Bassett Healthcare Network
Community Health Navigation

Policy/Procedure:	Health Home Plus SMI Policy
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Policy:

Health Home Plus (HH+) is an intensive level of Health Home Care Management to provide the highest risk HH Members with Serious Mental Illness (SMI) with the services needed to stabilize their health and social service needs in the community. To ensure the intensive needs of these individuals are met, Lead Health Homes and CMAs 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 to meet current DOH requirements for serving this population. 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. Partnering CMAs are responsible for submitting written attestation to Bassett CHN Health Home, and Bassett will attest to the Department of Health (DOH)/OMH on behalf of Partnering CMAs who will provide HH+, and that meet the staff qualifications, credentials, and ability to Provide HH+ Services. CMAs must have formal policies and procedures in place for ensuring such qualifications and credentials are current at the time of HH+ service delivery. Partnering CMAs who are approved for the HH+ rate, are subject to audit by Bassett CHN, New York 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 Partnering HH Care Management provider.

*This Policy consolidates all guidance for HH+ SMI and AOT Members from existing Bassett Policies into one policy, and provides updated clarity on eligible HH+ SMI populations and staff qualifications, and the service requirements for HH+ SMI Members.

Quality Management and Performance Improvement

Each month Bassett CHN will review sampled HML's for Health Home Plus billing and adherence to this policy. The Care Management Record will be reviewed to ensure proper HH+ supporting documentation is present in the record and the service needs are reflected in the member's Plan of Care. Trends will be identified and shared with the Quality Management and Performance Improvement Committee for follow-up action, as necessary.

Procedures

A. CMA Eligibility & Attestation to Serve HH+ SMI Members

1. CMAs must meet basic eligibility to provide and bill for HH+ SMI or AOT services

a. Prior to May 2018, the ability to provide/bill HH+ services were limited to former Office of Mental Health Targeted Case Management (TCM) providers (aka OMH Legacy Providers).
b. Starting May 2018, all other CMAs have the ability to serve the HH+ SMI population.
c. AOT Members may only be served and billed at the HH+ level by former OMH legacy CMAs, unless otherwise authorized by the State.

2. Before providing HH+ SMI Services, the CMA must complete and submit a "Bassett CHN Health Home Plus (HH+) for Individuals with SMI – Attestation" Form to Bassett CHN Operations Manager, attesting that the CMA will ensure the following requirements are met in order to provide and bill HH+ SMI services:
    a. CMA has a process for immediate assignment of HH+ Member and the provision of HH+ services, as outlined in policy guidance
    b. CMA is able to meet staff qualification requirements, as outlined in policy guidance
    c. CMA has a process to ensure HH+ caseload sizes do not exceed the ratio of 1 qualified HH+ care manager per every 20 HH+ Members (1:20 ratio)
    d. CMA has a process to ensure the minimum service intensity requirements outlined in policy guidance are met
    e. CMA meets each of the following additional requirements for providing HH+ Services (i., ii., and iii.)
        i. CMA meets at least two of the following criteria:
            a) CMA is operated by an organization that provides OMH-licensed, -funded, or –certified services, in addition to Care Management for individuals with SMI
            b) CMA currently serves individuals with SMI
            c) CMA demonstrates knowledge of the behavioral health managed care benefit package and has working relationships/partnerships with the local mental health delivery system

        AND

        ii. CMA Supervisors & Care Managers are proficient in the following core competencies:
            a) Conducting appropriate screening and performing/arranging for more detailed assessments
            b) Planning and coordinating care management needs
            c) Maintaining engagement of high-need individuals

        iii. CMA either has a working relationship, or is in the process of developing one, with the LGU/SPOA in their service county. In addition, CMA must have knowledge of LGU/SPOA protocols and resources for accessing local mental health services.

3. **Care Management Agencies (CMAs) Eligible to Serve HH+ Individuals**

Effective March 1, 2021, only CMAs designated by the NYS OMH as Specialty Mental Health Care Management Agencies (MH CMAs) will be eligible to enroll newly referred individuals meeting HH+ SMI eligibility criteria. Only Specialty MH CMAs with authorization by the State, LGU and lead Health Home(s) will have the ability to accept referrals, serve and bill HH+ for individuals on AOT. 4 In the case where a HH member becomes HH+ SMI eligible while enrolled with a non-Specialty MH CMA, lead Health Homes shall ensure care managers are informing HH+ eligible members of their option to transfer to a Specialty MH Care Management Agency, and ensuring access to Specialty MH Care Management, as appropriate.

4. **Attestation**

All designated Specialty MH CMAs are required to submit written attestation to the NYS OMH, verifying their intention to provide Specialty Mental Health Care Management, and to having protocols in place for ensuring compliance with all required program standards outlined in this guidance. Lead Health Homes must have formal policies and procedures to support HH+ service delivery and billing. For more information on the attestation process, please visit the OMH website.

B. Care Manager Qualifications to Serve HH+ SMI Members

1. HH+ SMI services can only be provided by a HH Care Managers that meet all the following requirements for Education and Experience, Supervision, and Training (a., b., c. & d.):
   a. Staff Education and Experience**:
      i. A Master's degree in one of the qualifying fields* and one (1) year of Experience; OR
      ii. A Bachelor's degree in one of the qualifying fields* and two (2) years of Experience; OR
      iii. A Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and two (2) years of Experience; OR
      iv. A Bachelor's degree or higher in ANY field with either: three (3) years of Experience, or two (2) years of experience as a Health Home care manager serving the SMI or SED population; OR
      v. HH Care Managers approved for waiver of HCBS Assessor qualifications prior to 11/15/16***

      * Qualifying fields include education 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.

      ** Experience must consist of one of the following:
      - Providing direct services to people with Serious Mental Illness, Developmental Disabilities, Alcoholism or Substance Abuse, and/or children with SED; **or**
      - Linking individuals with Serious Mental Illness, children with SED, Developmental Disabilities, and/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).

      ***If a CM currently permitted to serve HH+ individuals through a waiver later leaves the agency, the CMA is required to replace them with new staff that meet the HH+ Staff qualifications.

   b. Supervised by someone meeting any one of the following requirements (i, ii, or iii):
      i. Licensed level healthcare professional with prior experience in a behavioral health setting (includes: Physicians, Psychiatrists, Physician's Assistants, Nurse Practitioners, Psychiatric Nurse Practitioners, Registered Professional Nurses, Licensed Practical Nurses, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Master Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Licensed Psychoanalysts, Licensed Creative Arts Therapists, & Licensed Occupational Therapists); **OR**
      ii. Master's level professional with two (2) years prior supervisory experience in a behavioral health setting; OR

iii. Any person for whom a waiver of these qualifications has been granted by NYSDOH*

a) CMA Supervisors who were approved for a waiver of the qualifications needed to supervise HCBS Assessors 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. If a Supervisor 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.

c. Training (only required for staff providing HH+ service to AOT Members):

i. Staff assigned to HH+ AOT members must receive training in the statutory basis of the AOT Program (Section 9.60 of the New York Mental Hygiene Law (MHL)), and all associated reporting requirements detailed in the law, as well as policies by the Mental Health/Hygiene Department of the County/Local Governmental Unit (LGU).

d. Core Competencies for HH Plus Staff

Staff Core Competencies Supervisors will be responsible for ensuring care managers receive adequate support and access to resources that encourage development of skills necessary to improve quality of life and outcomes for high-need individuals with SMI. Supervisors and direct care management staff must be proficient in the following areas:

i. Conduct appropriate screening and either performing or arranging for more detailed assessments when needed (e.g., high-risk substance use or mental health related indicators, harm to self/others, abuse/neglect and domestic violence). This includes the CMA's demonstrated ability to complete the required New York State Eligibility Assessment for Health and Recovery Plan (HARP) enrolled members.

ii. Plan and coordinate care management needs for high-need SMI individuals including: Navigating the mental health service system-including ability to make referrals to mental health housing services, crisis intervention/ diversion, peer support services.

iii. Knowledge of the behavioral health managed care benefit package

iv. Ability to collaborate with inpatient staff and MCO (as applicable) to affect successful transitions out of inpatient or institutional settings. Addressing the quality, adequacy and continuity of services to ensure appropriate support for individuals' mental health and psychosocial needs.

v. Must complete plans of care and coordinate with MCOs for HARP members utilizing the Home and Community Based Services (HCBS) benefit package.

vi. Maintain engagement with individuals who are often disengaged from care, have difficulty adhering to treatment recommendations, or have a history of homelessness, criminal justice involvement, first-episode psychosis and transition-age youth. Key skills and practices to engage high-need SMI individuals include:

Motivational Interviewing
Suicide Prevention
Risk Screening
Trauma Informed Care
Person-centered care planning and interventions
Recovery-Oriented Approaches (e.g., WRAP)

2. Caseload of Care Managers serving HH+ SMI Members shall not exceed (1) full-time employee (FTE) to 12 HH+ recipients, but no greater than 1:15.

C. Member Eligibility for Health Home Plus SMI (HH+ SMI) or AOT

1. HH+ SMI services are a level of HH Care Management available for Members with SMI AND a Qualifying Risk Category (Both a. and b. below)
   a. Serious Mental Illness (SMI) (Must meet both i. and ii. below to be designated as SMI)
      i. Mental Health Diagnosis (one of the following diagnoses/categories):
         a) Psychotic Disorders: F21, F22, F23, F20.81, F20.9, F25.0, F25.1, F06.2, F06.0, F06.1, F28, F29
         b) Bipolar Disorders: F31.11, F31.12, F31.14, F31.2, F31.73, F31.74, F31.9, F31.0, F31.31, F31.32, F31.4, F31.5, F31.75, F31.76, F31.9, F31.81, F34.0, F06.33, F06.34, F31.89
         c) Obsessive-Compulsive Disorders: F42
         d) Depression: F34.8, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F233.3, F33.41, F33.42, F33.9, F34.1, N94.3, F06.31, F06.32, F06.34, F32.8,F32.9, F34, F32.08
         e) Anxiety Disorders: F41.9, F41.0, F41.1, F44.81, F40.0, F43.10
         f) Personality Disorders: F60.0, F60.1, F60.3, F60.04, F60.5, F60.6, F60.9, F60.81, F21
      ii. Functional Impairment as a result of their qualifying MH Diagnosis (One or more of the following):
         a) Marked difficulties in self-care such as personal hygiene, diet, clothing, avoiding injuries, securing health care, or complying with medical advice; or
         b) Marked restrictions of activities of daily living such as maintaining a residence, getting and maintaining a job, attending school, using transportation, day-to-day money management, or accessing community service; or
         c) Marked difficulties in maintaining social functioning such as establishing and maintaining social relationships, interpersonal interactions with primary partners, children and other family members, friends, or neighbors, social skills, compliance with social norms, or appropriate use of leisure time; or
         d) Frequent deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner in work, home, or school setting.
         e) Individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in task, or require assistance in the completion of tasks.
   b. Eligible Risk Category (One of the following):
      i. Current AOT court order (must be served by an OMH Legacy Provider CMA)
      ii. Enhanced Service Package / Voluntary Agreement:
         a) An agreement made with LGU to adhere to a prescribed community treatment plan (including HH Care Management), rather than be subject to an AOT court order. (These agreements are most frequently used as trial periods before initiating

a formal AOT order or used following a period of AOT, when the Person is deemed ready to transition off an AOT order.)

iii. Expired AOT court order within the past 12 months

iv. State Facility Release (discharge from State Psychiatric Centers or Central New York Psychiatric Center (CNYPC) corrections-based mental health units within the past 12 months

a) Persons discharged from State PCs or CNYPC into an OMH State-operated residence (including Transitional Living Residence [TLR], Transitional Placement Program [TPP], State Operated Community Residence [SOCR], or Residential Care Center for Adults [RCCA] programs), located on Psychiatric Center (PC) campus grounds are eligible for health home services.

i). These OMH programs, by design, provide a high level of support reimbursed by existing residential rates. Later when the individual is ready for discharge from the on-campus State-operated residence, the individual will then become eligible for HH+ for 12 consecutive months post-discharge from the residence

ii). Exception: The HH+ rate code may be billed for Individuals on AOT who receive HH+ services as outlined in this guidance.

v. Discharge from Assertive Community Treatment (ACT) to step-down to a lower level of service (HH+SMI).

vi. Homeless (Meeting the Housing Urban Development (HUD) Category One - Literally Homeless definition: Lacking a fixed, regular, and adequate nighttime residence):

a) Having 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;

b) 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

c) 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.

vii. High Utilization of Inpatient/Emergency Department services (One of the following):

a) Three (3) or more psychiatric inpatient hospitalizations within the past year; or

b) Four (4) or more Psychiatric ED visits within the past year (includes Comprehensive Psychiatric Emergency Department [CPEP] under an observation status, or other psychiatric emergency/respite programs).

c) Three (3) or more medical inpatient hospitalizations within the past year and who have a diagnosis of Schizophrenia or Bipolar.

viii. Criminal Justice involvement: Release from incarceration (jail, prison) within the past 12 months and requiring linkage to community resources to avoid re-incarceration as a result of poor engagement in community services and supports.

ix. Ineffectively engaged in Mental Health Treatment (One of the following):

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

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

c) A lack of compliance with treatment for mental illness that has resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; or

d) at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated (Section 9.60 of the New York Mental Hygiene Law)

x. Clinical Discretion: SMI individuals who do not meet eligibility for any other category can still be designated as eligible for HH+ services, based on the clinical discretion of the local Single Point of Access (SPOA) and/or Managed Care Organization (MCO).

a) 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:

i). An individual who is frequently at-risk for homelessness due to psycho-social related tendencies such as hoarding.

ii). Transition-age youth: Individuals transitioning out of child/adolescent services who require intensive care coordination through this transition.

iii). Individuals experiencing initial onset of mental illness without connection to mental health treatment.

iv). An individual's substance use is a barrier to engaging in community-based treatment and services.

v). 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.

D. Service Intensity & Documentation Requirements for HH+ SMI Members

1. If a potential Member is identified as HH+-eligible during Referral/Outreach:
   a. Bassett CHN Referral Coordinator will notify CMA Point of Contact receiving assignment that the Member is designated as HH+ and requires immediate attention for engagement
   b. The CMA/CM should initiate contact with the individual and/or referral source within 1 business day of receiving the referral/assignment.
   c. The CHN/CM and Referral Source should coordinate efforts in a way that provides for warm hand-off and/or immediate engagement working with high-need individuals.
   d. If the potential Member is being discharged from a facility or another program, the CHN/CM should be a participant in the facility/program discharge planning when feasible.

2. Prior to providing/billing enrolled HH+ SMI services for a specific Member, the CMA/HHCM must verify Member's HH+ eligibility and provide notification to the Lead Health Home and the Member's MCO of the intent to provide HH+ SMI services:
    a. Ensure documentation verifying HH+ SMI eligibility is uploaded to Member's Record:
        i. Medical documentation verifying SMI diagnosis
        ii. Documentation verifying the Member's HH+ SMI category of eligibility (For AOT Members: AOT Court order must be uploaded)
    b. Notify Bassett CHN Operations Manager, Quality Analyst, and Systems Analyst by email of intent to provide HH+ services to the Member
        i. Bassett CHN Health Home Administrator will review documentation
        ii. Once verified, Bassett CHN Administrator will activate the appropriate HH+ Program in the Member's Care Management Record
        iii. For AOT individuals, the CMA must inform the HH when a Member has been placed on court-ordered AOT, or when the court order has expired and has not been renewed.
    c. Notify Member's MCO of the Member's HH+ eligibility status according to specific MCO contact protocols.

3. Members receiving HH+ SMI services shall be provided with the following number and type of contact each month:
    a. For all non-AOT HH+ SMI Members:
        i. A minimum of four (4) Core Health Home 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.
        ii. Each contact must be documented in a separate Billable Note, indicating the type of contact that occurred
        iii. *The HH+ rate code can be billed only when these requirement is met and clearly documented in the individual's record.*
    b. For Members with an active AOT court order:
        i. Any Care Management related stipulations of the AOT Court Oder must be included in objectives/interventions of the Member's Health Home Care Plan
        ii. At least four (4) face-to-face contacts must be made within the month.
        iii. Each contact must be documented in a separate Billable Note, indicating the type of contact that occurred
        iv. AOT court
        v. See additional requirements that must be met in order to receive the HH+ rate for individuals on AOT in section E below.

    *AOT Members must have

4. If a Member resides in an Excluded Setting at time of Outreach or at any time during enrolled services, every effort shall be made to contact facility and participate in Discharge Planning, and to ensure smooth transition of services, including warm hand-off and appropriate engagement to establish a working relationship with the Member and address any transition of care needs.

5. CM/CMA must ensure that HML Billing is completed as appropriate each month, based on the Member's HH+ eligibility and the core services provided to the Member during the month:

a. HML Question 9: Is the Member in AOT?:
   - NO: If the Member does not have an active AOT court order
   - YES: If the Member has an active AOT court order (must be uploaded to record)

9a: Were the minimum required AOT services provided and caseload requirement met?
   - YES: Only if 4 face to face contacts were completed/documented by a qualified HH+ staff with proper caseload ratio
   - NO: If 4 face to face contacts were not completed by qualified staff

with b. HML Question 12: Is the member in the expanded HH+ population?
   - NO: If the Member is not eligible for HH+ SMI (If active AOT, answer no here)
   - YES: If the Member is eligible, select the appropriate SMI eligibility category (verifying documentation must be uploaded to record)

12a: Were minimum required HH+ services provided and the caseload requirement met?
   - YES: Only if 4 contacts (including at least 2 Face to Face) were completed/documented by a qualified HH+ staff with proper caseload ratio
   - NO: If 4 contacts (including at least 2 Face to Face) were not completed by qualified staff with proper caseload ratio

- The HH+ rate code can be billed for 12 consecutive months starting from the point a Member's HH+ eligibility becomes known to the CM and HH+ services have been provided.
- If a HH+ individual continues to meet eligibility in any category at the end of the 12-month initial time frame, HH+ billing may continue for 12 more months with supporting documentation.

6. CM/CMA must notify Bassett CHN Operations Manager and Quality Analyst by email if any of the following occur:
   a. A Member's AOT court-order expires
   b. A Member is no longer HH+ SMI eligible (Member does not meet any eligible category after 12 months from first HH+ eligible billing)
   c. Member is admitted to an Excluded Facility (Inpatient/Residential Care or Incarceration
   d. A HH+ Member is being Disenrolled or Transferred to another CMA
   e. An AOT Member is determined to be missing, as per section E. of this policy

*Bassett CHN Administrative staff will update the Member's Care Management Record Program to reflect the Member's current HH+ eligibility status as needed

E. Additional Requirements for AOT Members

1. The following program requirements apply to all individuals with a current AOT court order:
   a. Individuals receiving court-ordered AOT will be assigned to a CMA with behavioral health expertise or otherwise qualified to serve HH+ individuals, through the Local Governmental Unit's (LGU) AOT process.
   b. In many counties, SPOA may be included in the process by which the LGU assigns AOT individuals to a CMA.
   c. If an individual already receiving HH care management in the community is later ordered to AOT, the LGU must ensure that the care management agency serving that individual is eligible to serve AOT as described in this guidance. If the CMA is not eligible, the LGU must

direct a transfer to a CMA with the appropriate experience. It will then be the responsibility of the CMA to promptly notify the Health Home of the CMA transfer.

d. At least four (4) face-to-face contacts must be made within the month. *The HH+ rate code can be billed only when this requirement is met and clearly documented in the individual's record.*

e. If the care manager made effort to provide four (4) face-to-face contacts and the individual was not home, did not show up for an appointment or was otherwise not available, the CMA must report all efforts made to follow up with the individual using notification procedures as developed by the Local Government Unit (LGU).

    a) If the individual was not able to be seen, continued communication with the LGU should be made in order to determine what additional follow-up efforts may be required. All efforts must be documented in the individual's record.

    b) If at least one (1) Health Home core service was provided by a qualified care manager and the above requirements have been completed The HH High Risk/Need Care Management rate code may be billed for that given month.

f. If the individual with an AOT court order cannot be located and has had no credibly reported contact within *24 hours* of the time the care manager received either notice that the individual had an unexplained absence from a scheduled treatment appointment, or other credible evidence that the AOT individual could not be located, the individual will be deemed Missing. *A diligent search shall commence, as outlined in the OMH guidance* Assisted Outpatient Treatment Program: Guidance for AOT Program Operation (reissued February 2014).

g. If the care manager made effort to provide four (4) face-to-face contacts and was unable to due to Missing status, *HH+ rate can continue to be billed as long as the diligent search procedures referenced above are followed and clearly documented in the Member's Care Management Record.* The Member's Record shall also clearly indicate when the determination was made that the individual was missing. The diligent search shall continue until either the person is located, or the court order is no longer active.

    i. In the event a Member's AOT court order expires during search process, revert to following DSE procedures in Bassett CHN Lost to Contact and Re-engagement Policy

h. If all activities for performing a diligent search cannot reasonably be completed within the same month the individual is deemed Missing, the HH+ rate may still be billed for that month so long as the diligent search process commenced within timeframes specified in AOT Program Operation guidance.

i. A missing AOT individual is considered a significant event that must be reported to the LGU within 24 hours, following the LGU's protocol for reporting significant events.

Continued communication with the LGU should be made in order to determine what additional follow-up efforts may be required and shall also be documented clearly in the individual's record.

j. When the examining physician includes HHCM in the court-ordered treatment plan and the individual refuses to enroll in the Health Home, a copy of the AOT order shall be made available to the Health Home, which will then be able to enroll the individual and bill the HH+ rate code. However, the AOT order does not substitute for the individual's consent to share clinical information. Absent such specific consent, the HHCM may share clinical information for care coordination purposes to the extent permitted by section 33.13(d) of the Mental Hygiene law, which provides a limited treatment exception for the exchange of clinical information between mental health providers and Health Homes.

k. The CM will work with the LGU to ensure timely delivery of services as listed in the court order. Such services must include coordination of all categories of service listed in the AOT treatment plan.
l. All categories of service listed in the court-ordered AOT treatment plan shall also be included in the individual's integrated HH plan of care.
m. The CMA and/or other members of the treatment team must consult with the treating physician and the LGU's Director of Community Services or County AOT coordinator, who can then petition to the court for any material change needed to be made to the AOT treatment plan. Any additions or deletions of *categories of service* are considered material changes.
n. Changes needed to other services in the HH plan of care that are not listed in the AOT treatment plan (e.g., primary care services not listed in the AOT treatment plan), are not considered material changes and therefore do not require consult with the LGU.
o. Health Homes and Care Management Agencies shall be familiar with the statutory basis of the AOT program, or Kendra's Law (§9.60 of NYS Mental Hygiene Law), including the requirement that care management is a mandatory service category on every court-ordered treatment plan. This guidance outlines the contact requirements for care management.
p. The CMA shall comply with all reporting requirements of the AOT Program as established by the LGU. Localities may have their own requirements that are above the minimum contact standards of four times per month. Additionally, the CMA must report assessment and follow-up data to the Office of Mental Health (OMH) through the Child and Adult Integrated Reporting System (CAIRS) at 6-month intervals.

F. Care Management Models That Meet HH+ SMI Requirements

1. 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:
   a. One HH+ SMI qualified Care Manager with HH+ Only Caseload:
      - Maximum case load of 20 HH+ Members.
   b. One HH+ qualified Care Manager with Mixed Caseload (HH+ and non-HH+):
      For the purposes of caseload stratification and resource management; a caseload mix of HH+ and non-HH+ is allowable if the HH+ ratio is less than or equal to 20 HH+ recipients to one (1) qualified 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.
   c. Care Management Team providing HH+ Services (must meet the following requirements):
      The required team caseload shall be a maximum of 20 HH+ individuals per one (1) FTE on the team. The team caseload must maintain the ratio of 20 HH+ individuals per each FTE on the team. For every 40 HH+ individuals, the team must have at least one (1) qualified HH+ care manager. For example, a team serving 50 HH+ individuals shall include two (2) qualified HH+ care managers. The table below outlines the number of FTEs to the possible caseload range:

Number of Full-Time Employees	Caseload Range
2	40 HH+ Individuals
3	41-60 HH+ Individuals
4	61-80 HH+ Individuals

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.

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.

G. HH+ Stepdown Requirements

HH+ Stepdown Requirements HHSP's must work with members to devise a Stepdown plan prior to transitioning off of HH+. The member's needs, goals, and objectives should be considered when setting new service level expectations. HHSP's should assist members in developing a plan that assures appropriate service level intensity.

Health Home Service Providers can bill at an enhanced rate while transitioning a member off HH+. The HHSP will indicate on the member's HML that they are part of the HH+ Expanded Population and "NO" the minimum core services were not met. This will trigger the HML to be billed out at the 1874 Rate code ($360.00). The HHSP may bill at this rate code for a period of 6 months.

BCHN recommends that CHN's follow up with MCO's (Fidelis, Excellus, CDPHP, UHC) regarding the specific requirements of putting forth a stepdown plan, which should include a discharge plan and reasons for a reduction in service intensity.

For Fidelis Members, a Health Home Step Down Form must be completed and submitted to *SMHealthHomeInquiry@fideliscare.org*. Additionally, please do the following;

Fidelis Care Health Home Step Down Process

1. **Reason for Health Home Step-Down –** Members who are considered "low acuity" but still require case management will be discharged from the health home program and referred to Fidelis Care.

2. **Lead Health Home notifies Fidelis of member disenrollment** – via the "Health Home Step-Down Form" sent to the Health Home Inbox (SMHealthHomeInquiry@fideliscare.org), which includes:

a) Member demographic information

b) If member is currently connected with a Fidelis CM

c) Whether or not a follow up by a Fidelis CM is required
d) If CM required, specify clinical service or BH referral
e) Note any outstanding needs
f) Attached discharge summary

3. **Internal notification to Fidelis CM department** –The Fidelis Health Home team will monitor the Health Home inbox for referrals and compile disenrollments. These members will be assigned a Fidelis CM within 30 days based on nature of ongoing case management needs.
a) **Warm Hand-off** – If a warm hand-off is requested Fidelis *requires* the submission of "Health Home Step-Down Form" one week prior, to allow for assignment.

4. **CM outreach** – CM will outreach the member within a week of assignment. If unsuccessful, the CM will continue outreach and passive case management weekly for one month (30 days from discharge date from HH).

5. **Follow up** – If member agrees to care management, CM will follow up according to department standard. If member declines case management, CM will passively manage this member for 30 days.
a) If after 30 days, the CM and member determine the member can benefit from returning to health home care management, the CM will contact the Fidelis Health Home team to determine if a health home referral is appropriate.
b) If after 30 days, the CM and member determine the member has successfully transitioned from any need for case management then the case will be closed.
c) If after 30 days, the CM and member determine the member requires ongoing care management, but does not require health home level of care, the CM will continue follow up with member according to department procedure.

Related Forms & Documents:

1. **HH+ Attestation Form**
2. **Fidelis Health Home Step Down Form**