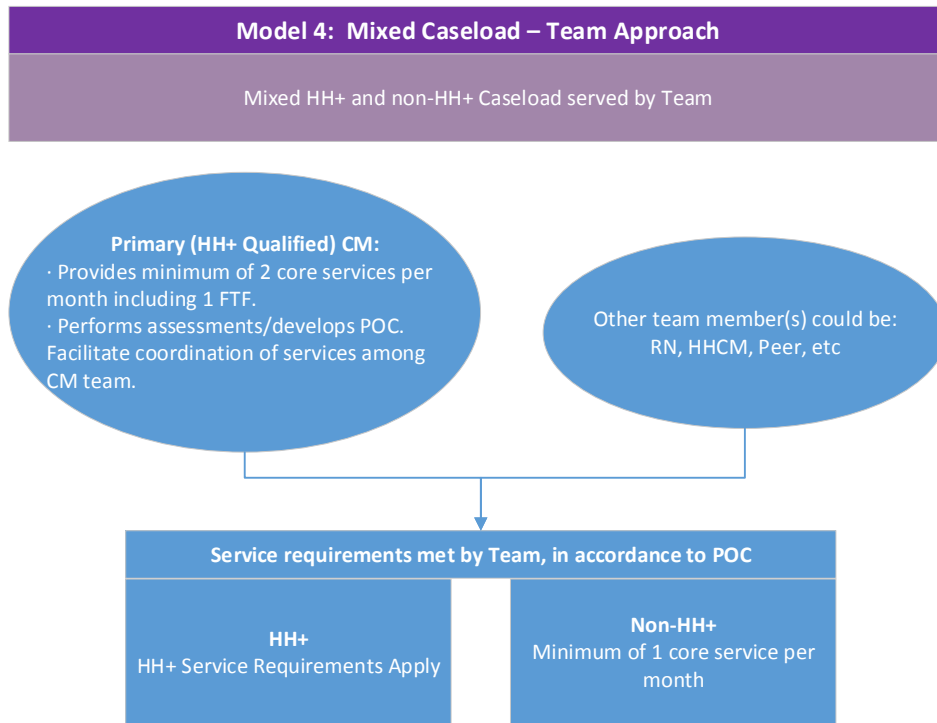
Number of Full-Time Employees	Caseload Range
2	16-30 HH+ Individuals
3	31-45 HH+ Individuals
4	46-60 HH+ Individuals

- 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.

**Mixed Caseload-Team Approach:**

A team approach may be used to serve a mixed caseload of HH+ and non-HH+ individuals. The weighted point system as outlined above can be used to formulate the caseload capacity for the team. Program requirements outlined for mixed caseloads and team approach would apply.



- Below is an example of a HH+ Team serving a mixed caseload with three (3) FTE on the team. Staff members on this team include one (1) qualified HH+ care manager, one (1) non-qualified care manager, a part-time (.5 FTE) peer and a part-time (.5 FTE) Registered Nurse. The example uses the same recommended categories and point values as outlined above. Using the same calculation method as outlined above, the recommended point range for a team of three (3) FTE would be 108-135 points.

<b>HH+ Mixed Caseload – Team Approach with three (3) FTE team members</b>			
Category	Number of Individuals	Calculation	Points by Category
HH+ (3 points)	21	21 (individuals) x 3 (points) =	63
High Touch (2 points)	18	18 (individuals) x 2 (points) =	36
Low Touch (1 point)	35	35 (individuals) x 1 (point) =	35
	Total 35		Total 134

In this example, the caseload ratio for the team is 3:74 composed of a mix of 21 HH+ (3 points each), 18 High Touch (2 points each) and 35 Low Touch (1 point each) totaling 134 points, which is in the recommended mixed caseload point range of 108-135 points.

## Appendix B

### Care Management Models that Meet HH+ Requirements

